



APPLICATION FOR EMPLOYMENT

Thank you for your interest in KK Dental Associates, LLC. KK Dental Associates, LLC is an equal opportunity employer, we do not discriminate on the basis of age, sex, religion, color, national origin, ancestry, marital status, disability, arrest and court record, sexual orientation, or other protected categories in accordance with state and federal laws. No application will be rejected as a result of a disability that, with reasonable accommodation, does not prevent performance of the essential job duties. If you require accommodation during the employment process, including assistance in the completion of this employment application, please let us know. Failure to fully complete this employment application will result in the application not being processed.

Today's Date:

PERSONAL INFORMATION (Please Print)

Name: (last, first, middle)		Social Security No.:	
Address:		Telephone No.:	Alternate Tel. No.:
City:	State:	Zip Code:	
Email address:		Are You 18 Years Or Older? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DESIRED EMPLOYMENT

Position Applying For:		Date You Can Start:	Salary Desired:
Are You Employed Now? <input type="checkbox"/> Yes <input type="checkbox"/> No	If So, May We Inquire Of Your Present Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ever Applied To This Company Before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?	
Ever Worked For This Company Before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?	
Reason For Leaving:			
Name Of Last Supervisor At This Company:			
Who Referred You To This Company? <input type="checkbox"/> Employment Agency <input type="checkbox"/> Newspaper Advertising <input type="checkbox"/> State Employment Office <input type="checkbox"/> College Placement Service <input type="checkbox"/> Friend <input type="checkbox"/> Walk-In <input type="checkbox"/> Other			

GENERAL INFORMATION

Subjects Of Special Study Or Research Work:
Special Training:
Special Skills:

EMPLOYMENT RECORD

Starting with PRESENT or MOST RECENT employment. Please account for any gaps in employment. If more space is needed, please attach additional sheets.

Company Name:	Position:	Start Date:	Starting Salary:	Ending Salary:
Address:	Telephone Number:	End Date:	Reason for Leaving:	
City/State/Zip Code:	Supervisor Name:		Supervisor Title:	
Duties Performed:				

Company Name:	Position:	Start Date:	Starting Salary:	Ending Salary:
Address:	Telephone Number:	End Date:	Reason for Leaving:	
City/State/Zip Code:	Supervisor Name:		Supervisor Title:	
Duties Performed:				

Company Name:	Position:	Start Date:	Starting Salary:	Ending Salary:
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City/State/Zip Code:	Supervisor Name:		Supervisor Title:	
Duties Performed:				

EDUCATION/TRAINING

	Name of School	Years Completed	Diploma/Degree Certificate
High School			
Technical/Trade			
College/University			
Describe Specialized Training, Apprenticeship, Skills, and Extra-Curricular Activities			

OTHER

Do you have the legal right to work in the United States? Yes No
(If hired, you will be required to provide identification to prove eligibility for employment.)

Have you been employed or attended school using any other name? Yes No
 If yes, please indicate names previously used: _____

Do you have friends or relatives working for the Company? Yes No
 If Yes, who? _____ Relationship to you: _____

Have you previously applied for a position with the Company? Yes No
 If Yes, when and for what position? _____

Are you able to perform the essential functions of the job with or without reasonable accommodations?
 Yes No

If No, please indicate how you can properly and safely perform the duties of the position with the accommodations: _____

Medical Information: After an offer of employment is made, but before employment duties begin, applicants may be required to undergo a physical or medical examination at Company expense and by a Company-chosen physician, with the offer of employment conditioned on the result of such examination. Employees, at any time during the course of their employment, may be required to undergo a medical examination at Company expense and by a Company-chosen physician. I authorize the physician conducting the examination and any laboratory testing any specimen obtained by the physician to disclose results of the examination and the laboratory test to the Company.

Applicant's Initials

Please list any other job skills (e.g. office, computer, or language skills, etc.) you feel are related to the job you are applying for: _____

REFERENCES (other than relatives)

Name	Occupation
Address	Telephone No.
Name	Occupation
Address	Telephone No.

CERTIFICATION (Please read carefully, initial each paragraph, and sign below.)

_____ I certify that I have answered the above questions truthfully and have not withheld any information
initial relative to my application. I understand that any falsification, misrepresentations, or omissions, as well as any misleading statements or omissions of the application information, attachments, and supporting documents generally will result in denial of employment or immediate termination, if discovered after hire.

_____ I consent to and authorize Hawaii Dental Group, Inc. to make a full and complete investigation of my
initial personal or employment history and authorize any former employer, person, firm, corporation, school, credit agency, government agency or other entity to provide Hawaii Dental Group, Inc. with any information of any sort (including fact or opinion) they may have regarding me related to my suitability for employment. In consideration of Hawaii Dental Group, Inc. review of this application, I release Hawaii Dental Group, Inc. and all providers of any information from any liability as a result of furnishing and receiving this information.

_____ If employed by Hawaii Dental Group, Inc., I agree to conform to the guidelines and policies of the
initial Company. I understand that my employment and compensation can be terminated at any time, with or without cause, and with or without notice, at the option of Hawaii Dental Group, Inc., or myself. I understand that the President of the company is the only person who will ever have the authority to create any other terms of employment and/or to enter into any employment contract and that all such contracts must be in writing and signed by both parties. However, I also understand that unless otherwise stated in an employment contract, the company may change, withdraw and interpret other policies (including wages, hours, and working conditions) as it deems appropriate.

_____ I understand and agree that I may be required to submit to a drug testing and a complete post-offer
initial medical examination, as part of my application for employment. I also understand and agree that I may be required to submit to a complete medical examination during my employment with Hawaii Dental Group, Inc., provided that such examination is job-related and consistent with business necessity. Hawaii Dental Group, Inc will pay the cost of such examination. I authorize the physician conducting the examination and any laboratory testing any specimen obtained by the physician or collection site to disclose the results of the examination and the laboratory test to Hawaii Dental Group, Inc. in accordance with state and federal laws. Hawaii Dental Group, Inc will keep such results confidential and disclose the results only to persons who need to know or where required by law. Also, I agree to fully cooperate and provide Hawaii Dental Group, Inc. with any additional consents(s) and/or release(s) as required by Hawaii Dental Group, Inc. to investigate my employment application.

_____ I understand and agree that any offer of employment, my continued employment, and the terms,
initial conditions, and privileges of my employment shall be conditional and terminable based on any arrest, court, or conviction record that I may now have or may have in the future, as provided for in H.R.S. §378-3.

_____ Although Hawaii Dental Group, Inc. makes every effort to accommodate individual preferences,
initial business needs may at times make the following conditions mandatory: overtime, shift work, rotating work schedule, or a work schedule other than the weekdays. I understand and accept these as conditions of my employment.

_____ I understand and agree that all of the foregoing terms and conditions will become part of my
initial employment relationship with Hawaii Dental Group, Inc. if Hawaii Dental Group, Inc employs me.

Authorization/Signature of Applicant: _____ Date: _____