Triumph Pediatric Clinic
4900 Massachusetts Ave, NW
Suite 340
Washington, DC 20003
Ph: 240.339.4976
Fax: 202.396.2437

Triumph Ortho Clinic
1331 H St, NW
Suite 200
Washington, DC 20005
Ph: 240.339.4976
Fax: 202.396.2437

Application for Employment

We are an equal opportunity employer and do not discriminate in employment. No question on this application is used for limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Equal access to employment, services, and programs is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the organization.

Applicant name: ____
Date: ____________________
Position(s) applied for or type of work desired: ____
Address: ____
Street Apartment # City State Zip code
Telephone #: ________________________________
Type of employment desired: _____ full-time _____ part-time _____ PRN
Date available to start work: ____
Are you able to meet the attendance requirements? ☐ Yes ☐ No
Are you willing to work overtime if necessary? ☐ Yes ☐ No
Can you travel if required by this position? ☐ Yes ☐ No
Have you ever been previously employed by our organization before? ☐ Yes ☐ No
Can you submit proof of legal employment eligibility and identity? ☐ Yes ☐ No
If you are under 18, can you furnish a work permit if it is required? ☐ Yes ☐ No
Have you ever been convicted o f a crime in the last 7 years? ☐ Yes ☐ No
If yes, please explain (a conviction will not automatically bar employment):
____
____
Driver's license number (if driving is an essential job duty): __________________________________
How were you referred to us? ____

Employment History

Please provide all employment information for your past three employers starting with the most recent.
You may refer to resume if one is attached.
Employer: ____
Position held: ___________________
Address: ____
Telephone #: ____________________
Immediate supervisor and title: ____
Dates employed: from ________________ to _________________
Salary: _____________________
Job summary: ____
Reason for leaving: ____

Employer: ____

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Position held: ___________________

Address: ____
Telephone #: _______________
Immediate supervisor and title: ____
Dates employed: from _________________ to __________________
Salary: _____________________
Job summary: ____
Reason for leaving: ____

Employer: ____
Position held: ___________________
Address: ____
Telephone #: _______________
Immediate supervisor and title: ____
Dates employed: from _________________ to __________________
Salary: _____________________
Job summary: ____
Reason for leaving: ____

Other Skills and Qualifications
Summarize any job-related training, skills, licenses, certificates, and/or other qualifications:
____
____
____
____
____
____

Educational History
List school name and location, years completed, course of study, and any degrees earned:
High school: ____
College: ____
Other: ____

References:
List 3 professional references with telephone numbers and number of years known:
1.) ____
2.) ____
3.) ____

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I hereby authorize Triumph Therapeutics to contact, obtain, and verify the accuracy of information contained in this application from all previous employers, educational institutions, and references. I also hereby release from liability the potential employer and its representatives for seeking, gathering, and using such information to make employment decisions and all other persons or organizations for providing such information.

I understand that any misrepresentation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate termination of employment if I am employed, whenever it may be disclosed.

If I am employed, I acknowledge that there is no specified length of employment and that this application does not constitute an agreement or contract for employment. Accordingly, either the employer or I can terminate the relationship at will, with or without cause, at any time, so long as there is no violation of applicable federal or state law.

I understand that it is the policy of this organization not to refuse to hire or otherwise discriminate against a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the ADA.

I also understand that if I am employed, I will be required to provide satisfactory proof of identity and legal work authorization within three days of being hired. Failure to submit such proof within the required time shall result in immediate termination of employment.

I represent and warrant that I have read and fully understand the foregoing, and that I seek employment under this condition.

____

Signature of Applicant Date

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CLINICIANS ONLY

_________________________________ **(name of clinic)**

1. Have you ever been the subject of prosecution or convicted of any of the following:

a. Any offense related to the delivery of services under Medicare or Medicaid programs, or any program funded by the Social Security Act (Maternal and Child Health Services Program or the Block Grants to State for Social Services Program)? ☐ YES ☐ NO

b. A criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service? ☐ YES ☐ NO

c. Fraud, theft, embezzlement, or other financial misconduct in connection with the delivery of a health care item or service? ☐YES ☐ NO

d. Obstructing an investigation of any crime stated above? ☐ YES ☐ NO

e. Unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? ☐ YES ☐ NO

2. Have you ever been required to pay any civil monetary penalty due to false, fraudulent, or impermissible claims under any state or federal health care program? ☐ YES ☐ NO

3. Have you ever been required to pay any civil monetary penalty to induce a reduction or limitation of health care services to beneficiaries? ☐ YES ☐ NO

4. Are you currently or have you ever been the subject of any proceeding, which may result in any payments stated in questions 2 and 3? ☐ YES ☐ NO

5. Have you ever been excluded from participation in the Medicare, Medicaid, or Maternal and Child Health Services Program, or any program funded under the Block Grants to States for Social Services Program? ☐ YES ☐ NO

____

Signature of Applicant Date