



Behavioral Optometry • Vision Therapy and Rehabilitation Samantha Slotnick, OD, FAAO, FCOVD

PRE-EMPLOYMENT QUESTIONNAIRE: BACKGROUND AND INTERESTS

LEGAL NAME: _____ DATE: _____

Please call me "_____."

GENERAL INFORMATION:

- Are you looking for full time work? ___ Yes, ___ No .
- Can you work part time? ___ Yes. ___ No.
If YES, how many hours per week? _____ hours Please list below the hours you are available for work.
Monday: _____ Tuesday: _____
Wednesday: _____ Thursday: _____
Friday: _____ Saturday: _____

3. Are you interested in working outside of the office (outreach)? ___ Yes, ___ No .

4. Can you make yourself available for special trainings, if given notice?

5. Areas in our office you want to work or have experience:
(Mark with an "X" if you are interested, and an "E" if you have experience in the area)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Answer phones | <input type="checkbox"/> Assist Dr/patient | <input type="checkbox"/> Billing | <input type="checkbox"/> Calculate fees |
| <input type="checkbox"/> Checking eligibility | <input type="checkbox"/> Cleaning | <input type="checkbox"/> Clean instruments | <input type="checkbox"/> Collect \$/make change |
| <input type="checkbox"/> Collections | <input type="checkbox"/> Communications | <input type="checkbox"/> Comp programming | <input type="checkbox"/> Concierge |
| <input type="checkbox"/> Conflict resolution | <input type="checkbox"/> Coordinate meetings | <input type="checkbox"/> Dispense contacts | <input type="checkbox"/> Dispensing glasses |
| <input type="checkbox"/> Filing records | <input type="checkbox"/> Frame styling | <input type="checkbox"/> Insurance billing | <input type="checkbox"/> Interprofess liaison |
| <input type="checkbox"/> Laboratory work | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Letter writing | <input type="checkbox"/> Make appointments |
| <input type="checkbox"/> Management | <input type="checkbox"/> Manage records | <input type="checkbox"/> Marketing | <input type="checkbox"/> Media coordination |
| <input type="checkbox"/> Monitoring patients | <input type="checkbox"/> Multiple ph lines | <input type="checkbox"/> Patient case history | <input type="checkbox"/> Patient communic |
| <input type="checkbox"/> Patient ph calls | <input type="checkbox"/> Prepping patients | <input type="checkbox"/> Program develop | <input type="checkbox"/> Public relations |
| <input type="checkbox"/> Recalling patients | <input type="checkbox"/> Reception | <input type="checkbox"/> Sales | <input type="checkbox"/> Scheduling |
| <input type="checkbox"/> Speeches | <input type="checkbox"/> Special programs | <input type="checkbox"/> Special testing | <input type="checkbox"/> Sports Vision |
| <input type="checkbox"/> Standard accounting | <input type="checkbox"/> Surveys | <input type="checkbox"/> Teaching patients | <input type="checkbox"/> Testing patients |
| <input type="checkbox"/> Tutoring | <input type="checkbox"/> Triage patients | <input type="checkbox"/> Training staff | <input type="checkbox"/> Use PC computer |
| <input type="checkbox"/> Use tablet/ smartphone | <input type="checkbox"/> Vision Therapy | <input type="checkbox"/> Word processing | <input type="checkbox"/> Work with patients |

6. What visual or medical tests can you conduct? _____

7. What experience do you have working with, caring for, or teaching children? _____

8. What types of patients would you feel comfortable if you were asked to work with them?

Please mark with an "X"

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> physical handicaps | <input type="checkbox"/> infants | <input type="checkbox"/> children |
| <input type="checkbox"/> adults | <input type="checkbox"/> geriatric patients | <input type="checkbox"/> other: _____ |

9. How do you plan to get to work? (Car, bus, other: _____)

10. What foreign languages can you speak to help our non-English speaking patients?
___ Spanish, ___ Portuguese, ___ ASL, ___ Other: _____

11. When can you start if hired?
Date: _____, Are you still employed? ___ Yes, ___ No

12. Why did you leave your last job, or why are you leaving your current job?

13. Were you terminated? ___ Yes, ___ No, When? _____
Why? _____

WORK EXPERIENCE/ SKILLS:

1. Past Job Titles: _____

2. What did you enjoy doing at your previous jobs?

3. What did you dislike doing at your previous jobs?

4. a) We have all experienced conflict sometime in our lives. Describe a conflict you had (with a co-worker, patient, boss...not a family conflict) and what you did to resolve the situation.

b) If this conflict were to arise tomorrow, would you handle it the same way? What might you do differently?

PERSONAL BEHAVIORAL TRAITS

1. What traits do you wish you could overcome?

2. Do you like to visit and talk with your co-workers? ___ Yes, ___ No
Does this ever interfere with work? ___ Yes, ___ No

3. Do you prefer to work as a group or alone? Why?

4. On a scale from 1 to 10, how would you rate yourself in the following areas?

___ Ability to follow instructions	___ Attendance/punctuality	___ Initiative/Self-Management
___ Knowledge of optometry	___ Leadership abilities	___ Organization
___ Personal hygiene	___ Quality of work	___ Speed of work
___ Team/Interpersonal skills		

5. What long-term goals do you have for your career and your future life? (Continued on next page)

6. What situations in your personal life would prevent you from coming to work?

7. How would you describe a "perfect" job for you?

8. Is there anything you would like us to know about you? Why you want this job? Why you are the best person for this job? Or anything at all.

HYPOTHETICAL SITUATIONS

1. A co-worker is not doing her share of the workload. What steps would you take?

2. A patient calls and begins to complain loudly about the bill, insisting on having her account settled immediately. Dr. Slotnick is working with a new patient evaluation. The waiting room has three adults and two children, and there is a patient in the therapy room with a therapist. How would you manage the irate patient?

SALARY INFORMATION

1. What was your salary at your last place of employment? \$ _____ / hour or \$ _____ / month

What benefits did you have at your last job? Circle those that you we can verify you had.
medical, dental, vision, pharmacology What do you think this cost your employer? \$ _____ / month

2. What is the minimum salary you would accept during your training? \$ _____ / hour or \$ _____ / month

Which benefits do you need provided by your employer? Circle those that you want provided.
medical, dental, vision, pharmacology What do you think this will cost your employer? \$ _____ / month

EMPLOYMENT APPLICATION

LEGAL NAME: _____ DATE: _____

ADDRESS: _____

_____ CITY: _____ ZIP: _____

PHONE: _____ ALTERNATE PHONE: _____

RESUME ATTACHED? ___ YES, ___ NO, ___ TO BE MAILED

EDUCATION: (LIST ALL POST HIGH SCHOOL INFORMATION ONLY):

SCHOOL/INSTITUTION	MAJOR OR AREA OF STUDY	DATES ATTENDED	DEGREES EARNED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REFERENCES:

(1 PAST FELLOW EMPLOYEE, 1 FRIEND, 1 INSTRUCTOR, 1 OTHER REFERENCE; NO RELATIVES)

NAME	ADDRESS	PHONENUMBER	YRS KNOWN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMPLOYMENT HISTORY (LIST YOUR PAST EMPLOYERS, ADDRESSES, PHONE NUMBERS, POSITION & DATES OF EMPLOYMENT)

EMPLOYER	CITY	PHONE	POSITION	DATES
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I attest that all information provided on this employment application form and all other forms attached to it are truthful to the best of my knowledge and that I give permission to Dr. Samantha Slotnick. and her management team to contact my references and past employers to determine my qualifications for employment in her office.

Signature of Applicant

Date