

EDUCATION

Include high school, college, and graduate work in order taken:

<u>School</u>	<u>Date of Attendance</u>	<u>Semester Hrs.</u>	<u>Major</u>	<u>Degree</u>

EXPERIENCE

<u>Name of School</u>	<u>Location</u>	<u>Dates</u>	<u>Number Years</u>	<u>Position</u>

PROFESSIONAL REFERENCES

<u>Name</u>	<u>Address & Phone</u>	<u>Position</u>

APPLICANT STATEMENT

I certify that all statements made in this application are true and complete, and that any intentional misstatements of material facts will subject me to disqualification or dismissal. In submitting this application for employment, I authorize an investigation of all statements contained herein.

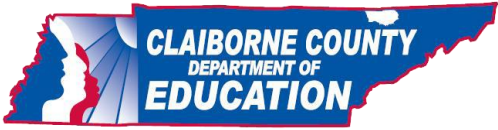
I further certify that I (____ have ____ have not) been dismissed from any previous employment for improper or unprofessional conduct, inefficient service, neglect of duty, incompetence, or insubordination as defined in Tennessee Code Annotated Section 49-5-501. (If "have" is indicated, explain fully the details of each instance of conduct on a separate sheet of paper. The employer's non-renewal of a yearly contract need not be indicated unless the non-renewal was based on one of the factors listed above.)

I understand that any intentional misrepresentation of any of these certifications may subject me to the penalties prescribed in Tennessee Code Annotated Section 49-5-406.

Legal Name (printed): _____

Applicant Signature: _____ Date: _____

---FOR OFFICE USE ONLY---			
Required Documents	YES	NO	References Checked By _____
Background Check Clear	YES	NO	Date of Background Clearance _____
Interview Date _____			Interviewed By _____
Date of Physical Exam _____			
Hire Date _____			Position _____
School _____			



**PHYSICIAN'S CERTIFICATE
FOR CLAIBORNE COUNTY BOARD OF EDUCATION EMPLOYEE**

I, _____, *hereby certify that I am a*
(Physician's Name)

licensed physician in _____ *County, State of Tennessee, and that*
(County)

on _____ *I examined* _____
(Date) (Claiborne County Board of Education Employee)

*and found him/her to be free of any physical ailment, disease, or defect that would disqualify
him/her as an employee of the Claiborne County School System.*

(Signature of Examining Physician)

Printed or stamped name of physician and office address:

NOTE: A tuberculosis x-ray, skin test, or evaluation (screening) is required.

Test Result: _____

(Signature of Health Professional)

(Date)