Work History: Auricular Detoxification Specialist

Date Form Completed:_ __ __ / __ __/ __ __ __ __

1. LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	DEGREE (MD OR DO)

	SEX M F	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YY)
		__ __ __ - __ __ - __ __ __ __	__ __ / __ __/ __ __ __ __ CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

STREET NUMBER	STREET NAME		APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
2. RECORD WORK HISTORY CHRONOLOGICALLY – Complete Work History beginning with present employment and concluding with graduation. You must account for all breaks in work history, including, volunteer work and periods of unemployment. If the work was not related to the practice of auricular detoxification therapy, please list only the name of the business, job title and dates worked. DO NOT list your description of job duties for non-ADT related jobs.			E-MAIL ADDRESS

A. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
TOTAL TIME WORKED _____/_____ MONTH YEAR	**APPROXIMATE NUMBER OF PATIENTS:_____** **APPROXIMATE NUMBER OF PATIENT VISITS:_____**	
B. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
TOTAL TIME WORKED _____/_____ MONTH YEAR	**APPROXIMATE NUMBER OF PATIENTS:_____** **APPROXIMATE NUMBER OF PATIENT VISITS:_____**	

Work History: Auricular Detoxification Specialist (CONTINUED)		
C. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
TOTAL TIME WORKED _____/_____ MONTH YEAR	**APPROXIMATE NUMBER OF PATIENTS:_____** **APPROXIMATE NUMBER OF PATIENT VISITS:_____**	
D. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
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E. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
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