

# MOA Job Posting Submission Form

Start Date \_\_\_\_\_ End Date (if applicable) \_\_\_\_\_

My dates can be flexible (e.g. two weeks in July/August) \_\_\_\_\_

**POSTING STATUS**— please check  all boxes that apply (click the box once if filling out online)

- |                                    |                                    |  |                                    |                                |
|------------------------------------|------------------------------------|--|------------------------------------|--------------------------------|
| <input type="checkbox"/> Permanent | <input type="checkbox"/> Temporary | <input type="checkbox"/> Full-time                                 | <input type="checkbox"/> Part-time | <input type="checkbox"/> Shift |
| <input type="checkbox"/> Casual    |                                    | <input type="checkbox"/> Other (e.g. mat leave/vacation/sick time) | _____                              |                                |

**SCHEDULE** — (day & times, if applicable)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Mo _____ to _____ | <input type="checkbox"/> Tu _____ to _____ | <input type="checkbox"/> We _____ to _____ | <input type="checkbox"/> Th _____ to _____       |
| <input type="checkbox"/> Fr _____ to _____ | <input type="checkbox"/> Sa _____ to _____ | <input type="checkbox"/> Su _____ to _____ | <input type="checkbox"/> Work hours are flexible |

**PRACTICE INFORMATION** — please check  all boxes that apply

- Solo Practice  
  Group Practice  
  Walk-in Clinic  
  Combination (specify) \_\_\_\_\_

Contact Name \_\_\_\_\_

Clinic/Physician Name(s) (optional) \_\_\_\_\_

Area of City \_\_\_\_\_

EMR Name \_\_\_\_\_ eFax Software Name \_\_\_\_\_

**CONTACT INFORMATION**— please fill in all areas and specify  preferred methods of contact for applicants. Please be aware that checked information will be accessible to interested candidates via a public website.

Tel \_\_\_\_\_  Fax \_\_\_\_\_

Email \_\_\_\_\_

**POSTING DESCRIPTION** — describe the practice/position in detail; include patient demographics, # of clinic rooms, physicians, team composition, # of MOAs, and any special considerations.

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**POSTING REQUIREMENTS** — please check  all boxes that apply

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|-------------------|------------------------------|-----------------------------------|-----------------------------------|-------------------------|------------------------------|-----------------------------------|-----------------------------------|
| Reception         | <input type="checkbox"/> n/a | <input type="checkbox"/> Required | <input type="checkbox"/> Optional | <b>Document Linking</b> | <input type="checkbox"/> n/a | <input type="checkbox"/> Required | <input type="checkbox"/> Optional |
| Scheduling        | <input type="checkbox"/> n/a | <input type="checkbox"/> Required | <input type="checkbox"/> Optional | Billing                 | <input type="checkbox"/> n/a | <input type="checkbox"/> Required | <input type="checkbox"/> Optional |
| Management skills | <input type="checkbox"/> n/a | <input type="checkbox"/> Required | <input type="checkbox"/> Optional | Uniform                 | <input type="checkbox"/> n/a | <input type="checkbox"/> Required | <input type="checkbox"/> Optional |

Other requirements \_\_\_\_\_

*\*Please note this posting will be listed on the public side of the Division's website.*