

Virginia Physicians Incorporated

ACKNOWLEDGMENT

ALL APPLICANTS MUST READ AND SIGN THE FOLLOWING:

I certify that the information contained in this application is correct to the best of my knowledge and understand that falsification of this information is grounds for dismissal in accordance with Virginia Physicians, Inc. policy. I authorize the references listed on this application to provide any and all information concerning my previous employment and any pertinent information they have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing the same to you.

In consideration of my employment, I agree to conform to the rules and regulations of Virginia Physicians, Inc. and my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at the option of either the Practice or myself. I understand that no representative of Virginia Physicians, Inc. other than by written representation by the Board of Directors, has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing.

Name: _____

Signature: _____

Date: _____