

**EMPLOYMENT APPLICATION**

In considering your application for employment, the facility may conduct a detailed and thorough investigation which may include but is not limited to a criminal record check, interviews or inquires of prior employers, coworkers, acquaintances, relatives or friends.

LAST NAME			FIRST	MIDDLE	HOME TELEPHONE NO.				
PRESENT ADDRESS			CITY	STATE	ZIP CODE		CONTACT TELEPHONE NO.		
PERMANENT ADDRESS			CITY	STATE	ZIP CODE		E-MAIL ADDRESS (optional)		
ANY PREVIOUS NAMES (S)? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, IDENTIFY ALL OTHER NAMES INCLUDING MAIDEN NAME:						BEST TIME TO CONTACT YOU:		DATE AVAILABLE FOR WORK:	
POSITION APPLIED FOR:				SALARY DESIRED:		CHECK WHAT YOU WOULD YOU CONSIDER WORKING: FULL TIME / REGULAR <input type="checkbox"/> FULL TIME / TEMPORARY <input type="checkbox"/> PART TIME / REGULAR <input type="checkbox"/> PART TIME / TEMPORARY <input type="checkbox"/>			
HOW DID YOU LEARN ABOUT THIS POSITION? (NEWSPAPER, INTERNET, FRIEND, IF OTHER – PLEASE LIST)									
RELATIVES OR FRIENDS EMPLOYED IN THIS FACILITY? YES <input type="checkbox"/> NO <input type="checkbox"/>						WOULD YOU CONSIDER WORKING: <input type="checkbox"/> WEEKENDS/HOLIDAYS YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> ROTATING SHIFTS YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> ON CALL YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> ANY SHIFT YES <input type="checkbox"/> NO <input type="checkbox"/>			
NAME:		DEPT:		RELATIONSHIP:					
HAVE YOU EVER BEEN EMPLOYED BY THIS FACILITY? YES <input type="checkbox"/> NO <input type="checkbox"/> WHEN?				ARE YOU 18 YRS OF AGE OR OLDER? YES <input type="checkbox"/> NO <input type="checkbox"/>					
ARE YOU A U.S. CITIZEN OR AN ALIEN LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES? YES <input type="checkbox"/> NO <input type="checkbox"/>						SHIFT AVAILABILITY (check all that apply): DAYS <input type="checkbox"/> EVENINGS <input type="checkbox"/> NIGHTS <input type="checkbox"/>			
LONG RANGE OCCUPATIONAL GOALS:									
HAVE YOU EVER BEEN CONVICTED OF, OR PLEAD GUILTY TO, A CRIME OTHER THAN A MISDEMEANOR TRAFFIC VIOLATION)? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, WHICH STATE(S), AND EXPLAIN: (You are not required to disclose any SEALED or EXPUNGED criminal records.)									
HAVE YOU EVER BEEN INVOLVED IN THE SUBSTANTIATED ABUSE OR NEGLECT OF CHILDREN OR ADULTS UNDER THE LAWS OF THIS OR ANY OTHER STATE OF THE UNITED STATES? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, WHICH STATE(S), AND EXPLAIN:									
HAVE YOU BEEN SANCTIONED, CITED, REPORTED, OR EXCLUDED FROM PARTICIPATION IN MEDICARE, MEDICAID, OR ANY OTHER HEALTHCARE RELATED LAW OR REGULATION? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN:									
If your answer is "yes" to either of the above, you will not automatically be disqualified from employment consideration, except as required by state or federal law.									

**EDUCATION / SKILLS**

SCHOOL	NAME AND ADDRESS OF SCHOOL	COURSE OF STUDY	CHECK LAST YEAR COMPLETED				DID YOU GRADUATE?	LIST DIPLOMA OR DRGREE	
			1	2	3	4			
HIGH							<input type="checkbox"/> YES <input type="checkbox"/> NO		
COLLEGE							<input type="checkbox"/> YES <input type="checkbox"/> NO		
COLLEGE							<input type="checkbox"/> YES <input type="checkbox"/> NO		
OTHER Business College or Special Courses: (Include Special Military Training, Post Graduate and Nursing)									
AREA(S) OF SPECIALIZATION OR MAJOR INTEREST:					LIST OF OFFICE SKILLS INCLUDING COMPUTER/SOFTWARD EXPERIENCE:				
LIST HEALTH CARE, BUSINESS, OR INDUSTRIAL EQUIPMENT OPERATED:						WORD PROCESSING: (Approx, WPM)			

PROFESSIONAL LICENSES				PROFESSIONAL CERTIFICATIONS			
<input type="checkbox"/> CURRENTLY LICENSED	<input type="checkbox"/> ELIGIBLE FOR LICENSE	LICENSE OR REGISTRATION EVER SUSPENDED, REVOKED OR ON PROBATION?		<input type="checkbox"/> CURRENTLY CERTIFIED			
<input type="checkbox"/> CURRENTLY REGISTERED	<input type="checkbox"/> ELIGIBLE FOR REGISTRATION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> ELIGIBLE FOR CERTIFICATION			
IF YES, EXPLAIN							
TYPE:	STATE:	DATE:	NO:	TYPE:	STATE:	DATE:	
<input type="checkbox"/> CURRENTLY LICENSED	<input type="checkbox"/> ELIGIBLE FOR LICENSE	LICENSE OR REGISTRATION EVER SUSPENDED, REVOKED OR ON PROBATION?		<input type="checkbox"/> CURRENTLY CERTIFIED			
<input type="checkbox"/> CURRENTLY REGISTERED	<input type="checkbox"/> ELIGIBLE FOR REGISTRATION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> ELIGIBLE FOR CERTIFICATION			
IF YES, EXPLAIN							
TYPE:	STATE:	DATE:	NO:	TYPE:	STATE:	DATE:	

**HAMMOND-HENRY HOSPITAL EMPLOYMENT APPLICATION (CON'T)**

**MILITARY/VOLUNTEER SERVICE:**

Briefly describe duties and skills acquired through military or volunteer service: (include dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS EXPERIENCE**

**PROVIDE INFORMATION REGARDING PREVIOUS EMPLOYMENT BEGINNING WITH MOST RECENT EMPLOYER.**

JOB TITLE:	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY (Hr/Mo/Yr):
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EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DUTIES: \_\_\_\_\_  
\_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_

MAY WE CONTACT YOUR CURRENT EMPLOYER?  YES  NO

JOB TITLE:	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY (Hr/Mo/Yr):
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EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DUTIES: \_\_\_\_\_  
\_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_

JOB TITLE:	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY (Hr/Mo/Yr):
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EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DUTIES: \_\_\_\_\_  
\_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_

JOB TITLE:	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY (Hr/Mo/Yr):
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EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DUTIES: \_\_\_\_\_  
\_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_

**PLEASE IDENTIFY AND EXPLAIN ANY GAPS IN EMPLOYMENT LONGER THAN THREE (3) MONTHS:**

\_\_\_\_\_  
\_\_\_\_\_

**HAMMOND-HENRY HOSPITAL EMPLOYMENT APPLICATION (CON'T)**

**LANGUAGE**

**LANGUAGE SKILLS – DO NOT COMPLETE UNLESS REQUESTED**

LANGUAGE	DO YOU?	<input type="checkbox"/> SPEAK:	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> READ:	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> WRITE:	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT
LANGUAGE	DO YOU?	<input type="checkbox"/> SPEAK:	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> READ:	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> WRITE:	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT

**REFERENCES**

**LIST AT LEAST THREE (3) REFERENCES WHO ARE NOT RELATIVES OR EMPLOYERS:**

NAME AND RELATIONSHIP	TITLE	COMPANY NAME AND ADDRESS	TELEPHONE #

**SIGNATURE**

**CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW**

I hereby affirm that the information provided on this application (and accompanying resume, if any) is true and complete. I understand that any false or misleading representations or omissions made on the application or during the hiring process may disqualify me from further consideration for employment and may result in discharge even if discovered at a later date.

I understand that employment may be conditioned upon successfully passing a medical examination and that I may be required to satisfactorily complete a drug screening as a condition of employment.

I hereby authorize persons, schools, my current employer (if applicable) and previous employers and other organizations to provide this facility and its affiliates with any requested information regarding my application or suitability for employment, and I completely release all such persons or entities from any and all liability related to the providing or use of such information.

I understand that my employment is at-will which means that I may terminate the employment relationship at any time and for any reason with or without notice, and that the facility has the same right. I understand that no one has the authority to enter into any agreement contrary to the preceding sentence, except for a written agreement signed by an administrative representative of this facility and notarized.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY**

HIRED? Yes  No  SEE COMMENTS BELOW

REFERENCES CHECKED AND BY WHOM:	REFERENCE #1	DATE	REFERENCE #2	DATE	REFERENCE #3	DATE

PERSONNEL NOTES (please keep all information factual) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

IF APPLICANT IS 18 YRS. OLD OR LESS, IS PROOF OF AGE ON FILE? Yes <input type="checkbox"/> No <input type="checkbox"/>	INTERVIEWERS SIGNATURE
STARTING DATE <input type="checkbox"/> EXEMPT <input type="checkbox"/> NON-EXEMPT	COMPLETION OF EVALUATION PERIOD DATE APPROVED BY
DEPARTMENT COST CENTER	SIGNATURE
POSITION/JOB SITE	<input type="checkbox"/> FULL TIME <input type="checkbox"/> ONCALL STATUS <input type="checkbox"/> PART TIME <input type="checkbox"/> ROTATION
STARTING SALARY/GRADE DIFFERENTIAL	SHIFT EMPLOYEE NUMBER
NOTIFY IN CASE OF EMERGENCY NAME RELATIONSHIP	ADDRESS TELEPHONE #

Hammond-Henry Hospital is an Equal Employment Opportunity Employer.  
 We comply with all applicable state and federal civil rights and equal employment laws and regulations.