APPLICATION FOR EMPLOYMENT

Date of Application _____ Position(s) applying for _____

Equal opportunity is given to all applicants regardless of race, color, age, sex, religion, national origin, disability, pregnancy, genetic information, and military or veteran status.

This application shall become void after 30 days but can be reactivated for an additional 30 days by written request of the applicant.

PERSONAL INFORMATION

Name _____
First Middle Last

Address _____
Number Street City State

Home Phone_____ Cell Phone _____ Email_____

Salary Required _____ Date available to start work if a position is offered _____

- Are you at least 18 years of age? □ Yes □ No
- Have you ever applied for work here before? □ Yes □ No If yes, when? _____
- Have you ever worked here before? □ Yes □ No If yes, when? _____
- Are you either a U. S. citizen or an alien who has the legal right to work in the U. S.? □ Yes □ No
- Have you ever been convicted of a crime or pled guilty or nolo contendere to a charge involving moral turpitude, abuse, assault, battery, arson, larceny, robbery, burglary, sex offenses (including gratification of lust), identity theft, possession or sale of drugs, murder, manslaughter, or any other crime involving a vulnerable adult or child? □ Yes □ No
- If yes, explain? _____
- Are you able to perform the essential functions of the position(s) for which you are applying with or without a reasonable accommodation? □ Yes □ No
- Do you have a reliable means of transportation to work? □ Yes □ No
- Do you have personal or other obligations that would cause you to miss work? □ Yes □ No
  If yes, explain? _____
- If hired, will you be engaged in any other work, business, or school? □ Yes □ No If yes, explain? _____
  _____
- How did you find out about this position? □ Current Employee □ Job Posting □ Newspaper Ad □ Our Website □ Social Media □ Other _____
- Name of person that referred you? _____
- Do you have relatives working for our Facility? □ Yes □ No If yes, provide name(s) _____
  _____

1. If offered a position, the Immigration Reform and Control Act of 1986 requires you to furnish proof of your employment authorization and your identity before you begin work.
2. If offered a position, a background check, including a criminal record check, will be conducted.

Shift & Travel Availability

- Schedules you can work? (Check all that apply) □ Day □ Evening □ Night □ Rotating □ Weekend □ Holiday
- Employment Status Desired? □ Full Time □ Part Time □ PRN □ Temporary

- How often are you willing to travel? □ Day Only □ None □ Some □ Often
  □ Overnight □ None □ Some □ Often

License and Registration Information for Nurses and Professional Individuals

State	License Number	Expiration Date	Type

Have you ever had or do you currently have a restricted license? □ Yes □ No If yes, explain _____

_____

EDUCATIONAL INFORMATION – Include Military Education and Training

Education	Name and Address of School	# Years Completed	Graduated (Yes or No)	Degree/Major
High School				
College				
Graduate School				
Special Training				

Employment History—Account for all employment, Starting with the most recent job. You may attach additional pages if necessary.

Company Name & Address	# Years Employed	Final Position	Supervisor's Name & Contact number	Describe Duties	Salary	Reason for Leaving

Military Service? Branch:	# Years Served:	Rank Achieved	Duties

Were you honorably discharged? If no, explain.

May we contact your current employer? □ Yes □ No

SPECIALIZED HEALTHCARE & OFFICE EXPERIENCE

Years	Years	Years	Years
□ Nurse Supervisor	□ Security	□ Transportation	□ Secretarial/Clerical
□ Registered Nurse	□ Food Service	□ Laboratory Tech	□ Accounting
□ Practical Nurse	□ Housekeeping	□ Maintenance	□ Bookkeeping
□ Nurse Aide	□ Laundry	□ Electrical Maintenance	□ Cashier
□ EKG/EEG Tech	□ Physical Therapy	□ Heating & Air	□ MS Word
□ Respiratory Therapy	□ Physical Therapy Aide	□ Pharmacy Tech	□ MS Excel
□ Radiological Tech	□ Occupational Therapy	□ Purchasing	□ MS PowerPoint
□ Unit Secretary	□ Medical Records	□ Human Resources	□ Information Technology
□ Surgery Tech	□ Coding/Billing	□ Public Relations	□ Other _____

Applicant Name: _____ Date: _____
Last First M.I.

I authorize North Sunflower Medical Center, or its agents, to obtain any information about my work history or personal information, including my character and qualifications, credit rating, driving record, criminal record, education and previous employment. I authorize all persons, schools, companies, information service bureaus, governmental agencies and law enforcement authorities to release any information concerning my background to North Sunflower Medical Center, whether or not it is in their records. I also authorize North Sunflower Medical Center to obtain this information from any company that is in the business of providing applicant background checks. I hereby release the individuals or entities providing this information from all liablity of any damage caused by issuing this information.

_____ _____
Date Signature of Applicant

Please provide at least three (3) work references: References could be contacted by personnel of North Sunflower Medical Center (supervisors or administration). These references should be able to provide accounts of your character and/or qualifications to perform the job for which you are applying. Please be assured that all information obtained from these references will be held in strict confidence.

Name of Contact: _____
Title: _____ Phone: _(___)_____
Company: _____
Address: _____
Street Address *Apartment/Unit #*
_____
City *State* *Zip Code*

Name of Contact: _____
Title: _____ Phone: _(___)_____
Company: _____
Address: _____
Street Address *Apartment/Unit #*
_____
City *State* *Zip Code*

Name of Contact: _____
Title: _____ Phone: _(___)_____
Company: _____
Address: _____
Street Address *Apartment/Unit #*
_____
City *State* *Zip Code*

READ CAREFULLY

DISCLOSURE AND AUTHORIZATION TO RELEASE CONSUMER INFORMATION

In connection with your employment or application for employment with Healthcare Facility, a consumer report may be obtained. A consumer report includes any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. By signing this form below, you hereby authorize Healthcare Facility and any of its agents, to obtain a consumer report on you.

I HEREBY AUTHORIZE HEALTHCARE FACILITY, AND ANY OF ITS AGENTS, TO OBTAIN A CONSUMER REPORT ON ME.

_____ DATE

_____ SIGNATURE OF APPLICANT/EMPLOYEE

READ CAREFULLY

I certify that the answers given by me to the foregoing questions and statements are true and complete to the best of my knowledge, and that I have withheld nothing that would, if disclosed, affect this application unfavorably. I acknowledge that misrepresentation or omission of facts called for in this application is cause for my not being hired or my termination at any time without prior notice to me.

I authorize Healthcare Facility to release to other prospective employers or information service bureaus, any information regarding my employment with Healthcare Facility or the information set forth in this application or gained by Healthcare Facility from any other companies, agencies, schools or persons named in this application, including information regarding my employment, character, qualifications and other information they may have regarding me, whether or not it is in their records. I hereby release Healthcare Facility from all liability for any damage caused by issuing this information to outside individuals.

If employed, I agree as a condition of continued employment to acquaint myself with, and to abide by all Rules, Regulations and Policies as established or amended by Healthcare Facility. However, I understand that any employment is at-will which means that my employment and compensation can be terminated with or without notice at any time, and for any reason other than an illegal reason, at the option of Healthcare Facility or myself. Nothing in this Application of Employment or the regulations and policies of the Healthcare Facility should be construed to constitute a contract of employment between Healthcare Facility and the applicant. I understand that no Healthcare Facility representative, other than the Administrator, in writing, has any authority to enter into an agreement for employment for any specified period of time, or to make any agreement contrary to this policy. I understand that my terms and conditions of employment may be changed at any time with or without notice to me.

If I am employed, I further understand and agree that when my employment is terminated for any reason, I must return all of the Healthcare Facility's property in my custody, including, but not limited to, any documents, Healthcare Facility equipment, office keys, manuals, identification cards and name badges before I am entitled to final payment of any amounts due me on separation. I also understand that the value of these items, if not returned, along with any monies I might owe Healthcare Facility, may be deducted from my final paycheck; to the extent as allowed by law.

_____ _____

DATE SIGNATURE OF APPLICANT

READ CAREFULLY

AUTHORIZATION TO RELEASE EMPLOYMENT AND EDUCATION RECORDS

I, _____, hereby authorize Healthcare Facility, or its agents, to obtain all records and/or information relating to my education and employment history. I hereby authorize all persons, entities or agencies possessing records and/or information relating in any way to my education and employment history to release all such information to Healthcare Facility's Human Resources Department.

I hereby release Healthcare Facility, and its agents, from any and all liability related in any way to its request or receipt of the information authorized herein, and I do also hereby release any and all persons, entities or agencies possessing records and/or information relating in any way to my education and employment history for any and all liability related in any way to the release of information in accordance with this Authorization.

_____ _____

DATE SIGNATURE OF APPLICANT