

ASHLEY COUNTY MEDICAL CENTER

P.O. Box 400, Crossett, AR 71635

(870) 364-4111

APPLICATION FOR EMPLOYMENT

THIS HOSPITAL IS AN EQUAL OPPORTUNITY EMPLOYER. FEDERAL AND STATE LAWS PROHIBIT DISCRIMINATION IN EMPLOYMENT PRACTICES BECAUSE OF RACE, COLOR, RELIGION, AGE, SEX, NATIONAL ORIGIN OR HANDICAP. NO QUESTIONS ON THIS APPLICATION ARE ASKED FOR THE PURPOSE OF LIMITING OR EXCLUDING ANY APPLICANT'S CONSIDERATION FOR EMPLOYMENT.

POSITION DESIRED

POSITION DESIRED _____

TODAY'S DATE _____

SOURCE OF REFERRAL

- CONTACTED ON MY OWN OTHER _____
 CURRENT EMPLOYEE _____
 NEWSPAPER AD _____
 STATE EMPLOYMENT AGENCY _____
 SCHOOL PLACEMENT SERVICE _____

NAME

NAME (PRINT) LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
IF YOU CANNOT BE REACHED AT ABOVE PHONE NUMBER, WHERE MAY WE CONTACT YOU _____				
HAVE YOU EVER WORKED FOR THIS HOSPITAL? () NO () YES				
IF YES, WHEN AND WHAT DEPARTMENT _____				
HAVE YOU PREVIOUSLY APPLIED FOR EMPLOYMENT HERE? () YES () NO; IF YES, WHEN? _____				
LIST ANY FRIENDS EMPLOYED AT THIS HOSPITAL _____				
LIST ANY RELATIVES EMPLOYED AT THIS HOSPITAL _____				
ARE YOU 18 YEARS OF AGE OR OLDER? _____				
NOTIFY IN EMERGENCY _____ ADDRESS _____				
PHONE _____				

PERSONAL

ARE YOU A U.S. CITIZEN OR AN ALIEN LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES? () YES () NO
HAVE YOU EVER BEEN CONVICTED (OR PLEADED GUILTY) OF A CRIME (OTHER THAN MINOR TRAFFIC VIOLATIONS)? () YES () NO; IF YES, EXPLAIN: _____
A CONVICTION DOES NOT AUTOMATICALLY DISQUALIFY YOU FROM EMPLOYMENT.
HAVE YOU EVER USED OR BEEN KNOWN BY ANOTHER NAME(S) () NO () YES
IF YES, PLEASE LIST NAMES AND DATES _____

A RESUME OF YOUR EMPLOYMENT RECORD WILL NOT BE ACCEPTED IN LIEU OF THE INFORMATION BELOW; HOWEVER, A RESUME MAY BE INCLUDED AS A SUPPLEMENT TO THE APPLICATION.
 EMPLOYMENT HISTORY MAY WE CONTACT THESE EMPLOYERS? () YES () NO

List all jobs and activities, including part-time employment while in school, U.S. Military Service, Self-Employment and Volunteer Work. Begin with the most recent.

EMPLOYER (PRESENT OR MOST RECENT)		STREET ADDRESS, CITY, STATE, ZIP	
AREA CODE / PHONE NUMBER		SUPERVISOR (NAME AND TITLE)	
YOUR JOB TITLE		FROM (MO./YR.)	TO (MO./YR.)
DESCRIPTION OF YOUR DUTIES		BASE SALARY RATE*	
		START \$ _____ PER _____	
		END \$ _____ PER _____	
REASON FOR LEAVING		*BASE PAY IS YOUR BASIC RATE OF PAY EXCLUDING OVERTIME PREMIUMS, SPECIAL BONUSES OR ALLOWANCES. THE RATES YOU INDICATE MAY BE CHECKED WITH FORMER EMPLOYERS.	
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EMPLOYMENT HISTORY

REFERENCES

TECHNICAL REFERENCES

LIST TWO PEOPLE FAMILIAR WITH YOUR WORKING / TECHNICAL ABILITY, WHO WE MAY CONTACT.
EXCLUDE RELATIVES.

NAME	BUSINESS OR POSITION	ADDRESS	(AREA CODE) PHONE

MAY WE CONTACT YOUR PRESENT EMPLOYER FOR REFERENCES () NO () YES

MAY WE CONTACT YOU AT YOUR PRESENT PLACE OF EMPLOYMENT () NO () YES

IF YES, PLEASE ENTER YOUR AREA CODE / PHONE NO. _____ EXT. _____

U.S. MILITARY SERVICE

HAVE YOU SERVED IN THE U.S. MILITARY () NO () YES DATES _____

IF YES, PLEASE DESCRIBE ANY SPECIALTY TRAINING RECEIVED

EDUCATION & TRAINING

SCHOOLS	NAME AND ADDRESS OF INSTITUTION ATTENDED / ATTENDING	NUMBER OF YEARS COMPLETED	GRADUATED		DEGREE RECEIVED	GRADE AVERAGE	AREAS OF SPECIALIZATION
			YES	NO			
HIGH SCHOOL							
COLLEGE							
OTHERS							

OTHER TRAINING OR DEGREES

SCHOOL(S) _____ CITY _____ STATE _____

COURSE _____ DEGREE EARNED _____

PROFESSIONAL LICENSES AND CERTIFICATES

TYPE	STATE	NUMBER	EXPIRATION DATE

PLEASE CHECK AREAS IN WHICH YOU HAVE HAD EXPERIENCE OR TRAINING

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> TYPING SPEED _____ WPM | <input type="checkbox"/> CRT | <input type="checkbox"/> NUCLEAR MEDICINE | <input type="checkbox"/> CORONARY CARE |
| <input type="checkbox"/> SHORTHAND _____ WPM | <input type="checkbox"/> KEY PUNCH | <input type="checkbox"/> ULTRA SOUND | <input type="checkbox"/> PEDIATRICS |
| <input type="checkbox"/> DICTATING MACHINE | <input type="checkbox"/> PBX OPERATOR | <input type="checkbox"/> CHEMISTRY | <input type="checkbox"/> EMT |
| <input type="checkbox"/> BOOKKEEPING | <input type="checkbox"/> RECEPTIONIST | <input type="checkbox"/> BACTERIOLOGY | <input type="checkbox"/> CENTRAL SUPPLY |
| <input type="checkbox"/> ACCOUNTING | <input type="checkbox"/> MEDICAL TRANSCRIPTION | <input type="checkbox"/> BLOOD BANKING | <input type="checkbox"/> OR / RECOVERY |
| <input type="checkbox"/> MEDICAL TERMINOLOGY | <input type="checkbox"/> DATA PROCESSING | <input type="checkbox"/> EKG | <input type="checkbox"/> ORTHOPEDICS |
| <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> STOCK RECEIVING & SHIPPING | <input type="checkbox"/> EEG | <input type="checkbox"/> EMERGENCY ROOM |
| | <input type="checkbox"/> HOUSEKEEPING / CUSTODIAL | <input type="checkbox"/> ICU | <input type="checkbox"/> MEDICAL / SURGICAL |
| | <input type="checkbox"/> DIETARY / FOOD SERVICE | <input type="checkbox"/> NURSING AIDE / ORDERLY | |

EDUCATIONAL / SKILLS

UNEMPLOYMENT PERIODS

(During past 5 years) If there are any unemployment periods of a month or more between schooling, military or employed periods, please list the dates, along with the names and addresses of persons other than relatives who can confirm this information.

FROM (MO. / YR.)	TO (MO. / YR.)	NAME (LAST, FIRST)	ADDRESS (CITY, STATE, ZIP)

Occasionally the form of an application blank makes it difficult for an individual to adequately summarize his / her complete background. To assist us in finding the proper position for you in our hospital, use the space below to summarize any additional information necessary to describe your full qualifications.

CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW.

APPLICANT'S AGREEMENT

I hereby certify that the foregoing statements are true and correct to the best of my knowledge, and I grant the Hospital permission to verify all information. I understand that any misleading or false statements or omission of pertinent information from this application may be considered as sufficient cause for rejection of this application, or for dismissal if discovered subsequent to my employment. I authorize past employers, doctors, and all listed references to give information they may have regarding me and I release them and their organizations from all liability for any damages whatsoever for issuing same.

I hereby consent to a pre-employment physical including drug and alcohol testing. If I am hired, I hereby consent to any future examinations that include drug and alcohol testing that may be required by the Hospital. I understand that my failure to submit to any physical examination including drug and alcohol testing may result in my termination of employment.

If employed by Ashley County Medical Center I will comply with all the rules, regulations and policies of this Hospital and the unit or department where I am assigned. I also understand that my employment is for an indefinite term and is terminable at any time, by either myself or the Hospital for any reason. I understand that no management official has any authority into any agreement contrary to the foregoing or make any oral assurance or promise of continued employment.

If employed, I agree to accept changes in assignments of shifts and to accept scheduled vacation time so that the needs of the Hospital and patients are met.

I UNDERSTAND THAT THIS APPLICATION FOR EMPLOYMENT IS ONLY ACTIVE FOR 30 DAYS AND THEN I MUST REAPPLY BY COMPLETING A NEW APPLICATION.

SIGNATURE

(Applicant's Signature)

Date

FOR DEPARTMENT USE ONLY	
DATE TO START WORK _____	DEPARTMENT _____
RATE OF PAY _____ GRADE _____	COST CENTER # _____
YEARS OF EXPERIENCE CREDIT _____	JOB TITLE _____
SHIFT (CIRCLE ONE) DAYS EVENINGS NIGHTS 7p 7a	
HOURS PER PAY PERIOD _____	STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PERMANENT
REHIRE () YES	<input type="checkbox"/> PART TIME <input type="checkbox"/> TEMPORARY
	<input type="checkbox"/> PRN