



**EDUCATION**

Schools Attended	Name and Address of School	Select Last Year Completed	Did you Graduate?	Type of Degree or Certificate Received	Major Course of Study and Your Name While Attending
High School		<input type="checkbox"/> 9	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diploma <input type="checkbox"/> GED	
		<input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12			
Jr. College Vocational or Military Training		<input type="checkbox"/> 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate	
		<input type="checkbox"/> 2			
College or University		<input type="checkbox"/> 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate	
		<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
Graduate School		<input type="checkbox"/> 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate	
		<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			

**OFFICE SKILLS**

Check those with which you have experience:

- Word     Excel     E-mail     Medical Terminology     Keyboarding Speed \_\_\_\_\_ wpm  
 Switchboard     Medical Transcription     Shorthand Speed \_\_\_\_\_ wpm

List any special skills or qualifications which you feel are relevant to the job for which you are applying:

\_\_\_\_\_

**PROFESSIONAL LICENSES and/or CERTIFICATIONS**

License/Registration #	Organization or State Issued	Profession	Date Issued	Expiration Date
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_____	_____	_____	_____	_____
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Any Restrictions on your License?  Yes  No If yes, explain \_\_\_\_\_CPR Certified?  Yes  No NRP Certified?  Yes  No Other Certifications?  Yes  NoACLS Certified?  Yes  No Please list \_\_\_\_\_Are you currently on the Nursing Assistant Registry?  Yes  No**MILITARY**Were you in the Armed Forces?  Yes  No If yes, what Branch \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_ Rank at Discharge \_\_\_\_\_

What were your duties? \_\_\_\_\_

Did you receive any specialized training?  Yes  No If yes, describe \_\_\_\_\_**LANGUAGE**

_____	Speak <input type="checkbox"/> Yes <input type="checkbox"/> No	Read <input type="checkbox"/> Yes <input type="checkbox"/> No	Write <input type="checkbox"/> Yes <input type="checkbox"/> No
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**EMPLOYMENT RECORD (List last or present position first)**

Present and Former Employers	Dates Employed	Salary Range	Position & Duties
<b>Name of Present or Last Employer</b>	From	Starting	
Address			
City/State/Zip	To	Ending	Your name when working there
Supervisor Phone			Reason for Leaving
<b>Name</b>	From	Starting	
Address			
City/State/Zip	To	Ending	Your name when working there
Supervisor Phone			Reason for Leaving
<b>Name</b>	From	Starting	
Address			
City/State/Zip	To	Ending	Your name when working there
Supervisor Phone			Reason for Leaving
<b>Name</b>	From	Starting	
Address			
City/State/Zip	To	Ending	Your name when working there
Supervisor Phone			Reason for Leaving

**GENERAL INFORMATION**

If hired, you will be required to provide documentation verifying citizenship or eligibility to work in the U.S.

Please list, sequentially, all the names by which you have been known \_\_\_\_\_

If hired, can you furnish proof that you are you, at least 18 years of age, or if under 18, do you have a permit to work?

Yes  No

Do you have any commitments to another employer? If yes, please state with whom and explain how they may affect your employment with our facility?

Yes  No \_\_\_\_\_

Have you ever been convicted of or pleaded guilty to a crime (felony), or are any other criminal charges pending against you?

Yes  No

If yes, for what, when and where? \_\_\_\_\_

*Conviction of a criminal offense will not necessarily preclude your employment.*

Have you ever been excluded from providing services to Medicare or Medicaid patients/clients?

Yes  No \_\_\_\_\_

**REFERENCES**

Are you Employed Now?  Yes  No May We Communicate with your Present Employer?  Yes  No  
List three professional references (no relatives) we may contact.

Name	Address	City, State, Zip	Phone
Name	Address	City, State, Zip	Phone
Name	Address	City, State, Zip	Phone

Names of friends or relatives employed by this Facility:

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

**EMPLOYMENT UNDERSTANDING**

*Please read the following statements carefully before you initial each paragraph and sign your name.*

**"I HEREBY CERTIFY that the answers given by me to the above questions and statements are true and correct and hereby voluntarily authorize this Facility to contact references, past or present employers, persons, schools, law enforcement agencies and any other sources of information which may be relevant to my application for employment. Further, I release from all liability or responsibility all persons, companies or corporations supplying such information. I voluntarily grant this release to support my application for employment at Memorial Hospital & Hancock County Senior Services and agree to inform the Facility of any special concerns I may have related to information which may be discovered during this investigation in the space below. I further understand that all information and documents acquired by Memorial Hospital & Hancock County Senior Services will be maintained as confidential by the Facility, and that the Facility will not release such information to me. It is understood and agreed that any misrepresentation, false statement, or omissions by me in this Application will be sufficient reason for rejection of my application or for dismissal at any time during my employment, without liability to this Facility. I have read, understand and agree to the above statement. (Please initial here). \_\_\_\_\_**

**I further understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that no representative of the Facility has the authority to enter into any agreement for employment for any specified period of time and that this Facility is not guaranteeing employment for anyone. No employment contract is created by virtue of my being hired by this Facility. I have read, understand and agree to the above statement. (Please initial here). \_\_\_\_\_**

**If employed, I agree to abide by all of the work and safety rules of the Facility. If employed, I will be required to complete an Employment Verification Form (I-9). I agree to any and all pre-placement assessment(s) as may be deemed necessary by Memorial Hospital & Hancock County Senior Services, and further understand that my employment is contingent upon my completion of the Facility pre-placement assessment. I understand that this Facility is committed to maintain a drug-free workplace. I am aware that the Facility may require a drug test as part of the hiring process. Also, if employed, I realize that the Facility may conduct post-accident and reasonable suspicion drug and/or alcohol testing of its employees. I have read, understand and agree to the above statement." (Please initial here). \_\_\_\_\_**

**As a condition of employment and in accordance with patient safety standards require all persons to have an annual influenza vaccination or to complete a statement of declination for qualified exemption. (Please initial here). \_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**