

HOSPITAL JOB APPLICATION FORM

Note: To be considered for employment, all sections of the application must be completed, signed and dated.

PLEASE PRINT

Position Applied For: _____ Date Submitted: _____

Last Name First Name Last 4 Digits of Social Security #

Present Address Telephone #

City State Zip Code

E-Mail Address

PERSONAL INFORMATION:

<p>Are you 18 years of age or older? Yes: _____ No: _____ (If no, state age: _____)</p> <p>If under 18 you will need to provide a work permit.</p>	<p>How did you hear about Hospital employment opportunities?</p> <p>Advertisement: _____ Friend: _____ Website: _____ Walk in: _____ Employee: _____</p> <p>Name of friend/employee: _____</p>
<p>Are you on the GSA/OIG or OMIG Exclusion lists? Yes: _____ No: _____</p> <p>If yes, give details: _____ _____</p>	

Position Applied For: _____

Shift Preferred: Day ___ Evening ___ Night ___ Full Time ___ Part Time ___ Per Diem ___

What date will you be available to begin employment? _____

Would you be interested in Temporary Employment? _____

Rate of pay expected? _____

Have you ever been employed at Hospital?

Yes: _____ No: _____

If yes, give dates: _____

EDUCATION:

Education	Name & Address	Did you graduate?	Diploma or Degree
High School/ GED _____		Yes _____ No _____	
College _____		Yes _____ No _____	
Other School _____		Yes _____ No _____	

Computer Skills:
MS Office _____
Outlook _____
Other _____

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS:

If Licensed, Registered or Certified:

Type: _____ State Issued: _____ No. _____

Type: _____ State Issued: _____ No. _____

Type: _____ State Issued: _____ No. _____

PREVIOUS WORK EXPERIENCE: (List current position first): Attach additional sheets if necessary

Employer	Dates		Work Performed
	From	To	
Address			
Job Title			
Supervisor: (not to obtain salary information)		Telephone No.:	
Reason for Leaving:			
Employer	Dates		Work Performed
Address	From	To	
Job Title			
Supervisor: (not to obtain salary information)		Telephone No.:	
Reason for Leaving:			