

APPLICATION FOR EMPLOYMENT

| POSITION APPLYING FOR (1) | | | | Date: | | Time: | |
|--|----------------------------|---|--------------------------------------|---|--------|--|--|
| This application shall become void after 30 days but can be reactivated for an additional 30 days by written request of the applicant. | | Name (First, Middle, Last) | | | | "Equal opportunity is given to all applicants regardless of race, creed, color, national origin, sex, age or individuals with disabilities." | |
| | | Have you worked under any other name or SS #? | | | | | |
| Address (Number, Street, City, State and Zip) | | | | | | Area Code - Phone No. | |
| Education | Name and Address of School | Years (2) Attended | Graduated | | Date | Degree / Major | |
| | | | Yes | No | | | |
| High School | | | | | | | |
| College | | | | | | | |
| Graduate School | | | | | | | |
| Special Training | | | | | | | |
| Are you over the age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Ever applied for work here before? _____ If so, when? _____ | | Are you either a U.S. citizen or an alien who has the legal right to work in the job for which you are applying? (3) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | Please list relative and/or friends working here: | | | |
| Who referred you to us? | | Have you ever been convicted of a crime? If yes, explain (4) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Work History: Account for all employment, including period of unemployment. Start with the most recent. (You may attach additional pages if necessary) | | | | | | | |
| Dates | | Company and Address | Supervisor's Name and Final Position | Describe Duties | Salary | Reason for Leaving | |
| From | Thru | | | | | | |
| | | | | | | | |
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| | | | | | | | |
| May we contact your current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Have you ever been displaced or discharged by a previous employer because of absenteeism, tardiness, or any other non-attendance of work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Military Experience Branch | | From | Thru | Rank Achieved | | Special Schools or Training | |

1. If applying for more than one position, an application for each position must be submitted by the applicant.
2. The Age Discrimination in Employment Act of 1967, as amended, prohibits discrimination on the basis of age with respect to individuals who are 40 years old or older. The dates designated for school attendance will be used strictly for the purpose of verifying application information and obtaining references.
3. 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.
4. Criminal history record checks will be required as provided by and conducted in accordance with Mississippi Code Annotated Section 43-11-13 and the "Minimum Standards of Operation for Mississippi Hospitals" adopted by the Mississippi State Department of Health, Health Facilities and Certification Division.

Shift and Travel Availability

What hours are you willing to work?
 Day (7 to 3) Evening (3 to 11) Night (11 to 7) Other
 Extended Day (7 a.m. to 7 p.m.) Full Time
 Extended Night (7 p.m. to 7 a.m.) Part-time
 Are you willing to work overtime? Yes No

Are you willing to work Saturday, Sunday and Holiday?
 No Rotate Occasional

Date available to start work? _____

How often are you willing to travel?
 Day only Some Often None
 Overnight Some Often None

How far do you live from here? _____

Do you have a means of transportation to get to and from work?
 Yes No

Do you have personal or other obligations that would cause you to frequently miss work? Yes No If Yes, explain _____

If hired will you be engaged in any other work, or business, or school?
 Yes No If Yes, hours _____

Days _____ nature of work. _____

What salary do you require? _____

License and Registration Information for nurses and professional individuals

| State | License Number | Dates | Type |
|-------|----------------|-------|------|
| | | | |
| | | | |
| | | | |

SPECIALIZED HOSPITAL EXPERIENCE

SPECIALIZED OFFICE EXPERIENCE

- | | |
|---|--|
| <input type="checkbox"/> Supervisor Nurse _____ | <input type="checkbox"/> Security Guard _____ |
| <input type="checkbox"/> Registered Nurse _____ | <input type="checkbox"/> EKG Technician _____ |
| <input type="checkbox"/> Practical Nurse _____ | <input type="checkbox"/> Inhalation Therapist _____ |
| <input type="checkbox"/> Nurse's Aide _____ | <input type="checkbox"/> Radiology _____ |
| <input type="checkbox"/> Orderly _____ | <input type="checkbox"/> X-Ray Technician _____ |
| <input type="checkbox"/> Food Service _____ | <input type="checkbox"/> X-Ray Aide _____ |
| <input type="checkbox"/> Chef/Cook _____ | <input type="checkbox"/> Physical Therapy Aide _____ |
| <input type="checkbox"/> Housekeeping _____ | <input type="checkbox"/> Medical Transcript _____ |
| <input type="checkbox"/> Laundry _____ | <input type="checkbox"/> Medical Record Clerk _____ |
| <input type="checkbox"/> Porter _____ | <input type="checkbox"/> Medical Secretary _____ |
| <input type="checkbox"/> Window Cleaner _____ | <input type="checkbox"/> Switchboard _____ |
| <input type="checkbox"/> Laboratory Tech. _____ | <input type="checkbox"/> Pharmacy Asst. _____ |
| <input type="checkbox"/> Maintenance Mech _____ | <input type="checkbox"/> Purchasing _____ |
| <input type="checkbox"/> Engineer/Fireman _____ | <input type="checkbox"/> EEG Tech. _____ |
| <input type="checkbox"/> Photography _____ | <input type="checkbox"/> Personnel _____ |
| <input type="checkbox"/> Public Relations _____ | <input type="checkbox"/> O.R. Tech _____ |
| | <input type="checkbox"/> Other _____ |

- | | |
|--|--|
| <input type="checkbox"/> Typing _____ | <input type="checkbox"/> Clerical Work _____ |
| <input type="checkbox"/> Dictation _____ | <input type="checkbox"/> Credit _____ |
| <input type="checkbox"/> Bookkeeping _____ | <input type="checkbox"/> Cashier _____ |
| <input type="checkbox"/> Record Filing _____ | Microsoft _____ |
| <input type="checkbox"/> Mailing Clerk _____ | <input type="checkbox"/> Word <input type="checkbox"/> Access |
| <input type="checkbox"/> Calculator _____ | <input type="checkbox"/> Excel _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Powerpoint <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Desktop Publishing _____ |
| | What type? _____ |

ADDITIONAL WORK EXPERIENCE

- | | |
|--|--|
| <input type="checkbox"/> Electrician _____ | <input type="checkbox"/> Air Conditioner _____ |
| <input type="checkbox"/> Carpenter _____ | <input type="checkbox"/> General Maintenance _____ |
| <input type="checkbox"/> Painter/Plasterer _____ | |
| <input type="checkbox"/> Plumber _____ | |
| <input type="checkbox"/> Other _____ | |

Are you able to perform the essential job functions for the position for which you are applying with or without a reasonable accommodation? Yes No

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 previous notice to me.

I authorize the hospital/company to release to other prospective employers or information service bureaus, any information regarding my employment with the hospital/company or the information set forth in this application or gained by the hospital/company 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 the hospital/company from all liability for any damage caused by issuing this information to outside individuals.

I agree to submit myself upon request by the hospital/company, subsequent to a conditional job offer, for physical examination by a physician designated by the hospital/company, and to future physical or mental examinations the hospital/company may require at a later date as a condition of continued employment, as may be permitted by law.

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 the hospital/company. However, I understand that my employment and compensation can be terminated with or without notice at any time, and for any reason, at the option of the hospital/company or myself. Nothing in this Application of Employment should be construed to constitute a contract of employment between the hospital/company and the applicant. I understand that my terms and conditions of employment may be changed at any time.

If I am employed, I further understand and agree that when my employment is terminated by retirement or otherwise, I must return all of the hospital/companies property in my custody, including, but not limited to, any documents, hospital/company equipment, office keys, manuals, identification cards and name pins 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 the hospital/company, may be deducted from my final paycheck.

DATE

SIGNATURE OF APPLICANT

Rev. 3/06

| | | |
|--|-------------------------------------|---|
| Add to payroll _____ Date _____ Rate _____ | Department _____ Job Title _____ | Position offered _____ Position Rejected _____ _____ Applicant Signature |
|--|-------------------------------------|---|

READ CAREFULLY
AUTHORIZATION TO RELEASE INFORMATION

I authorize the hospital/company, or its agent, 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 the hospital/company, whether or not it is in their records. I also authorize the hospital/company 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 liability or any damage caused by issuing this information.

Date

Signature of Applicant

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 liability of any damage caused by issuing this information.

Date Signature of Applicant

Please provide at least three (3) 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: _____ | | | |
| <i>Street Address</i> | | <i>Apartment/Unit #</i> | |
| <i>City</i> | | <i>State</i> | <i>ZIP Code</i> |

| | | | |
|------------------------|--|-------------------------|-----------------|
| Name of Contact: _____ | | | |
| Title: _____ | | Phone: () _____ | |
| Company: _____ | | | |
| Address: _____ | | | |
| <i>Street Address</i> | | <i>Apartment/Unit #</i> | |
| <i>City</i> | | <i>State</i> | <i>ZIP Code</i> |

| | | | |
|------------------------|--|-------------------------|-----------------|
| Name of Contact: _____ | | | |
| Title: _____ | | Phone: () _____ | |
| Company: _____ | | | |
| Address: _____ | | | |
| <i>Street Address</i> | | <i>Apartment/Unit #</i> | |
| <i>City</i> | | <i>State</i> | <i>ZIP Code</i> |