

**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 person, 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.

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Date

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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>	

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<i>City</i>	<i>State</i>	<i>ZIP Code</i>	

**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**

- |   | Years |   | Years |
|---|-------|---|-------|
| <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 Aid      | _____ | <input type="checkbox"/> Radiology            | _____ |
| <input type="checkbox"/> Orderly          | _____ | <input type="checkbox"/> X-Ray Technician     | _____ |
| <input type="checkbox"/> Food Service     | _____ | <input type="checkbox"/> X-Ray Aid            | _____ |
| <input type="checkbox"/> Chef/Cook        | _____ | <input type="checkbox"/> Physical Therapy Aid | _____ |
| <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 _____          |       |

**SPECIALIZED OFFICE EXPERIENCE**

- |   | Years |  | Years |
|---|-------|--|-------|
| <input type="checkbox"/> Typing         | _____ | <input type="checkbox"/> Calculator      | _____ |
| <input type="checkbox"/> Dictation      | _____ | <input type="checkbox"/> Billing Machine | _____ |
| <input type="checkbox"/> Bookkeeping    | _____ | <input type="checkbox"/> Clerical Work   | _____ |
| <input type="checkbox"/> Record Filing  | _____ | <input type="checkbox"/> Credit          | _____ |
| <input type="checkbox"/> Addressograph  | _____ | <input type="checkbox"/> Cashier         | _____ |
| <input type="checkbox"/> Comptometer    | _____ | <input type="checkbox"/> Copy Machine    | _____ |
| <input type="checkbox"/> Adding Machine | _____ | <input type="checkbox"/> Word processing | _____ |
| <input type="checkbox"/> Mailing Clerk  | _____ | What type? _____                         |       |
| <input type="checkbox"/> Other _____    |       |  |       |

**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 all of the job functions for the position for which you are applying with or without a reasonable accommodation?    Yes    No

5. This hospital has a policy of non-discrimination with respect to employment of individuals with disabilities. Information as to any handicap or disability obtained as a result of the foregoing inquiries will be kept confidential except as permitted or required by applicable law or regulation. Medical condition information is obtained for the purpose of allowing voluntary action to overcome the effects of conditions which might result in limited employment of qualified handicapped individuals. Providing the information is voluntary, and failure to do so will not result in adverse treatment.

# APPLICATION FOR EMPLOYMENT

POSITION APPLYING FOR (1)		APPLICATION FOR EMPLOYMENT				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) _____						Social Security No. _____		
						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							
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. Conviction of a crime is not an automatic bar to employment – all circumstances will be considered.

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 services 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.

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. 9/01

Add to payroll \_\_\_\_\_

Date \_\_\_\_\_

Rate \_\_\_\_\_

Department \_\_\_\_\_

Job Title \_\_\_\_\_

Position offered \_\_\_\_\_

Position Rejected \_\_\_\_\_

\_\_\_\_\_  
Applicant Signature