

NORTH OAK REGIONAL MEDICAL CENTER

P.O. Box 648, 401 Getwell Drive, Senatobia, Mississippi 38668

EMPLOYMENT APPLICATION

PLEASE READ AND CAREFULLY ANSWER ALL QUESTIONS. PRINT CLEARLY IN INK.

TODAY'S DATE: _____ LAST NAME: _____ FIRST: _____ MIDDLE: _____

SOCIAL SECURITY: _____

HOME ADDRESS STREET: _____ APT: _____ CITY: _____

STATE: _____ ZIP CODE: _____ HOME PHONE: _____ CELL PHONE: _____

ARE YOU 18 OR OVER? YES NO (IF HIRED, YOU WILL BE REQUIRED TO SUBMIT PROOF OF AGE)

NAME OF PERSON THROUGH WHOM YOU MAY BE CONTACTED FOR MESSAGE PURPOSES: _____

ADDRESS: _____ PHONE: _____

IF HIRED, CAN YOU FURNISH PROOF THAT YOU ARE LEGALLY PERMITTED TO WORK IN THE UNITED STATES? YES NO

WHAT OTHER NAME HAVE YOU BEEN EMPLOYED UNDER IF DIFFERENT FROM PRESENT NAME? _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR A MISDEMEANOR? YES NO

(Record of conviction does not necessarily disqualify you from employment consideration)

LIST NAMES OF RELATIVES EMPLOYED BY THIS FACILITY:

NAME: _____ DEPARTMENT: _____

NAME: _____ DEPARTMENT: _____

HOW DID YOU LEARN ABOUT THIS JOB OPENING? _____

HAVE YOU EVER BEEN EMPLOYED BY NORTH OAK REGIONAL MEDICAL CENTER? YES NO

IF YES, WHERE? _____ WHEN? _____

EDUCATIONAL RECORD

HIGH SCHOOL: _____ LOCATION: _____ CIRCLE LAST GRADE COMPLETED: 9 10 11 12 DIPLOMA? _____

COLLEGE: _____ LOCATION: _____ 1 2 3 4 DEGREE & MAJOR _____

COLLEGE: _____ LOCATION: _____ 1 2 3 4 DEGREE & MAJOR _____

OTHER EDUCATION, SPECIAL COURSES OR ACADEMIC HONORS: _____

COLLEGES IN WHICH YOU ARE CURRENTLY ENROLLED: _____

PROFESSIONAL LICENSES / CERTIFICATION

OFFICIAL USE ONLY

TYPE: _____ NUMBER: _____ STATE ISSUED: _____ DATE ISSUED: _____ EXPIRES ON: _____ CONFIRMED

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LIST ANY PROFESSIONAL ORGANIZATIONS OF WHICH YOU ARE A MEMBER (YOU MAY OMIT ANY WHICH INDICATES SEX, RELIGION, NATIONAL ORIGIN, ANCESTRY, HANDICAP OR DISABILITY, RACE, AGE, SEXUAL ORIENTATION, MARITAL STATUS OR VETERANS STATUS.)

US. MILITARY EXPERIENCE

BRANCH: _____ INITIAL BANK: _____ FINAL RANK: _____

SERVICESCHOOLSATTENDED: _____

SPECIALTY(NATUREOFDUTIES): _____

SKILLS

TYPING SPEED (LAST DATE TESTED): _____ SHORTHAND SPED (LATE DATE TESTED): _____

10 KEY ADD. MACH, BY TOUCH: YES NO

PBX (TYPE BOARD) _____ MEDICAL TERMINOLOGY: YES NO

LIST OTHER KNOWLEDGE OR SKILLS YOU POSSESS OR EQUIPMENT YOU CAN OPERATE: _____

JOB INTEREST

FIRST CHOICE: _____ SECOND CHOICE: _____ DATE AVAILABLE: _____

SALARY DESIRED: _____ HOURS & SHIFTS AVAILABLE: _____

FULL TIME: YES/ NO PART TIME: YES/ NO ON CALL: YES / NO DAYS: YES/NO EVENINGS: YES/NO NIGHTS: YES/NO

EMPLOYMENT HISTORY

PRESENT COMPANY: _____ MAY WE CONTACT? YES / NO PHONE NUMBER: _____

ADDRESS: _____ FULL TIME / PART TIME: _____ AVERAGE HOURS WEEKLY: _____

JOB TITLE: _____ FROM: MO/DAY/YR _____ TO: MO/DAY/YR _____

IMMEDIATE SUPERVISOR: _____ HOURLY SALARY: _____

NATUREOFDUTIES: _____

REASONFORLEAVING: _____

EXPLAIN TIME LAPSE: _____

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and I agree to have any of the statements checked by the hospital unless I have indicated to the contrary. I authorize the references listed above to provide the hospital any and all information concerning my previous employment and any pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to the hospital as well as from the use or disclosure of such information by the hospital or any of its agents, employees or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or, if I am hired, in my dismissal from employment. In consideration of my employment I agree to conform to the rules and standards of the hospital and agree that my employment and compensation can be terminated with or without cause, and with or without notice at any time, either at my option or at the option of the hospital. I understand that no employee or representative of the hospital other than the president of the parent company has any authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing. Further, the president of the parent company may not alter the at-will nature of the employment relationship unless he does so specifically and in writing. I also understand that all offers of employment are conditioned on the provision of satisfactory proof of an applicant identity and legal right to work in the U.S. I understand that any offer of employment with the hospital will be conditioned on completing a pre-employment medical examination and a pre-employment drug and alcohol test. A purpose of the medical examination is to determine whether I am able to perform the essential functions of the job I am offered with or without reasonable accommodation, to identify any reasonable accommodation if such is warranted, and to ensure that my performance of the essential functions does not present a direct threat to my health and safety or the health and safety of others. I agree to undergo such a pre-employment medical examination and drug and alcohol test. If hired by the hospital, I further agree to undergo any periodic medical examinations which are permitted or required by law. The hospital does comply with Federal and State laws which prohibit discrimination on the basis of race, color, age, sex, religion, national origin, ancestry, disability or handicap, Veteran status, medical condition (as defined by California law) and marital status.

Applicant's Signature: _____ Date: _____