Greenwood Leflore Hospital

So far advanced, so close to home

Application for Employment

It is the policy of Greenwood Leflore Hospital to provide employment opportunities without regards to race, color, religion, sex, national origin, age or disability.
Pre-employment drug screen required.

DATE ____________________ 20 ________
Valid for 90 Days Only

LAST NAME	FIRST NAME	MI	MAIDEN	SOCIAL SECURITY NO.

TUSFFU BDDRESS	CITY	STATE/ZIP	TELEPHONE NO.

NAME OF PERSON TO NOTIFY IN EMERGENCY/RELATIONSHIP	ADDRESS	TELEPHONE NO.

POSITION APPLIED FOR	MINIMUM SALARY ACCEPTED	DATE AVAILABLE FOR WORK	WHO REFERRED YOU TO US?

HAVE YOU EVER APPLIED TO THIS HOSPITAL BEFORE? YES ☐ NO ☐ IF YES, WHEN ____________
HAVE YOU EVER WORKED FOR THIS HOSPITAL BEFORE? YES ☐ NO ☐ IF YES, WHEN ____________
POSITION ____________________________

ARE YOU PRESENTLY EMPLOYED? YES ☐ NO ☐ WHAT SHIFT(S) ARE YOU WILLING TO ACCEPT? 7A-7P ☐ 8A-5P ☐ 3P-11P ☐ 7P-7A ☐ OTHER ☐
WHY DO YOU WANT TO CHANGE?
WILL YOU BE ABLE TO WORK ON SATURDAY ☐ SUNDAY ☐ HOLIDAYS ☐
ARE YOU SEEKING: FULL TIME ☐ PART TIME ☐ SUMMER TIME ONLY ☐

GIVE NAME AND RELATIONSHIP OF ANY RELATIVES WORKING HERE: ____________________

NAMES AND ADDRESSES OF SCHOOLS ATTENDED:		GRADE COMPLETED	YEAR COMPLETED	DEGREE EARNED OR GED
ELEMENTARY:				
HIGH SCHOOL:				
COLLEGE/UNIVERSITY:	COURSE:			
BUSINESS SCHOOL:	COURSE:			
VOCATIONAL SCHOOL:	COURSE:			

MILITARY SERVICE	DATES OF SERVICE	RANK	BRANCH	SPECIAL TRAINING

HAVE YOU EVER BEEN CONVICTED OF A CRIME OTHER THAN A MINOR TRAFFIC VIOLATION? YES ☐ NO ☐
Conviction of a crime is not an automatic bar of employment; all circumstances will be considered.

GIVE COMPLETE INFORMATION REGARDING PRESENT AND FORMER EMPLOYMENT.
IF YOU DO NOT WANT US TO CONTACT YOUR PRESENT EMPLOYER CHECK IN THIS BOX: ☐

DATES	NAME OF PRESENT OR PAST EMPLOYER	RATE OF PAY	SUPERVISOR'S NAME	REASON FOR LEAVING
FROM:		START:		
TO:	TELEPHONE NO:	FINISH:		
Address:				
Detailed position and Duties:				

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FROM:		START:		
TO:	TELEPHONE NO:	FINISH:		
Address:				
Detailed position and Duties:				

LICENSE AND REGISTRATION INFORMATION FOR NURSES AND PROFESSIONAL INDIVIDUALS:
PROFESSIONAL TITLE _____ LICENSE NUMBER _____ STATE OF REGISTRY _____

PROFESSIONAL AFFILIATIONS _____

HAS YOUR LICENSE EVER LAPSED OR BEEN REVOKED FOR ANY REASON? _____ WHY? _____

PLEASE GIVE THE NAMES AND ADDRESSES OF (3) PERSONS AS REFERENCES. THEY SHOULD BE ACQUAINTANCES FOR AT LEAST 2 YEARS. DO NOT LIST RELATIVES OR FORMER EMPLOYERS.

NAME	ADDRESS	TELEPHONE NO.	BUSINESS

Upon employment, will you be able to show proof of identity and authorization to work in the United States? Yes ☐ No ☐

PLEASE READ CAREFULLY

I understand that, unless sometime in the future, I enter a specific, written employment contract with Greenwood Leflore Hospital, the employment relationship between the hospital and myself is freely terminable at the will of either party. I agree that this at-will relationship cannot be altered in any way except by express written agreement signed by the Executive Director of the hospital. I understand that the hospital is free to modify or revoke its policies, rules and procedures at any time, and I agree that nothing in the hospital's policies, rules and procedures is to be construed as a promise or guarantee of continued benefits of employment.

I hereby authorize Greenwood Leflore Hospital ("the Hospital") to make a thorough investigation of my background including, but not limited to, my past employment and education. I further authorize the Hospital to obtain information from the Greenwood Police Department, the Leflore County Sheriff's Department, and any other law enforcement agency concerning my background. I hereby release from all liability any and all persons, agencies, companies, law enforcement agencies, corporations, and institutions who supply such information to the Hospital pursuant to this authorization. I authorize the Hospital to release to other prospective employers, the Greenwood Police Department, the Leflore County Sheriff's Department, and any other law enforcement agency any information regarding my employment with the hospital or the information set forth in this application or information gained by the hospital from other companies, schools or persons named in this application and give any information regarding my employment, character, qualifications or any other information that they may have regarding me, whether or not it is in their records. I hereby release the Hospital from all liability for any damages resulting from the issuing of this information.

All information and answers to questions herein are complete, true and correct, and I have not omitted any answer that I was able to give. I understand that any false statement or any omission of a material fact may because for denial of employment, or dismissal from employment at the Hospital.

If employed, I agree to acquaint myself with, and abide by all rules, regulations, and policies as established or amended from time to time by the Hospital.

I understand that nothing contained in this employment application or in the granting of an interview constitutes any offer of employment by the Hospital. I further acknowledge that, as of the date I signed this application, no representative of the Hospital has made me an offer of employment, or promised me that, if employed by the Hospital, I would receive specific benefits, including, but not limited to, a specified salary upon employment, or salary increases thereafter. I understand that if employed, no promises of future salary increases or increased benefits are binding upon the Hospital unless made in writing by the Executive Director.

I agree to submit myself upon request by the Hospital for a physical examination and drug screen by a physician designated by the Hospital, and to any future tests and examinations that the hospital may require at a later date, as a condition of continued employment. I acknowledge that the hospital reserves the right to inspect all packages, lunch boxes, vehicles, clothing or any other items carried on or off hospital property, and if employed, I agree to cooperate with such inspections as a continued employment.

Date _____ **Applicant's Signature** (to be signed in person when interviewed) _____

Viewer's Comments:

GREENWOOD LEFLORE HOSPITAL

EQUAL EMPLOYMENT OPPORTUNITY APPLICANT DATA FORM

IMPORTANT - To All Applicants: *To enable us to meet government reporting regulations and maintain an Affirmative Action Plan, Greenwood Leflore Hospital requests that you complete this personal data form.* ***Information will be used solely for government reporting purposes and will be detached and kept separate from your application.*** *Any information that you choose to provide will not be considered by Greenwood Leflore Hospital for employment purposes and will be treated as personal and confidential. Your voluntary cooperation is appreciated.*

NAME _____

JOB TITLE _____

DATE _____ ☐ MALE ☐ FEMALE

PLEASE CHECK OFF THE APPROPRIATE BOX(ES).

RACE/ETHNIC CATEGORY

☐ **HISPANIC OR LATINO** – A PERSON OF CUBAN, MEXICAN, PUERTO RICAN, SOUTH OR CENTRAL AMERICAN, OR OTHER SPANISH CULTURE OR ORIGIN, REGARDLESS OF RACE.

☐ **WHITE (NOT HISPANIC OR LATINO)** – A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF EUROPE, THE MIDDLE EAST, OR NORTH AFRICA.

☐ **BLACK OR AFRICAN-AMERICAN (NOT HISPANIC OR LATINO)** - A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (NOT HISPANIC OR LATINO)** - A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF HAWAII, GUAM, SAMOA, OR OTHER PACIFIC ISLANDS.

☐ **ASIAN (NOT HISPANIC OR LATINO)** - A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF THE FAR EAST, SOUTHEAST ASIA, OR THE INDIAN SUBCONTINENT, INCLUDING, FOR EXAMPLE, CAMBODIA, CHINA, INDIA, JAPAN, KOREA, MALAYSIA, PAKISTAN, THE PHILIPPINE ISLANDS, THAILAND, AND VIETNAM.

☐ **AMERICAN INDIAN OR ALASKA NATIVE (NOT HISPANIC OR LATINO)** - A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF NORTH AND SOUTH AMERICA (INCLUDING CENTRAL AMERICA), AND WHO MAINTAIN TRIBAL AFFILIATION OR COMMUNITY ATTACHMENT.

REFERRAL SOURCE

☐ ADVERTISEMENT ☐ OTHER (PLEASE DESCRIBE _____)

☐ EMPLOYEE REFERRAL ☐ GOVERNMENT AGENCY ☐ WALK-IN