Your Hospital's Logo Here

APPLICATION FOR EMPLOYMENT

Mailing Address: Attn. Human Resources, Your Street, City, State, Zip

Fax: (202) 555-1212 • **TDD Number:** (202) 555-1212 • **Internet:** www.yourhosp.org

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE APPLICATION:

Answer all items on this application. Take time to list pertinent information, including references, carefully and completely. **Failure to do so may prevent consideration for a position for which you are qualified.** All information provided by the applicant on this form is subject to verification. Inability on our part to confirm statements made by you may prevent consideration for employment.

We take affirmative action to comply with all applicable laws of the District of Columbia and the Federal Government regarding employment practices. Xxxxxxx Hospital is an equal opportunity employer and does not discriminate on the basis of age, race, religion, sex, color, national origin, mental or physical disability, political affiliation, sexual orientation, matriculation, marital status, family responsibility, or personal appearance.

PLEASE TYPE OR PRINT IN INK. ANSWER ALL QUESTIONS COMPLETELY.

PERSONAL

NAME: (LAST) (FIRST) (MIDDLE)	DATE OF APPLICATION
ADDRESS: *(NUMBER AND STREET NAME, APARTMENT NO)*	
CITY, STATE, ZIP CODE:	
TELEPHONE NUMBERS: HOME: ( ) WORK: ( )	EMAIL ADDRESS:
HAVE YOU EVER APPLIED FOR A POSITION WITH US BEFORE? ☐ YES ☐ NO	SOCIAL SECURITY NUMBER:

ARE YOU A FORMER HOSPITAL EMPLOYEE? ☐ YES ☐ NO	DATE:	DEPARTMENT:
ARE YOU EITHER A U.S. CITIZEN OR AN ALIEN WITH THE LEGAL RIGHT TO WORK IN THE U.S.? ☐ YES ☐ NO	ARE YOU 18 YEARS OR OLDER? ☐ YES ☐ NO	

POSITION(S) DESIRED

POSITION(S) APPLYING FOR:	DEPARTMENT:	STATUS DESIRED
1.		☐ Full Time ☐ Part Time ☐ Temporary ☐ On Call ☐ Per Diem
2.		SHIFT PREFERENCE ☐ Days ☐ Evenings ☐ Nights ☐ Rotating ☐ Weekends
3.		WHEN CAN YOU BEGIN WORK? / MINIMUM SALARY ACCEPTABLE?

As the hospital is on a 7-day schedule, it may be necessary to work any shift, weekend, or holiday, as needed. Also, you may be hired for a specific work week or shift and later be required to change your work week or shift. Normally, you will be given two weeks notice of such a change.

I accept these conditions of employment: ☐ YES ☐ NO

If no, please explain: _____

LICENSE / REGISTRY INFORMATION

PLEASE COMPLETE IF LICENSURE IS REQUIRED FOR POSITION(S) YOU ARE SEEKING

Type	State	License Number	Original License Date	Most Recent Renewal Date	Expiration Date
1.					
2.					

Have you applied for reciprocity in D.C.?
☐ YES ☐ NO ☐ Not Required

License ever been suspended or revoked? ☐ YES ☐ NO

Give reason and date: _____

A revocation or suspension of your license / registry will not necessarily be a bar to your employment. Your revocation or suspension will be discussed during the pre-employment interview process and Hospital will consider your revocation(s) or suspension(s) in making its hiring decision.

THIS HOSPITAL IS AN EQUAL OPPORTUNITY EMPLOYER

EMPLOYMENT HISTORY

EMPLOYMENT HISTORY MUST BE FILLED OUT COMPLETELY. You may submit a resume to supplement your work history, but you must still answer the questions on this form. Be sure to include accurate information about where to locate immediate supervisors and references.

1. LAST / CURRENT EMPLOYER: DATES: **From:** **To:** (Month / Day / Year) (Month / Day / Year) LAST Amount $ SALARY: Per ☐ Hour ☐ Week ☐ Month ☐ Full Time ☐ Part Time ☐ On-Call ☐ Per Diem REASON FOR LEAVING:	NAME AND ADDRESS OF EMPLOYER Zip Code NAME / TITLE / DEPARTMENT OF YOUR IMMEDIATE SUPERVISOR Phone ( )	TITLE: UNIT / DEPT: DESCRIBE YOUR WORK:
2. LAST / CURRENT EMPLOYER: DATES: **From:** **To:** (Month / Day / Year) (Month / Day / Year) LAST Amount $ SALARY: Per ☐ Hour ☐ Week ☐ Month ☐ Full Time ☐ Part Time ☐ On-Call ☐ Per Diem REASON FOR LEAVING:	NAME AND ADDRESS OF EMPLOYER Zip Code NAME / TITLE / DEPARTMENT OF YOUR IMMEDIATE SUPERVISOR Phone ( )	TITLE: UNIT / DEPT: DESCRIBE YOUR WORK:
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4. LAST / CURRENT EMPLOYER: DATES: **From:** **To:** (Month / Day / Year) (Month / Day / Year) LAST Amount $ SALARY: Per ☐ Hour ☐ Week ☐ Month ☐ Full Time ☐ Part Time ☐ On-Call ☐ Per Diem REASON FOR LEAVING:	NAME AND ADDRESS OF EMPLOYER Zip Code NAME / TITLE / DEPARTMENT OF YOUR IMMEDIATE SUPERVISOR Phone ( )	TITLE: UNIT / DEPT: DESCRIBE YOUR WORK:
5. LAST / CURRENT EMPLOYER: DATES: **From:** **To:** (Month / Day / Year) (Month / Day / Year) LAST Amount $ SALARY: Per ☐ Hour ☐ Week ☐ Month ☐ Full Time ☐ Part Time ☐ On-Call ☐ Per Diem REASON FOR LEAVING:	NAME AND ADDRESS OF EMPLOYER Zip Code NAME / TITLE / DEPARTMENT OF YOUR IMMEDIATE SUPERVISOR Phone ( )	TITLE: UNIT / DEPT: DESCRIBE YOUR WORK:

EDUCATION AND TRAINING

TYPE OF SCHOOL	NAME / ADDRESS OF SCHOOL	MAJOR / MINOR or COURSE OF STUDY	# of YRS FINISHED	DID YOU GRADUATE	DEGREE CONFERRED
High School					
Undergraduate College					
Graduate / Professional					
Certifications					

SKILLS: *Estimate*

TYPING: _____ WPM

COMPUTER SKILLS: _____

GENERAL INFORMATION

HOW DID YOU LEARN ABOUT THIS POSITION? _____

LIST ANY RELATIVES WORKING FOR THIS HOSPITAL

NAME: _____ DEPARTMENT: _____

NAME: _____ DEPARTMENT: _____

LIST ANY OTHER NAMES USED:

CAN YOU PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION FOR WHICH YOU ARE APPLYING?: ☐ YES ☐ NO

HAVE YOU BEEN CONVICTED OF A MISDEMEANOR OR FELONY?

☐ YES ☐ NO If yes, give (1) Date; (2) Charge; (3) Place; (4) Court; (5) Action taken by Court: _____

NOTE: *A CONVICTION WILL BE CONSIDERED UNDER APPLICABLE D.C. HEALTH CARE REGULATIONS AND HOSPITAL POLICY*

READ CAREFULLY BEFORE SIGNING

By my signature below, I certify that: I have read and understand this application, that I have not withheld any information requested, and that the answers on this application are true and correct to the best of my knowledge. I authorize this Hospital representatives to verify the statements made herein by investigation as deemed appropriate and by seeking references from previous employers and personal references and release all other parties from any liability with respect given to any information given. I understand that my employment is contingent upon the truth of the statements made herein, satisfactory reference checks, the results of the pre-employment physical and criminal background check. **I certify that my body is free from any illegal or controlled substances except prescribed to me by my medical practitioner. I agree to take a pre-employment physical examination and substance abuse screening as per Safety Policy SM-1-1-13b - Drug Free Workplace. Failure or refusal to consent or provide specimen(s) for analysis at the time requested will result in the withdrawal of the offer of employment. Also if I fail to pass the substance abuse screening or if my specimen shows evidence of adulteration or substitution, the offer of employment will be withdrawn.**

Further, I understand that should I be accepted for employment, I will fully adhere to the rules, regulations, and policies of this Hospital. I agree to take blood and urine tests to determine the content of alcohol and/or drugs in my body when requested to do so by authorities of this Hospital. Also, I agree to take an annual health examination consisting of tests, procedures, and examination as designated by the hospital. I understand that failure to comply with these requests could result in disciplinary action up to and including discharge.

I understand that nothing contained in this employment application or in the granting of an interview is intended to create an employment contract between this Hospital and myself for either employment or the providing of any benefits. No promises regarding employment have been made to me and I understand that no such promise or guarantee is binding upon this Hospital unless it is made in writing. If an employment relationship is established, I understand that I have the right to terminate my employment at any time and that the hospital retains a similar right. This Hospital does not accept applications for employment unless there is a position vacancy open to outside recruitment. All applicants for employment at this Hospital are treated as active applications for a period of 30 calendar days from the date on which they are received. If you are not offered employment within that time and you wish to continue to be considered for future openings, it will be necessary for you to complete another application if there is a position vacancy open to outside recruitment. This will make you eligible for consideration for another 30 days.

I understand that any misrepresentation or falsification of facts on this application is cause for rejection of my application and/or termination in the event of my employment.

_____ SIGNATURE OF APPLICANT

_____ DATE

EMPLOYMENT HISTORY *(Continued)*

6. LAST / CURRENT EMPLOYER: DATES: **From:** **To:** (Month / Day / Year) (Month / Day / Year) LAST Amount $ SALARY: Per ☐ Hour ☐ Week ☐ Month ☐ Full Time ☐ Part Time ☐ On-Call ☐ Per Diem REASON FOR LEAVING:	NAME AND ADDRESS OF EMPLOYER Zip Code NAME / TITLE / DEPARTMENT OF YOUR IMMEDIATE SUPERVISOR Phone ( )	TITLE: UNIT / DEPT: DESCRIBE YOUR WORK:
7. LAST / CURRENT EMPLOYER: DATES: **From:** **To:** (Month / Day / Year) (Month / Day / Year) LAST Amount $ SALARY: Per ☐ Hour ☐ Week ☐ Month ☐ Full Time ☐ Part Time ☐ On-Call ☐ Per Diem REASON FOR LEAVING:	NAME AND ADDRESS OF EMPLOYER Zip Code NAME / TITLE / DEPARTMENT OF YOUR IMMEDIATE SUPERVISOR Phone ( )	TITLE: UNIT / DEPT: DESCRIBE YOUR WORK:

Summarize All Other Jobs On a Separate Sheet of Paper

FOR EMPLOYMENT OFFICE USE ONLY:

REFERRAL SOURCE: _____

OFFER: _____ TD: _____

OIG EXCLUSION: ☐ FOUND ☐ NOT FOUND DATE: _____

DC NURSE ABUSE REGISTRY: ☐ FOUND ☐ NOT FOUND DATE: _____

Kroll Background America

AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND / OR INVESTIGATIVE CONSUMER REPORT

I, the undersigned consumer, do hereby authorize **Your Hospital**, by and through its independent contractor, **KROLL BACKGROUND AMERICA, INC. ("KBA")**, to procure a consumer report and/or investigative consumer report on me.

These above-mentioned reports may include, but are not limited to, information as to my character, general reputation, personal characteristics and mode of living, discerned through employment and education verifications; personal references; personal interviews; my credit history based on reports from any credit bureau; my driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; any other public record.

I understand that, I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to **KBA**, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 168 let. seq.

I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to **Your Hospital**, by and through **KBA**, including, but not limited to, any and all courts, public agencies, law enforcement agencies and credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release **Your Hospital**, **KBA** and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report and/or investigative consumer report hereby authorized. I understand that this Authorization/Release form shall remain in effect for the duration of my employment with said Company.

Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application for employment will be terminated based on any false, omitted or fraudulent information.

Signature: _____ **Date:** _____

Printed Name: First Middle Last

Other Names Used / Dates Used

Current Address: Street / P.O. Box City State Zip Code County Dates

Addresses For the Past Seven Years: **(If more space is needed, use back of form)**

					FROM	*TO*
Street / P.O. Box	City	State	Zip Code	County	Dates	
Street / P.O. Box	City	State	Zip Code	County	Dates	

Social Security Number: _____ Daytime Telephone Number: _____

Driver's License Number: _____ State of Issuance: _____ Date of Birth*: _____ Gender*: _____

- Have you ever been convicted of a crime or convicted in a military court martial? ☐ YES ☐ NO
- Have you ever been sanctioned or had a professional license suspended or revoked? ☐ YES ☐ NO
- Are you currently under any investigation or pending charge? ☐ YES ☐ NO

*** This information will enable us to properly identify you in the event we find adverse information during the course of our background search.**