

EAST PHILLIPS COUNTY HOSPITAL DISTRICT EMPLOYMENT APPLICATION

1001 E. Johnson Street - Holyoke, CO 80734

Applicant Information: All sections must be completed even if resume is included. Additional paper may be attached if needed.

Last Name:		First Name:		Middle Initial:
Address:		City:	State:	Zip Code:
Home Telephone:	Cell Number:	Social Security Number:	Date Available:	Starting Salary Needed:

Have you ever worked for Melissa Memorial Hospital, or were you ever a contract employee for MMH? Yes No
 If yes, where? _____ When? _____ Under what name? _____

Do you have a friend or relative working here? Yes No
 If yes, name: _____ Department: _____ Relationship: _____

Our minimum age for hiring is 17. Please check the appropriate box for your age group. 17 18+

Position Information: A separate application must be completed for every two positions.

Position you are applying for:	Second Position:
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Will accept (check all that apply): Day Evenings Nights Weekends Full-time Part-time Temp Per Diem

Skills: Check each of the skills listed below in which you are proficient.

Computer: <input type="checkbox"/> Windows <input type="checkbox"/> DOS <input type="checkbox"/> Outlook <input type="checkbox"/> Programming <input type="checkbox"/> Microsoft Office <input type="checkbox"/> Network Environment <input type="checkbox"/> Word <input type="checkbox"/> Web Design <input type="checkbox"/> Excel <input type="checkbox"/> Graphics <input type="checkbox"/> Access <input type="checkbox"/> Desk Top Publishing <input type="checkbox"/> PowerPoint <input type="checkbox"/> Other _____ <input type="checkbox"/> Data Entry <input type="checkbox"/> Other _____ <input type="checkbox"/> 10 key <input type="checkbox"/> Other _____	Clinical: <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> OR/Surgery <input type="checkbox"/> Critical Care <input type="checkbox"/> Ortho/Neuro <input type="checkbox"/> Emergency <input type="checkbox"/> Pediatric <input type="checkbox"/> EMS <input type="checkbox"/> Psych Care <input type="checkbox"/> Home Health <input type="checkbox"/> Radiology <input type="checkbox"/> Intensive Care <input type="checkbox"/> Skilled Nsg. <input type="checkbox"/> Med/Surg <input type="checkbox"/> Telemetry <input type="checkbox"/> OB/GYN <input type="checkbox"/> _____ <input type="checkbox"/> Oncology <input type="checkbox"/> _____	Other: <input type="checkbox"/> Medical Terminology <input type="checkbox"/> Medical Billing <input type="checkbox"/> Medical Records Coding <input type="checkbox"/> Filing <input type="checkbox"/> Switchboard <input type="checkbox"/> Transcription <input type="checkbox"/> Typing wpm _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
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Languages: List languages, other than English, in which you are fluent: _____

Education:

School	Name of School	Location	Course of Study	Did you Graduate	Year Completed
High School				<input type="checkbox"/> Yes <input type="checkbox"/> No	1 2 3 4
College					
Other					

Professional licenses, registration and/or certifications: DO NOT include driver's license

Type:	State:	Date Issued:	Expires:	Number:
Type:	State:	Date Issued:	Expires:	Number:
Type:	State:	Date Issued:	Expires:	Number:

Has your professional license ever been suspended or revoked? No Yes If yes, explain: _____

Employment History: The following information must be completed. List the most recent position first.

May we contact your current employer? Yes No If no, explain: _____

Start Date: Mo. Yr.	Name of Employer:	Position Title:	Ending Salary: \$ Per
End Date Mo. Yr.	Address: Street City State Zip	Supervisor:	Telephone: ()
Briefly describe the work you performed:		Reason for leaving:	
Start Date: Mo. Yr.	Name of Employer:	Position Title:	Ending Salary: \$ Per
End Date Mo. Yr.	Address: Street City State Zip	Supervisor:	Telephone: ()
Briefly describe the work you performed:		Reason for leaving:	
Start Date: Mo. Yr.	Name of Employer:	Position Title:	Ending Salary: \$ Per
End Date Mo. Yr.	Address: Street City State Zip	Supervisor:	Telephone: ()
Briefly describe the work you performed:		Reason for leaving:	

REFERENCES

REFERENCES: PLEASE LIST THREE (3) REFERENCES WE MAY CONTACT

Name/Phone Number
Name/Phone Number
Name/Phone Number

CRIMINAL HISTORY

Criminal History: Please note that conviction of a crime is not an automatic disqualification for consideration for employment. Falsification of information will result in rejection of application, withdrawal of conditional job offer or termination of employment.

Have you ever plead guilty to, been convicted of, or received probation, probation with an alternative sentence, conditional discharge or pretrial diversion for any crime? If yes, list information on criminal offense(s), date(s), and disposition: YES NO

Are you currently serving probation, conditional discharge, or pretrial diversion for any crime? If yes, provide details on offense, disposition and current status: YES NO

Have you ever been accused or convicted of Medicare Fraud or Abuse? YES NO

Explain any "yes" responses:

CRIMINAL HISTORY CHECK WAIVER

AUTHORIZATION TO OBTAIN RECORDS AND OTHER INFORMATION FOR EMPLOYMENT PURPOSES

To the applicant: This form must be filled out completely. Leave **NO** blanks. Direct any questions to the Human Resources office. **READ ALL INFORMATION CAREFULLY BEFORE SIGNING.**

I hereby authorize East Phillips County Hospital to utilize the services of an outside agency to make an investigation of my criminal history records. I understand that these investigations will include information of public record, which could include DMV records; civil and criminal court records; county, state and federal tax liens; and other records, as may be appropriate. I understand I have a right to make a written request within a reasonable time for the disclosure of the name and address of the consumer reporting agency so that I may obtain a complete disclosure of the nature and scope of the investigation.

The facts set forth in my application for employment are true and complete. I understand that if employed, any false statement or omission of information on my application form may result in my termination. I further understand that this application is not intended to be a contract of employment, nor does this application serve as an obligation in any way to employ me or not to employ me.

I hereby fully waive any rights or claims I have or may have against you and any outside agency utilized by you as a result of any information which is obtained in this investigation. I understand that this information will be used only for employment, or for legitimate business purpose.

A photocopy of this authorization shall be deemed an original and shall be accepted as such by every person.

PLEASE PRINT CLEARLY

Last Name	First Name	Middle Name
Other Names Used - include maiden name, aliases and nick names		
Address		
City	State	Zip Code
Telephone ()	Social Security Number	Date of Birth
Drivers License Number	State	Expiration Date
		Type

SIGNATURE

Signature	Date
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AGREEMENT, AUTHORIZATION, AND CONSENT FOR RELEASE OF BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I, _____
 LAST NAME FIRST NAME MIDDLE NAME (PLEASE INCLUDE Jr., Sr., II, III Etc.)

understand that in conjunction with my application for employment, work to be performed under contract, promotion, volunteer position, reassignment, and/or retention ("Work"), **Melissa Memorial Hospital** will use the services of an outside agency to research and verify the information I have provided on my application for employment including my personal background, character, professional standing, work history and qualifications. This agency will provide a written report of its findings to **Melissa Memorial Hospital**. **Melissa Memorial Hospital** uses **Sterling Infosystems, Inc.**, a consumer-reporting agency, as an agent to perform its Employment related background investigations.

Sterling Infosystems, Inc. will utilize various sources of information it deems appropriate including but not limited to: criminal conviction records, current and former employers, department of motor vehicle records, military records, credit reporting agencies, education records, professional and personal references and workers compensation records including any and all injuries in compliance with the Americans with Disabilities Act. I agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to **Melissa Memorial Hospital**, and **Sterling Infosystems, Inc.**

I agree, authorize and consent to the procurement of a Consumer Report and/or an Investigative Consumer Report and understand that it may contain information about my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. This authorization in original or copy form shall be valid for my term of Work from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by **Melissa Memorial Hospital** if Work is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to **Melissa Memorial Hospital**. I further understand that I may request a copy of the report, and that when doing so, proper identification will be required and I should direct my request to: **Sterling Infosystems, Inc.**, 5750 West Oaks Boulevard, Suite 100, Rocklin, CA 95765. I understand that residents of all states will automatically receive a copy of the report if an adverse action is taken regarding the employment application, or upon request as outlined herein.

CHECK THIS BOX IF you are applying for work with a California, Minnesota or Oklahoma based employer and you would like a copy of your Consumer Report if one is prepared in the investigation of your background. CA Codes 1785.20.5 & 1786.16(a)(5)(b)(1), MN Code 13C Subdivision 2, OK Code 24 O.S. §148

LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES FOR POSITIVE IDENTIFICATION PURPOSES REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. PLEASE PRINT CLEARLY.

Signed _____ Today's Date _____

Name as it appears on your driver's license _____ Position Applied For _____

Social Security Number _____ Date of Birth _____ Driver's License Number _____ State _____

Other names you have used, or are also known as, including maiden name, name changes and any aliases:

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST 7 YEARS

Mo./Yr. / Mo./Yr

Current Address: _____ /
 Street Apt.# City State Zip Code From / To?

Former Address: _____ /
 Street Apt.# City State Zip Code From / To?

Former Address: _____ /
 Street Apt.# City State Zip Code From / To?

Former Address: _____ /
 Street Apt.# City State Zip Code From / To?