



Equal Employment Opportunity Policy

This hospital is an equal opportunity employer. Hospital policy prohibits discrimination on the basis of race, color, religion, ethnicity, national origin, age, sex, or marital, veteran, or handicapped status. No question on this application is asked for the purpose of limiting or excluding any applicant's consideration for employment because of his or her race, color, religion, ethnicity, national origin, age, sex, or marital, veteran, or handicapped status.

APPLICATION FOR EMPLOYMENT

PLEASE TYPE OR PRINT

IN ORDER THAT WE MAY BETTER UNDERSTAND YOUR QUALIFICATIONS AND INTERESTS AND TO ASSURE YOU THE FULLEST CONSIDERATION, PLEASE COMPLETE ALL OF THE ITEMS LISTED BELOW.

	SOCIAL SECURITY NO.		
Date NAME			
(Last)	(First)	(Middle)	
IF EMPLOYMENT, EDUCATION, OR MILITARY RECORDS ARE UNDER A NAME OTHER THAN THE NAME ABOVE PLEASE GIVE OTHER NAME.			
(Last)	(First)	(Middle)	
PRESENT ADDRESS			
(Number)	(Street)	(City)	(State) (Zip Code)
TELEPHONE NUMBER	LENGTH OF RESIDENCE		ARE YOU 18 YEARS OF AGE OR OLDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
WERE YOU PREVIOUSLY EMPLOYED BY US? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES", WHEN, IN WHAT DEPARTMENT?	
POSITION APPLIED FOR:		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> WEEK-ENDS <input type="checkbox"/> SUMMER	
1. MINIMUM SALARY ACCEPTABLE:	2. HOURS OF WORK PREFERRED	DATE AVAILABLE FOR EMPLOYMENT	
IS A MEMBER OF YOUR IMMEDIATE FAMILY EMPLOYED AT BROWNSVILLE GENERAL HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF SO, IN WHICH DEPARTMENT?	

EDUCATION

	FROM		TO		NO. OF CREDITS	DEGREE/DIPLOMA	Q.P.A.	MAJOR	MINOR
	MO	YR	MO	YR					
HIGH SCHOOL									
COLLEGE OR UNIVERSITY									
GRADUATE SCHOOL									
TECHNICAL OR PROFESSIONAL									
OTHER									

PROFESSIONAL LICENSURE AND **NUMBER** YOU NOW HOLD AND FROM WHICH **STATE**

Expiration Date

EMPLOYMENT RECORD MAY WE CONTACT YOUR PRESENT EMPLOYER YES NO

List employers – most recent first

EMPLOYER'S NAME	ADDRESS	PHONE NO.
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TYPE OF BUSINESS	DATES EMPLOYED	FROM	TO	FINAL SALARY
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NATURE OF DUTIES (Including Supervisory)

NAME OF YOUR SUPERVISOR	REASON FOR LEAVING
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EMPLOYER'S NAME	ADDRESS	PHONE NO.
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TYPE OF BUSINESS	DATES EMPLOYED	FROM	TO	FINAL SALARY
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NATURE OF DUTIES (Including Supervisory)

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EMPLOYER'S NAME	ADDRESS	PHONE NO.
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TYPE OF BUSINESS	DATES EMPLOYED	FROM	TO	FINAL SALARY
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NATURE OF DUTIES (Including Supervisory)

NAME OF YOUR SUPERVISOR	REASON FOR LEAVING
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CLERICAL EXPERIENCE		NURSING EXPERIENCE		MACHINES YOU OPERATE
<input type="checkbox"/> Accounts Payable	<input type="checkbox"/> Medical Secretary	<input type="checkbox"/> Critical Care Training	<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Adding Machine
<input type="checkbox"/> Accounts Receivable	<input type="checkbox"/> Medical Transcriber	<input type="checkbox"/> Cardiac Monitor Interpretation	<input type="checkbox"/> O.R.	<input type="checkbox"/> Personal Computer
<input type="checkbox"/> Admitting/Registration	<input type="checkbox"/> Payroll	<input type="checkbox"/> ER Training/Experience	<input type="checkbox"/> Charge/Head Nurse	<input type="checkbox"/> Calculator
<input type="checkbox"/> Billing	<input type="checkbox"/> Receptionist	<input type="checkbox"/> Telemetry	<input type="checkbox"/> Supervisory Experience	<input type="checkbox"/> Dictation Equipment
<input type="checkbox"/> Cashier	<input type="checkbox"/> Med. Rec. Clerk	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Word Processor
<input type="checkbox"/> Clerk Typist	<input type="checkbox"/> Stores Clerk	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Recovery Room	Typing Speed WPM: _____
<input type="checkbox"/> Filing		<input type="checkbox"/> Med/Surg	<input type="checkbox"/> Orthopedic	Shorthand Speed WPM: _____
<input type="checkbox"/> Hospitalization Ins. Billing			<input type="checkbox"/> Other: _____	

DO YOU READ, WRITE OR SPEAK ANY FOREIGN LANGUAGE? IF YES, PLEASE LIST THE LANGUAGE(S)

YES NO

MILITARY SERVICE		
WERE YOU IN THE U.S. ARMED FORCES?	IF "YES", WHAT BRANCH?	
<input type="checkbox"/> YES <input type="checkbox"/> NO		
DATES OF DUTY: FROM (Month, Day, Year)	TO (Month, Day, Year)	RANK AT DISCHARGE
LIST OF DUTIES IN THE SERVICE INCLUDING SPECIAL TRAINING		

PERSONAL REFERENCES: (Not former employers or relatives)		
NAME AND OCCUPATION	ADDRESS	PHONE NUMBER
PERSON TO BE NOTIFIED IN CASE OF ACCIDENT OR EMERGENCY:		PHONE NO.
HAVE YOU EVER PLEADED GUILTY TO, OR BEEN CONVICTED OF, ANY VIOLATION OTHER THAN A MISDEMEANOR OR SUMMARY OFFENSE?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, DESCRIBE IN FULL:		

Employment is dependent upon satisfactorily passing a pre-placement physical given to all applicants for employment.

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief, and hereby grant the Hospital permission to verify such answers and investigate all references. I understand that any false statements on this application may be considered sufficient cause for rejection of this application or for dismissal if such false information is discovered subsequent to my employment. I authorize the employers, schools or persons named above to give any information regarding my previous employment, character, general reputation and personal characteristics, together with any information they have regarding me whether or not it is in their records. I understand that under the Federal Fair Credit Reporting Act, I have the right to make a written request within a reasonable period of time for a complete and accurate disclosure by the Hospital of the nature and scope of any investigation requested by the Hospital of a consumer reporting agency. If this application for employment is denied either wholly or partly because of information contained in a consumer report from a consumer reporting agency, the applicant understands that the Hospital shall so advise him or her, and shall supply the name and address of the consumer reporting agency making the report. I hereby release said agency, employers, schools or persons from all liability for any damage for issuing this information. In addition, if accepted for employment, I hereby agree to abide by the rules and regulations of the Hospital.

Signed: _____ Date _____