

COMMUNITY MEMORIAL HOSPITAL • HAMILTON, NEW YORK 13346

EQUAL OPPORTUNITY AFFIRMATIVE ACTION EMPLOYER

APPLICATION FOR EMPLOYMENT

Please fill out this form fully, accurately, and in your own handwriting. Your cooperation will help us deal with your application more effectively. A personal interview will be requested, providing there is an opening meeting your qualifications.

Position applied for _____ Date _____

Name (Print) _____
LAST FIRST MIDDLE

Present Address _____
STREET CITY STATE ZIP CODE

How long at present address? _____ Telephone _____

Previous address _____
STREET CITY STATE

How long at previous address? _____ Social Security No. _____

Have you ever had a name change? Yes No If so, please list. _____

* If younger than 18, state age. _____ U.S. Citizen Yes No

*NOTE: Federal and State Human Rights laws prohibit discrimination in employment because of age, sex, national origin, race, color, creed, disability, marital status or handicap.

Have you ever been convicted of a crime (Exclude traffic violations)? _____

If yes, please explain _____

Did you serve in U.S. Armed Forces? Yes No From _____ To _____

Branch of service _____

In case of emergency, notify _____ Telephone _____

Address _____

Have you submitted an application previously? Yes No

Have you ever worked for this hospital before? Yes No If so, when? _____

What are your hobbies and sport interests? _____

Are you presently employed? Yes No If so, reason for desiring change _____

_____ May we refer to your present employer? Yes No

Starting salary or wages expected _____ Date Available _____

EDUCATION

Circle highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

	Name of School	Location	Dates Attended		Diploma or Degree
			From	To	
Grammar					
High School					
College					
School of Nursing					
Technical or Business					
Other Skills		Typing Speed		Short Hand	Business Machines

Membership in Professional Organizations (List):

THIS SECTION TO BE COMPLETED BY PROFESSIONAL AND LICENSED PRACTICAL NURSE APPLICANTS ONLY

Are you presently licensed to practice in New York State? Yes No Expiration Date _____ Date of Last Renewal _____

Registration number _____ Are you registered in another state? Yes No
 Name of state _____ Registration number _____

If not licensed, please indicate permit status: _____

Please list any professional registration, licensure, or certification you currently hold indicating:
 type _____ number _____ exp. date _____ state issued _____

Has administrative or disciplinary action ever been taken against you with respect to any professional registration, licensure or certification in New York State or in any other State: If so, please explain: _____

Is any administrative or disciplinary action now pending with respect to any professional registration, licensure or certification you hold in New York State or in any other State: If so, please explain: _____

THIS SECTION FOR TECHNICIANS AND TECHNOLOGISTS ONLY

Are you currently registered in New York State Yes <input type="checkbox"/> No <input type="checkbox"/>	Give number _____	If not, have you applied Yes <input type="checkbox"/> No <input type="checkbox"/>	Date State Board taken in home state _____	In what other states are you registered _____
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PERSONAL REFERENCES

Give the names of three persons, NOT RELATIVES OR EMPLOYERS, who have known you for several years:

Name	Address	Occupation

Community Memorial Hospital

Hamilton, New York 13346

(315) 824-1100

Dear Applicant:

Please complete numbers 1-9 on this form and return it with your completed application for employment. Complete one form for each school and place of employment.

I, _____, authorize Community Memorial Hospital to contact my present and previous employers, schools, and unless otherwise indicated, I further authorize my former employers to give any information as to my character and work or school record, including employment dates and positions held. I hereby release from all liability any damages, these individuals or companies are providing such information. I further understand that all hiring commitments are conditional based upon satisfactorily meeting statutory standard through a job related pre-employment physical examination and satisfaction completion of the applicable probationary period.

(1) _____ (2) _____
Signature Date

(3) Position Applying For _____

I was employed by (4) _____
Name of Company

(5) _____
Complete Address

From (6) _____ to (7) _____ In the
position (8) _____. During this period of employment,
I was known by the name of (9) _____.

FORMER EMPLOYER: PLEASE VERIFY ON THE REVERSE SIDE OF THIS FORM

Community Memorial Hospital

Hamilton, New York 13346

(315) 824-1100

FORMER EMPLOYER PLEASE COMPLETE

NAME: _____

EMPLOYED FROM: _____ TO: _____

	EXCELLENT	GOOD	FAIR	POOR
QUALITY OF WORK	_____	_____	_____	_____
WORK OUT-PUT (QUANTITY)	_____	_____	_____	_____
COOPERATION	_____	_____	_____	_____
ABILITY TO GET ALONG WITH OTHERS	_____	_____	_____	_____
ATTENDANCE	_____	_____	_____	_____

REASON FOR TERMINATION OF EMPLOYMENT: _____

WOULD YOU REHIRE _____

COMMENTS: _____

SIGNATURE: _____

TITLE _____ DATE: _____

Thank you for your cooperation
A return envelope is enclosed for your convenience

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WOULD YOU REHIRE _____

COMMENTS: _____

SIGNATURE: _____

TITLE _____ DATE: _____

Thank you for your cooperation
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List all employment, starting with your present or most recent employer, indicating date, job title, wage/salary, and reason for leaving.

List last 4 positions, giving last position first:

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

LIST ADDITIONAL WORK EXPERIENCE _____

EMPLOYMENT AGREEMENT

"I understand that the falsification or omission of any information requested will be grounds for refusal to hire or for termination. I authorize Community Memorial Hospital to investigate my suitability for employment by contacting my references, former employers, regulatory agencies regarding registration/licensing/certification, education institutions, and law enforcement agencies."

I understand that employment at COMMUNITY MEMORIAL HOSPITAL means that at any time when deemed necessary, I may be required to work rotating shifts or change my regular shift (if applicable) upon reasonable request.

I consent to any and all job related medical examinations required by the hospital and understand that if I am employed I will be on the applicable probationary period from date of employment. Upon my termination I authorize the release of reference information on my work.

SIGN YOUR NAME