

ELLINWOOD DISTRICT HOSPITAL - CLINIC APPLICATION FOR EMPLOYMENT

Please fill in all spaces. Enter N/A if item does not apply to you.

Name – Last	First	Middle	Social Security No.	Today's Date
Address - Street			Home Telephone No.	
			Cell No.	
City		State		Zip
Position Desired		Training For This Position (Former education shown on other side of form)		
Other Specified Training or Experience (Not necessarily for this Job)				
Current Employer			Reason For Desiring Change	
Why Do You Choose Hospital Work?				
What Prompted You To Apply Here For Employment?				
Are you related to Anyone In Our Employ? Who and How?				
Professional License Number		Type		State
Hobbies				
IN CASE OF EMERGENCY NOTIFY	Name		Relationship	
	Address		Telephone	

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EDUCATION

Name and Location of Schools or Colleges	Major Subject(s)	Did You Graduate? (Y) Yes (N) No	Date of Graduation (College – Vocational Only)	Type of Degree/Certificate

FORMER EMPLOYERS AND EXPERIENCE (References)

Name and Address	Nature of Experience	Period From To	Cash Salary	Other Compensation

PERSONAL REFERENCES (Not Relatives)

Name	Address	Phone	Relationship

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EMPLOYMENT UNDERSTANDING (Please read and sign)

This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, veteran status, or on the basis of age, physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this Institution the right to make a thorough investigation of my past employment and activities, including KBI background check. I agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical places as the institution shall designate. I understand that an offer of employment may be contingent on passing the background check, testing and physical examination which relates to the essential duties I would be required to perform.

I understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact appearing on the application form.

If employed, I will be required to complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility for employment.

Signed _____ Date _____

STOP --- APPLICANT PLEASE DO NOT WRITE IN SPACE BELOW

Interviewed by _____ Date _____

COMPENSATION

Date to Start Work _____ Dept. _____

I, the applicant, understand my compensation will be as follows:

Position _____

Remarks _____

	Month	Week	Hour
Cash _____			\$ _____

Other compensation at taxable value

Room _____ \$ _____

Meals a day \$ _____

Days a week \$ _____

Laundry _____ \$ _____

TOTAL \$ _____

Position Temporary? _____

Applicant's Initials _____

Date _____

Approved By: _____

Title _____