

Application for Employment

Date of Application: _____

Position Desired: _____ *please circle one:* Full Time Part Time

Date available to start work? : _____

What shifts are you available to work? Day Evening Night

Can you work rotating shifts? Yes No

Are you willing to work weekends and holidays when necessary? Yes No

IMPORTANT: Please print or write plainly.

Last Name: _____ First Name: _____ Middle Name: _____ Maiden Name: _____

E-Mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Area Code: () Phone Number: _____

Have you been previously employed at Virginia Gay Hospital Clinics, Home Health & Nursing & Rehab? Yes No

If "Yes", please give position held and dates of employment: _____

Were you referred to apply here? Yes No

If "Yes", please give name and department of who referred you: _____

Record of Education

	Name and Address of Educational Institution	Circle Highest Year Completed	Major	List Diploma or Degree
High School		7 8 9 10 11 12		
College or University		1 2 3 4 5 6		
Technical or Nursing School		1 2 3 4 5		
Other (Specify)				

Are you attending school now? Yes No

Professional License or Registration

Type:	State(s) Iowa	YES	NO	License or Certificate	Expiration Date
	Other:				
Type:	State(s) Iowa	YES	NO	License or Certificate	Expiration Date
	Other:				

Professional Organizations List all you belong or hold office.

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Special Skills & Qualifications List all for the position you are applying.

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Employment Record

List all employment for past fifteen years including self employment.

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per

Address (City, State, Zip):

Job Title: Supervisor's Name:

Describe Major Job Duties:

Reason for Leaving:

If presently employed may we contact your employer for references? Yes No

May we contact you at your place of employment? Yes No If "Yes", please enter area code and phone: ()

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per

Address (City, State, Zip):

Job Title: Supervisor's Name:

Describe Major Job Duties:

Reason for Leaving:

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per

Address (City, State, Zip):

Job Title: Supervisor's Name:

Describe Major Job Duties:

Reason for Leaving:

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per

Address (City, State, Zip):

Job Title: Supervisor's Name:

Describe Major Job Duties:

Reason for Leaving:

Personal Reference

Name:

Address (City, State, Zip):

Name:

Address (City, State, Zip):

Military Service

Branch of Service:

Rank: Dates of Service: From To

Specialty Training Received:

Are you a U.S. Citizen? Yes No

If you are not a citizen of the U.S., please enter type of Visa held and Alien Registration Number.

Type of Visa: Alien Registration No. :

Have you ever been convicted in a criminal court case (except of minor traffic violations)? Yes No

If "Yes", give details to where, when and on what charge:

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other state?

Yes No If "Yes", give details as to Where, When and on What Charge:

Are you on the OIG excluded provider list? Yes No If "Yes", date and why?

Virginia Gay Hospital is an equal employment opportunity employer. No person is unlawfully excluded from consideration for employment because of race, color, religious creed, national origin, ancestry, gender, age, veteran status, marital status, sexual orientation, transgender identity, or physical challenges. This policy applies not only to recruitment and hiring practices, but also in the areas of placement, promotion, transfer, rate of pay, and termination. 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, 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 examination and such future examinations as may be required of this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physician 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 terminate for any misstatement or omission of fact appearing on this 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 of employment.

Signature of Applicant Date

Applicant's Statement

IMPORTANT: Read carefully and initial each paragraph before signing.

By my signature and initials placed below, I certify that the information provided in this employment application (and accompanying resume, if any) is true and complete, and I understand that any false information or significant omissions may disqualify me from further consideration for employment and may be justification for my dismissal from employment if discovered at a later date. I agree to immediately notify the hospital if I should be convicted of a felony or any crime involving dishonesty or a breach of trust while my application is pending or during my period of employment, if hired.

_____ Initials

I give permission for a complete post-offer assessment and physical examination, and I consent to the release to the hospital of any and all medical information as may be deemed necessary by the hospital in judging my capability to do the work for which I am applying. I further understand that if medical conditions are diagnosed through the post-offer assessment or physical exam that would make it impossible for me to perform the duties as listed on the job description, the job offer may be withdrawn.

_____ Initials

I authorize the investigation of all statements contained in this application. I also authorize the hospital to contact my present employer, past employers and listed references.

_____ Initials

I authorize any person, school, current employer, and organizations named in this application from to provide the hospital with relevant information and opinion that may be useful to the hospital in making a hiring decision, and I release such persons and organizations from any legal liability in making such statements.

_____ Initials

I understand that this application does not, by itself, create a contract of employment. I understand and agree that, if hired, MY EMPLOYMENT IS FOR NO DEFINITE PERIOD OF TIME, and may, regardless of the date of payment of my wages or salary, BE TERMINATED AT ANYTIME.

_____ Initials

I understand also that I am required to abide by all rules and regulations of the employer.

_____ Initials

Date:

Signed:

State of Iowa
NON-LAW ENFORCEMENT RECORD CHECK REQUEST
FORM A

ACCOUNT NUMBER _____

**TO: Iowa Division of Criminal
Investigation
Bureau of Identification, 1st Floor
215 E 7th Street
Des Moines, Iowa 50319
(515) 281-4776
(515) 725-6080 (fax)**

FROM: _____

Phone # _____

Fax # _____

I am requesting an **IOWA CRIMINAL HISTORY** check on:

(Type or Print Legibly)

REQUEST

Last Name

(mandatory)

First Name

(mandatory)

Middle Name

(recommended)

Date of Birth

(mandatory)

Sex

(mandatory)

Social Security Number

(recommended)

Signature of Requester

There is a separate Form "A" required for each last name submitted

(DCI Use Only)

RESULTS

As of _____, a name and date of birth check revealed:

CCH record attached

No CCH record found

DCI initials _____

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation. Any information maintained by the DCI may be released as allowed by law.

Signature

Date