

Glenn Medical Center, Inc. - Application for Employment

1133 W. Sycamore St - Willows, CA 95988

HR: Office (530) 934-1881 : Fax 934-1818

Date: _____ Position applying for: _____ Social Security #: _____

Name: _____ Phone: _____ Message: _____

Address: _____

Are you applying for: Full Time Part Time Either Per Diem

Are you available to work: Weekends Holidays

What shifts are you available to work? Days Evenings Nights

Are you employed now? Yes No When would you be available to start work? _____

Please initial: ____ I realize the staffing needs of the Medical Center may require me to work extra days or take low census days.

Do you have the legal right to work and be employed in the U. S.? Yes No Are you 18 years of age or older? Yes No

Please initial: ____ I understand that if an offer of employment is made, I am required to furnish proof of U.S. citizenship or proof that I have the legal right to work in the U.S.

PERSONAL DATA	SKILLS																						
<p>If related to anyone in our employ, please state name and department:</p> <hr/> <p>Have you ever worked for Glenn Medical Center? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what department and/or site? _____</p> <p>Under what name? _____</p> <p>Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you been convicted of a misdemeanor (including a DUI) within the last seven years? Do not include misdemeanor convictions for which probation was completed and the case was dismissed by the court. (Do not include marijuana related convictions which occurred more than two years prior to the date of this application.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes to either or both of these questions please complete the following:</p> <p>Nature of conviction: _____ Date: _____</p> <p>Details of offense(s), including at a minimum the date of the conviction, the state and county in which it occurred, the jurisdiction (federal, state, etc.), and the nature of the offense. Please include any convictions in a military court.</p> <p>APPLICANTS FOR JOBS WITH ACCESS TO DRUGS OR MEDICATION: Have you ever been arrested for the use, possession, sale, cultivation, transportation, importation, gift distribution, or being under the influence of controlled substances or illegal narcotic drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain:</p> <hr/> <p>APPLICANTS FOR JOBS WITH REGULAR ACCESS TO PATIENTS: Have you ever been arrested for s sex-related offense? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain:</p> <hr/> <p>NOTE: If you respond yes to any of these questions, it will not automatically bar you from employment. Each circumstance will be decided on a case by case basis to determine whether or not it is relevant to the position for which you are applying.</p>	<p>Please check the skills you possess that are relevant to the position for which you are applying. Unrelated items may be checked at your discretion.</p> <p><input type="checkbox"/> Filing <input type="checkbox"/> Word Processing <input type="checkbox"/> Typing WPM _____ <input type="checkbox"/> Software _____</p> <p><input type="checkbox"/> Letter Composition <input type="checkbox"/> Data Processing Equipment</p> <p><input type="checkbox"/> Shorthand WPM _____ <input type="checkbox"/> Personal Computer</p> <p><input type="checkbox"/> Dictaphone <input type="checkbox"/> Type _____</p> <p><input type="checkbox"/> Payroll <input type="checkbox"/> Admitting</p> <p><input type="checkbox"/> Accounts Payable / Receivable <input type="checkbox"/> Medical Terminology</p> <p><input type="checkbox"/> Insurance Billing <input type="checkbox"/> Biomedical Equipment</p> <p><input type="checkbox"/> Switchboard <input type="checkbox"/> Other _____</p> <hr/> <p>Bilingual Ability: (languages) _____</p> <p>Please Initial: ____ I understand that if my bilingual skills are needed, I may be required to interpret occasionally.</p> <hr/> <p>NURSING POSITIONS ONLY <i>Specify # of months of actual work experience:</i></p> <table style="width: 100%;"> <tr> <td>Emergency Services _____</td> <td>Medical Surgical _____</td> </tr> <tr> <td>Critical Care / Telemetry _____</td> <td>Geriatric Skilled Nursing _____</td> </tr> <tr> <td>Perioperative _____</td> <td>Rehabilitation _____</td> </tr> <tr> <td>Homecare Services _____</td> <td>Catheterization Lab _____</td> </tr> <tr> <td>Oncology _____</td> <td>UR / Case Management _____</td> </tr> <tr> <td>Pediatrics _____</td> <td>OB: L&D / PP / NICU _____</td> </tr> <tr> <td>Gastroenterology _____</td> <td>Ambulatory Services _____</td> </tr> <tr> <td>Other: _____</td> <td>MICN <input type="checkbox"/> Exp. Date _____</td> </tr> <tr> <td>BLS (CPR) <input type="checkbox"/> Exp. Date _____</td> <td>AORN <input type="checkbox"/> Exp. Date _____</td> </tr> <tr> <td>ACLS <input type="checkbox"/> Exp. Date _____</td> <td>NRP <input type="checkbox"/> Exp. Date _____</td> </tr> <tr> <td>CCRN <input type="checkbox"/> Exp. Date _____</td> <td>PALS <input type="checkbox"/> Exp. Date _____</td> </tr> </table> <hr/> <p style="text-align: center;">PROFESSIONAL & TECHNICAL APPLICANTS ONLY</p> <p>Professional License Number: _____</p> <p>Type of License: _____</p> <p>Expiration Date: _____</p> <p>Have you ever received any disciplinary action against your license or certification in this or any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain:</p> <hr/> <p>NOTE: If you respond yes to this question, it will not automatically bar you from employment. Each circumstance will be decided on a case by case basis to determine whether or not it is relevant to the position for which you are applying.</p>	Emergency Services _____	Medical Surgical _____	Critical Care / Telemetry _____	Geriatric Skilled Nursing _____	Perioperative _____	Rehabilitation _____	Homecare Services _____	Catheterization Lab _____	Oncology _____	UR / Case Management _____	Pediatrics _____	OB: L&D / PP / NICU _____	Gastroenterology _____	Ambulatory Services _____	Other: _____	MICN <input type="checkbox"/> Exp. Date _____	BLS (CPR) <input type="checkbox"/> Exp. Date _____	AORN <input type="checkbox"/> Exp. Date _____	ACLS <input type="checkbox"/> Exp. Date _____	NRP <input type="checkbox"/> Exp. Date _____	CCRN <input type="checkbox"/> Exp. Date _____	PALS <input type="checkbox"/> Exp. Date _____
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EDUCATION	Name and Location of School	Graduated	No. of Years Attended	Major Course	Degree or Certification
High School					
College, Vocational, Tech					
College, Vocational, Tech					
College, Vocational, Tech					

List memberships in professional organizations which you feel would enhance your application, excluding any whose names would indicate your sex, race, religion, color, national origin, ancestry, age, medical condition, physical disability, mental disability, or marital status.

Give a complete EMPLOYMENT RECORD for the last seven years starting with present or last employer; include periods of unemployment. You may submit a resume, but the entire application MUST be completed. May we contact your present employer? Yes No

From: ___/___/___ Mo. Day Yr.	Company Name _____	Shift _____ <input type="checkbox"/> Full Time	Job Title: _____
To: ___/___/___ Mo. Day Yr.	Street Address _____	HOURS WORKED	Job Duties: _____
Starting Salary \$ _____	City _____ State _____ Zip _____	<input type="checkbox"/> Part Time _____	Reason for Leaving: _____
Ending Salary \$ _____	Phone _____ Supervisor _____	<input type="checkbox"/> On Call _____	
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Ending Salary \$ _____	Phone _____ Supervisor _____	<input type="checkbox"/> On Call _____	

Have you ever been involuntarily terminated from any prior employment? Yes No If yes, give reasons for termination and employer's name:

REFERENCES: Please provide the names of two persons not related to you, whom you have known at least one year.

NAME	ADDRESS	PHONE	BUSINESS	YRS ACQUAINTED

Glenn Medical Center, Inc., does not discriminate on the basis of sex, race, religion, color, national origin, ancestry, age, medical condition, physical disability, mental disability, marital status, or any other characteristic protected by state or federal law.

Initial: ___ I hereby certify that the information on this application is correct and complete to the best of my knowledge. I agree to have any of the statements checked by the Medical Center unless I have indicated to the contrary. I authorize the references listed above to provide the Medical Center any and all information concerning my previous employment and other pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to the Medical Center as well as from the use or disclosure of such information by the Medical Center or any of its agents, employees, or representatives. I understand that falsification or omission of any information on this application may result in the withdrawal of a job offer or, if I have been hired, immediate dismissal.

Initial: ___ If I am employed by the Medical Center, I agree to conform to its rules and regulations. I understand employment is based on the mutual consent of the employee and the Medical Center. Accordingly, with or without cause or advance notice, either I or the Medical Center can terminate the employment relationship at will, at any time. I further understand that no employee or representative of the Medical Center, other than the Chief Executive Officer, has the authority to enter into any agreement for employment for any specified period of time, or to make any express or implied agreement contrary to the foregoing.

Initial: ___ I understand that all offers of employment are conditioned on satisfactory responses to reference requests, proof of identity, and legal right to work in the U.S., successful completion of a background check, and satisfactory completion of a post offer medical examination. Medical examination includes laboratory testing of a urine sample from a prospective employee to determine the presence of certain drugs and/or alcohol in the body. The medical examination will be at the Medical Center's expense.

APPLICANT SIGNATURE: _____