



Application for Employment

OKMULGEE MEMORIAL HOSPITAL, INC. will consider applicants for all positions without regard of race, color, religion, sex, national origin, age or veteran status, or any other legally protected status. All information obtained from applicant will be maintained in Human Resources for one year from date of application.

(PLEASE PRINT)

Last Name:		First Name:		Middle Initial:	
Address:	(Number)	(Street)	(City)	(State)	(Zip Code)
Telephone Number:	Message Number:		Social Security Number:		
Maiden Names and/or Former Names Under Which You have Worked					

Describe or Name Position Applied For:			Application Date:		
Types of employment you will accept:		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Days <input type="checkbox"/> Nights <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> Relief <input type="checkbox"/> Temporary	Date when you are available to start work:		
			Alternate positions you will consider:		

EMPLOYMENT HISTORY

Start with your present or last job, and include any job-related military assignments, volunteer work or other experience related to the job for which you are applying. (Please use an extra sheet if more space is needed.)

1. Employer		Dates Employed		Worked Performed
		From	To	
Address _____ City _____ State _____ Zip _____				_____
Supervisor's Name _____ Telephone No. _____		Rate of Pay _____		
Job Title _____				
Reason for Leaving _____				
2. Employer		Dates Employed		Worked Performed
		From	To	
Address _____ City _____ State _____ Zip _____				_____
Supervisor's Name _____ Telephone No. _____		Rate of Pay _____		
Job Title _____				
Reason for Leaving _____				
3. Employer		Dates Employed		Worked Performed
		From	To	
Address _____ City _____ State _____ Zip _____				_____
Supervisor's Name _____ Telephone No. _____		Rate of Pay _____		
Job Title _____				
Reason for Leaving _____				

EDUCATION AND TRAINING															
	Elementary School				High School				College/University				Additional Information		
School Name and Location															
Years Completed	4	5	6	7	8	9	10	11	12	1	2	3	4	5+	
					Year: _____				Describe Degree(s) _____				Date: _____		
					<input type="checkbox"/> Diploma _____ <input type="checkbox"/> GED _____				License Type and Expiration Date: _____						
If a license, certificate or registration is required for the position for which you are applying, please answer the following questions:															
1) Has your license / certificate ever been suspended / revoked? 1-a. <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____ 1-b. Why? _____ 1-c. When were you or will you be reinstated? _____ 1-d. Driver's license: _____ 1-e. Expiration date: _____															
2) Were you sanctioned by Medicare or Medicaid? 2-a. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ 2-b. Describe the circumstances: _____ 2-c. Was legal action taken against you? _____ 2.d. For what agency or employer were you working at the time of the incident? _____ 2.e. When were you or will you be released from this sanction? _____															
3) I understand that in the event I am sanctioned or have my license / certificate suspended or revoked during my employment with OMH, I am responsible to disclose this information to OMH immediately. I further understand that failure to disclose this information will be grounds for immediate termination and possible legal action against me.															
SIGNED: _____ Date: _____															
Describe any specialized training, apprenticeship, skills, etc:															
ADDITIONAL INFORMATION															
1. To your knowledge, do you have any relatives working for OMH? <input type="checkbox"/> No <input type="checkbox"/> Yes – Give name(s) (Relatives may not work in same department)															
Department: _____															
2. Have you been convicted of a felony? (conviction will not necessarily disqualify an applicant from employment) <input type="checkbox"/> No <input type="checkbox"/> Yes – Give details, including dates: _____															
3. Can you travel if the job requires it? <input type="checkbox"/> Yes <input type="checkbox"/> No (Answer only if job requires travel) Can you work overtime if the job requires it? <input type="checkbox"/> Yes <input type="checkbox"/> No															
4. Do you have any circumstances which would limit your ability to do all the duties of this job on any day on any shift? <input type="checkbox"/> No <input type="checkbox"/> Yes – If so, describe what can be done to accommodate this condition: _____															
5. Have you worked for OMH before? <input type="checkbox"/> No <input type="checkbox"/> Yes – Give dates: From: _____ To: _____															
6. Are you legally able to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (Proof of citizenship or immigration status will be required upon employment.)															
REFERENCES															
Please give the name, address, and telephone number of three persons who are not related to you, and who would have knowledge of your experience and suitability for this position. (Failure to provide such references may disqualify you from further consideration.)															
Name				Address				Phone No.							
Name				Address				Phone No.							
Name				Address				Phone No.							
1. I understand that I may be required to pass an employment physical as a condition of employment, (includes drug-screen) 2. I authorize my previous schools, employers, organizations, and others I have named to furnish OKMULGEE MEMORIAL HOSPITAL, INC. my record and information concerning my suitability for employment. I hereby release them and OKMULGEE MEMORIAL HOSPITAL, INC. from all liability for requesting or releasing this information. 3. Upon my termination from employment with OKMULGEE MEMORIAL HOSPITAL, INC., I authorize release of information regarding my work, and I release OKMULGEE MEMORIAL HOSPITAL, INC. from liability for releasing such information. 4. I hereby certify that statements I have made in this application are true and complete. I understand the reasons for providing this information. I also understand that if I have intentionally made any false statements or withheld information, I may be terminated from my job, and I may be disqualified from re-employment.															
Applicant's Signature										Date					



SUPPLEMENTAL EMPLOYMENT INFORMATION

This information is being gathered for affirmative action under Section 503 of the Rehabilitation Act of 1973. This information requested is voluntary and will be kept confidential. An applicant will not be subject to any adverse treatment for refusing to complete the questionnaire.

AFFIRMATIVE ACTION QUESTIONNAIRE

The purpose of this section is to assist in monitoring Affirmative Action Programs and to aid in complying with any required Governing record keeping of periodic reporting. This information is not part of your employment application and will not be considered in the employment / selection process. If you choose to provide the information, please complete the following:

Title of job applied for: _____ Sex: Male Female

RACE (check one)

- White – origins in Europe, North Africa, or Middle East
- Asian – origins in Far East, E.S. Asia, India or Pacific Islands
- Black – origins in Africa
- Hispanic – Mexican, Puerto Rican, Cuban, Central or South American
- American Indian – origins in North America, to include Alaska

VETERANS / U.S. MILITARY STATUS

- (0) Non-Veteran
- (1) Pre-Vietnam Veteran
- (2) Pre-Vietnam Veteran with service incurred disability
- (3) Vietnam Era Veteran (8/5/64 – 5/7/75)
- (4) Vietnam Era Veteran with service incurred disability
- (5) Post Vietnam Veteran
- (6) Post Vietnam Veteran with service incurred disability

ACTIVE NATIONAL GUARD OR RESERVIST (check one)

- Yes
- No

PHYSICAL CONDITION

- (1) No Handicap
- (2) Physical Handicapped (No Facility Modification)
- (3) Physical Handicapped (Facility Modification)
- (4) Health Handicapped (Heart Attack, Diabetic, Seizures, etc.)
- (5) Mentally Handicapped (Learning Disability)



REFERENCE INQUIRY

TOP PORTION MUST BE FILLED OUT COMPLETELY

PLEASE PRINT REFERENCE NAME AND FULL ADDRESS BELOW

Previous Employer Name

Mailing Address

City

State

Zip

Employment Dates: From: _____

To: _____

Job Title While Employed: _____

Social Security Number: _____

You are authorized to furnish Okmulgee Memorial Hospital any information you may have. I release you from liability for damages arising from said information provided either orally or by letter.

Date

Signature of Applicant

APPLICANT: DO NOT WRITE BELOW THIS LINE

PREVIOUS EMPLOYER: Please complete the following and return in self-addressed envelope.

Are Employment dates correct? Yes No If no, correct dates are: _____

Reason for leaving? _____

Would you rehire? Yes No

If No, why? _____

Date: _____

Printed Name of Person Completing Form: _____

Signature of Person Completing Form: _____

Title: _____