

# APPLICATION FOR EMPLOYMENT

## COVINGTON COUNTY HOSPITAL

P.O. Box 1149 • Collins, MS 39428-1149

POSITION APPLYING FOR (1)		Date: _____ Time: _____ "Equal opportunity is given to all applicants regardless of race, creed, color, national origin, sex, age or individuals with disabilities."				
This application shall become void after 6 months but can be reactivated for an additional 6 months by written request of the applicant.					Name (First, Middle, Last)	
		Have you worked under any other name or SS #?			Social Security No.	
Address (Number, Street, City, State and Zip)				Area Code - Phone No.		
Education	Name and Address of School	Years (2) Attended	Graduated		Date	Degree / Major
			Yes	No		
High School						
College						
Graduate School						
Special Training						
Are you over the age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ever applied for work here before? _____ If so, when? _____		Are you either a U.S. citizen or an alien who has the legal right to work in the job for which you are applying? (3) <input type="checkbox"/> Yes <input type="checkbox"/> No Please list relative and/or friends working here:		
How did you hear about us?		Have you ever been convicted of a crime? If yes, explain (4) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Work History: Account for all employment, including period of unemployment. Start with the most recent. (You may attach additional pages if necessary)						
Dates		Company and Phone Number	Supervisor's Name and Final Position	Describe Duties	Salary	Reason for Leaving
From	Thru					
May we contact your current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Have you ever been displaced or discharged by a previous employer because of absenteeism, tardiness, or any other non-attendance of work? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Military Experience Branch	From	Thru	Rank Achieved	Special Schools or Training		

1. If applying for more than one position, an application for each position must be submitted by the applicant.
2. The Age Discrimination in Employment Act of 1967, as amended, prohibits discrimination on the basis of age with respect to individuals who are 40 years old or older. The dates designated for school attendance will be used strictly for the purpose of verifying application information and obtaining references.
3. If offered a position, the Immigration Reform and Control Act of 1986 requires you to furnish proof of your employment authorization and your identity before you begin work.
4. Criminal history record checks will be required as provided by and conducted in accordance with Mississippi Code Annotated Section 43-11-13 and the "Minimum Standards of Operation for Mississippi Hospitals" adopted by the Mississippi State Department of Health, Health Facilities and Certification Division.

**Shift and Travel Availability**

What hours are you willing to work?

Day (7 to 3)  Evening (3 to 11)  Night (11 to 7)  Other

Extended Day (7 a.m. to 7 p.m.)  Full Time

Extended Night (7 p.m. to 7 a.m.)  Part-time

Are you willing to work overtime?  Yes  No

Are you willing to work Saturday, Sunday and Holiday?

No  Rotate  Occasional

Date available to start

work? \_\_\_\_\_

How often are you willing to travel?

Day only  Some  Often  None

Overnight  Some  Often  None

How far do you live from here? \_\_\_\_\_

Do you have a means of transportation to get to and from work?

Yes  No

Do you have personal or other obligations that would cause you to frequently miss work?  Yes  No If Yes, explain \_\_\_\_\_

If hired will you be engaged in any other work, or business, or school?

Yes  No If Yes, hours \_\_\_\_\_

Days \_\_\_\_\_ nature of work.

What salary do you require? \_\_\_\_\_

**License and Registration Information for nurses and professional individuals**

State	License Number	Dates	Type

**SPECIALIZED HOSPITAL EXPERIENCE**

- |   | Years |  | Years |
|---|-------|--|-------|
| <input type="checkbox"/> Supervisor Nurse | _____ | <input type="checkbox"/> Security Guard        | _____ |
| <input type="checkbox"/> Registered Nurse | _____ | <input type="checkbox"/> EKG Technician        | _____ |
| <input type="checkbox"/> Practical Nurse  | _____ | <input type="checkbox"/> Inhalation Therapist  | _____ |
| <input type="checkbox"/> Nurse's Aide     | _____ | <input type="checkbox"/> Radiology             | _____ |
| <input type="checkbox"/> Orderly          | _____ | <input type="checkbox"/> X-Ray Technician      | _____ |
| <input type="checkbox"/> Food Service     | _____ | <input type="checkbox"/> X-Ray Aide            | _____ |
| <input type="checkbox"/> Chef/Cook        | _____ | <input type="checkbox"/> Physical Therapy Aide | _____ |
| <input type="checkbox"/> Housekeeping     | _____ | <input type="checkbox"/> Medical Transcript    | _____ |
| <input type="checkbox"/> Laundry          | _____ | <input type="checkbox"/> Medical Record Clerk  | _____ |
| <input type="checkbox"/> Porter           | _____ | <input type="checkbox"/> Medical Secretary     | _____ |
| <input type="checkbox"/> Window Cleaner   | _____ | <input type="checkbox"/> Switchboard           | _____ |
| <input type="checkbox"/> Laboratory Tech. | _____ | <input type="checkbox"/> Pharmacy Asst.        | _____ |
| <input type="checkbox"/> Maintenance Mech | _____ | <input type="checkbox"/> Purchasing            | _____ |
| <input type="checkbox"/> Engineer/Fireman | _____ | <input type="checkbox"/> EEG Tech.             | _____ |
| <input type="checkbox"/> Photography      | _____ | <input type="checkbox"/> Personnel             | _____ |
| <input type="checkbox"/> Public Relations | _____ | <input type="checkbox"/> O.R. Tech             | _____ |
|   |       | <input type="checkbox"/> Other                 | _____ |

**SPECIALIZED OFFICE EXPERIENCE**

- |  | Years |  | Years |
|--|-------|--|-------|
| <input type="checkbox"/> Typing        | _____ | <input type="checkbox"/> Clerical Work                             | _____ |
| <input type="checkbox"/> Dictation     | _____ | <input type="checkbox"/> Credit                                    | _____ |
| <input type="checkbox"/> Bookkeeping   | _____ | <input type="checkbox"/> Cashier                                   | _____ |
| <input type="checkbox"/> Record Filing | _____ | Microsoft  |       |
| <input type="checkbox"/> Mailing Clerk | _____ | <input type="checkbox"/> Word <input type="checkbox"/> Access      |       |
| <input type="checkbox"/> Calculator    | _____ | <input type="checkbox"/> Excel                                     |       |
| <input type="checkbox"/> Other         | _____ | <input type="checkbox"/> Powerpoint <input type="checkbox"/> Other | _____ |
|  |       | <input type="checkbox"/> Desktop Publishing                        | _____ |
|  |       | What type? _____   |       |

**ADDITIONAL WORK EXPERIENCE**

- |  |       |  |       |
|--|-------|--|-------|
| <input type="checkbox"/> Electrician       | _____ | <input type="checkbox"/> Air Conditioner     | _____ |
| <input type="checkbox"/> Carpenter         | _____ | <input type="checkbox"/> General Maintenance | _____ |
| <input type="checkbox"/> Painter/Plasterer | _____ |  |       |
| <input type="checkbox"/> Plumber           | _____ |  |       |
| <input type="checkbox"/> Other             | _____ |  |       |

Are you able to perform the essential job functions for the position for which you are applying with or without a reasonable accommodation?  Yes  No

## READ CAREFULLY

I certify that the answers given by me to the foregoing questions and statements are true and complete to the best of my knowledge, and that I have withheld nothing that would, if disclosed, affect this application unfavorably. I acknowledge that misrepresentation or omission of facts called for in this application is cause for my not being hired or my termination at any time without previous notice to me.

I authorize the hospital/company to release to other prospective employers or information service bureaus, any information regarding my employment with the hospital/company or the information set forth in this application or gained by the hospital/company from any other companies, agencies, schools or persons named in this application, including information regarding my employment, character, qualifications and other information they may have regarding me, whether or not it is in their records. I hereby release the hospital/company from all liability for any damage caused by issuing this information to outside individuals.

I agree to submit myself upon request by the hospital/company, subsequent to a conditional job offer, for physical examination by a physician designated by the hospital/company, and to future physical or mental examinations the hospital/company may require at a later date as a condition of continued employment, as may be permitted by law.

If employed, I agree as a condition of continued employment to acquaint myself with, and to abide by all Rules, Regulations and Policies as established or amended by the hospital/company. However, I understand that my employment and compensation can be terminated with or without notice at any time, and for any reason, at the option of the hospital/company or myself. Nothing in this Application of Employment should be construed to constitute a contract of employment between the hospital/company and the applicant. I understand that my terms and conditions of employment may be changed at any time.

If I am employed, I further understand and agree that when my employment is terminated by retirement or otherwise, I must return all of the hospital/companies property in my custody, including, but not limited to, any documents, hospital/company equipment, office keys, manuals, identification cards and name pins before I am entitled to final payment of any amounts due me on separation. I also understand that the value of these items, if not returned, along with any monies I might owe the hospital/company, may be deducted from my final paycheck.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF APPLICANT

Rev. 3/06

Add to payroll _____	Department _____	Position offered _____
Date _____	Job Title _____	Position Rejected _____
Rate _____		_____ Applicant Signature

**READ CAREFULLY**  
**AUTHORIZATION TO RELEASE INFORMATION**

I authorize the hospital/company, or its agent, to obtain any information about my work history or personal information, including my character and qualifications, credit rating, driving record, criminal record, education and previous employment. I authorize all persons, schools, companies, information service bureaus, governmental agencies and law enforcement authorities to release any information concerning my background to the hospital/company, whether or not it is in their records. I also authorize the hospital/company to obtain this information from any company that is in the business of providing applicant background checks. I hereby release the individuals or entities providing this information from all liability or any damage caused by issuing this information.

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Date

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Signature of Applicant