

ELECTRA MEMORIAL HOSPITAL • ELECTRA MEDICAL CLINIC • ELECTRA HOME HEALTH • ELECTRA MEDICAL SUPPLY • GOLDSMITH'S DRUG • IMAGINATION STATION

APPLICATION FOR EMPLOYMENT

PLEASE PRINT USING BALLPOINT PEN OR TYPE

IDENTIFICATION	LAST NAME		FIRST	MIDDLE	APPLICATION DATE	
	PRESENT ADDRESS: STREET & NUMBER			CITY	STATE	ZIP CODE
	HOME PHONE ()	BUSINESS PHONE ()	EMAIL ADDRESS		PREFERRED CONTACT METHOD	
	EMERGENCY CONTACT: NAME				ADDRESS	TELEPHONE ()
	DO YOU HAVE RELATIVES WORKING FOR ELECTRA HOSPITAL DISTRICT? <input type="checkbox"/> Yes <input type="checkbox"/> No			NAME	RELATIONSHIP	

JOB STATUS	POSITION OR TYPE OF WORK APPLYING FOR:				
	1.		2.		
	SEEKING <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary		SHIFT(S) WILLING TO WORK <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Evening <input type="checkbox"/> Rotating		AVAILABLE WEEKENDS? <input type="checkbox"/> Yes <input type="checkbox"/> No
	PRESENTLY EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No		MAY WE CONTACT YOUR PRESENT EMPLOYER? <input type="checkbox"/> Yes <input type="checkbox"/> No		DATE AVAILABLE FOR WORK
	WERE YOU PREVIOUSLY EMPLOYED BY ELECTRA HOSPITAL DISTRICT? <input type="checkbox"/> Yes <input type="checkbox"/> No		DATES EMPLOYED		LOCATION/FACILITY

EDUCATION AND TRAINING	Please indicate any educational, vocational, on-the-job, or any other training you have received which will aid us in placing you in the position that best meets your qualifications and/or in determining your qualifications for a position for which you desire to be considered.				
	HIGH SCHOOL: NAME	LOCATION	NO. YEARS COMPLETED	DEGREE RECEIVED	MAJOR/MINOR
	COLLEGE:				
	GRADUATE SCHOOL:				
	ADDITIONAL SCHOOLS OR SPECIAL TRAINING, INCLUDING LANGUAGES OR OTHER SKILLS				
	OFFICE MACHINES, PROFESSIONAL SOFTWARE, OR OTHER SPECIAL EQUIPMENT USED				TYPING SPEED WPM
	PROFESSIONAL LICENSE/CERTIFICATE: Type:	STATE ISSUED	NUMBER	DATE RECEIVED	EXPIRATION DATE
	PROFESSIONAL LICENSE/CERTIFICATE (2): Type:	STATE ISSUED	NUMBER	DATE RECEIVED	EXPIRATION DATE

GENERAL	HAVE YOU EVER BEEN CONVICTED OR PLED NOT GUILTY OR NO CONTEST TO A FELONY? IF YES, PLEASE EXPLAIN		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Checking "Yes" will not necessarily bar employment.		

WORK EXPERIENCE: Start with your present or last position and work back, accounting for all periods of unemployment.

PREVIOUS/LAST	NAME OF EMPLOYER		TYPE OF BUSINESS		ADDRESS	
	NAME OF SUPERVISOR			TITLE OF SUPERVISOR		TELEPHONE ()
	STARTED MONTH YEAR	LEFT MONTH YEAR	STARTING PAY		FINAL PAY	AVERAGE HOURS / WEEK
	JOB TITLE AND DESCRIPTION OF DUTIES AND RESPONSIBILITIES					REASON FOR LEAVING

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	NAME OF SUPERVISOR			TITLE OF SUPERVISOR		TELEPHONE ()
	STARTED MONTH YEAR	LEFT MONTH YEAR	STARTING PAY		FINAL PAY	AVERAGE HOURS / WEEK
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	JOB TITLE AND DESCRIPTION OF DUTIES AND RESPONSIBILITIES					REASON FOR LEAVING

REFERENCES: Please give the names of two professional references whom you have known at least one year.

NAME		BUSINESS		TELEPHONE ()
ADDRESS		RELATIONSHIP		YEARS ACQUAINTED

NAME		BUSINESS		TELEPHONE ()
ADDRESS		RELATIONSHIP		YEARS ACQUAINTED

Please read and initial each paragraph below.

If there is any part of this page that you do not understand, please seek clarification before signing.

_____ I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement on this application or on any documents used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ I hereby authorize Electra Hospital District to thoroughly investigate my references, work records, education and other matters to my suitability for employment and, further, authorize my current and former employers to disclose to the company any and all letters, reports, and other information pertaining to my employment with them, without giving me prior notice of such disclosure. In addition, I hereby release Electra Hospital District, my current and former employers, and all other persons, corporations, partnerships, and associations from any and all claims, demands, or liabilities arising out of or in any way related to such investigation or disclosure.

_____ I understand that if offered employment, the offer is contingent on my passing a pre-employment alcohol and drug screen, pre-employment physical, and criminal history record check. By signing this application, I voluntarily agree to submit to a pre-employment alcohol/drug screen, pre-employment physical, and criminal history record check upon receipt of a verbal offer of employment. I understand that failure to pass the alcohol/drug screen, physical, and/or criminal history record check will result in withdrawal of the employment offer.

_____ I understand that nothing contained in the application or conveyed to me during any interview which may be granted is intended to create an employment contract, implied or explicit, between me and Electra Hospital District. In addition, I understand and agree that if I am employed, my employment relationship with Electra Hospital District is strictly voluntary and at our mutual will. I understand that if employed, my employment is for no definite period and may be terminated at any time, with or without prior notice, with or without cause or reason, at the option of either myself or Electra Hospital District, and that no promises or representations contrary to the foregoing are binding on Electra Hospital District unless made in writing and signed jointly by the Administrator/CEO and myself.

_____ I understand and agree that any future changes in my title, duties, compensation, working conditions, and/or Electra Hospital District benefits, policies, and procedures will not alter our at-will agreements.

_____ I hereby certify that I am eligible to work in the United States. I understand that if offered employment, I will, as a condition of employment, be required to submit proof of my identity and legal right to work in the United States on my first day of employment.

_____ If the position applied for requires driving in the course of work, I understand that I will be required to possess a current and valid Texas driver's license and understand that I will be required to provide a copy of my official driving record and proof of insurance. I also understand that any offer of employment is contingent on my ability to be covered by Electra Hospital District's auto insurance, if required for my position.

My signature below certifies that I have read and understand this complete page, and agree to the terms and conditions outlined in this document.

_____ Date

_____ Applicant Signature

Electra Hospital District is an Equal Opportunity Employer. Prospective employees will receive consideration without discrimination regarding race, color, religion, sex, age, national origin, disability, or veteran status.