

WARM SPRINGS

Medical Center

HOSPITAL USE ONLY	
Application Date:	_____
Interview Date:	_____
Offer Date:	_____
Shift:	Status: _____
Returned To:	_____
Hourly Base:	_____
Start Date:	_____

P.O. Box 8, 5995 Spring Street • Warm Springs, Georgia 31830 • (706) 655-3331 • An Equal Opportunity Employer

APPLICATION FOR EMPLOYMENT

To The Applicant: Federal and State law prohibits discrimination in employment practices because of race, color, religion, sex, age, national origin, or disability. No question on this application is asked for the purpose of limiting or excluding any applicant's consideration of employment on the basis of the above. We appreciate your interest in Warm Springs Medical Center, and we are sincerely interested in your qualifications. Please be advised that all employees at Warm Springs Medical Center undergo a drug screen and criminal record check prior to beginning employment.

PLEASE PRINT IN BLACK OR BLUE INK (If requested information is not available or if it is unknown, please so indicate)

NAME (Last)	(First)	(Middle)	(Maiden)	SOCIAL SECURITY #
PRESENT ADDRESS (Number and Street)			HOME PHONE ()	CELL PHONE ()
City, State, Zip Code			HOW LONG?	BUSINESS PHONE ()
JOB DESIRED	FACILITY/LOCATION		RATE OF PAY EXPECTED	
Indicate Desired Status: <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER				
Indicate Shift Availability <input type="checkbox"/> ANY <input type="checkbox"/> DAY <input type="checkbox"/> EVENING <input type="checkbox"/> NIGHT <input type="checkbox"/> WEEKEND		HAVE YOU WORKED HERE BEFORE? <input type="checkbox"/> YES → WHEN: _____ <input type="checkbox"/> NO DEPARTMENT?: _____ SUPERVISOR?: _____		EARLIEST DATE AVAILABLE:

MISCELLANEOUS REQUIRED INFORMATION (Please answer all questions carefully)

Have you ever pleaded nolo contendere or guilty to or been convicted of a felony or a misdemeanor in the past ten (10) years? Conviction will not necessarily bar you from employment.
 YES NO If yes, explain _____

If you are applying for a position in which you would be operating a motor vehicle for WSMC, have you ever been convicted of a traffic violation?
 YES NO If yes, explain _____

Are you related to anyone employed by us? YES NO If Yes, give name and relationship: _____

Have you ever been discharged or resigned in lieu of being discharged by an employer? YES NO If yes, explain _____

How were you referred to Warm Springs Medical Center? (Please Specify)
 Newspaper Ad Posting Professional Publication Personal Contact Other _____

EDUCATION

HIGH SCHOOL: (Circle number of years completed.) 1 2 3 4 Year Graduated _____

School _____ City _____ State _____

High School Diploma: Yes No

COLLEGE: (Circle number of years completed.) 1 2 3 4

School _____ City _____ State _____

Major _____ Degree Earned _____ Date: _____

GRADUATE SCHOOL:

Area of Study _____ City _____ State _____

Major _____ Degree Earned _____ Date: _____

TECHNICAL EDUCATION, LICENSES & SPECIAL SKILLS (Non-Nursing Applicants Only)

School, Special Training, or Workshops _____ Area of Study _____

City _____ State _____ Telephone () _____ Date of Completion: _____

List the registration name, number and expiration date of any professional, technical or occupational license you now hold: _____

Do you type? Yes No _____ WPM Can you operate a word processor? Yes No _____ WPM

Do you use dictating equipment? Yes No Do you know medical terminology? Yes No

List any office equipment you operate, including personal computers and software: _____

NURSING APPLICANTS ONLY

<p>Check One:</p> <p><input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Clinical Nurse Specialist</p> <p><input type="checkbox"/> College Faculty <input type="checkbox"/> Other _____</p>	<p>Georgia Nursing License</p> <p>Number _____</p> <p>Expires _____</p>
<p>Primary Nursing Education: Length of Program _____</p> <p><input type="checkbox"/> Diploma <input type="checkbox"/> B.S. <input type="checkbox"/> A.D. Date of Graduation _____</p>	<p>Other Licenses</p> <p>State/Expires _____</p> <p>State/Expires _____</p>
<p>School of Nursing _____</p> <p>Address _____</p> <p>City, State, Zip Code _____</p>	
<p>INDICATE CLINICAL PREFERENCE: 1st, 2nd, 3rd Choice</p> <p>_____ EMERGENCY SERVICE _____ MATERNAL/CHILD _____ OPERATING ROOM _____ PACU</p> <p>_____ INTENSIVE CARE _____ MEDICAL/SURGICAL _____ ORTHOPEDICS _____ TELEMETRY / INTERMEDIATE</p> <p>_____ LABOR & DELIVERY _____ ONCOLOGY _____ OTHER _____</p>	

PERSONAL REFERENCES (No relatives or past employers)

Name	Address	Day Phone Number	Relation to Applicant

PLEASE COMPLETE THIS SECTION EVEN IF YOU HAVE ATTACHED A RESUME.

WORK EXPERIENCE (List all employment - include Military Service. Please explain any periods when not employed.) List current position first.

Current or Most Recent Employer		Street Address, City, State, Zip Code		Phone Number ()	
Supervisor (name, title, and telephone number)			Your Job Title		
Description of your duties			From (Mo./Yr.)	To (Mo./Yr.)	
			Rate \$ per		
			Reason for Leaving		

Employer		Street Address, City, State, Zip Code		Phone Number ()	
Supervisor (name, title, and telephone number)			Your Job Title		
Description of your duties			From (Mo./Yr.)	To (Mo./Yr.)	
			Rate \$ per		
			Reason for Leaving		

Employer		Street Address, City, State, Zip Code		Phone Number ()	
Supervisor (name, title, and telephone number)			Your Job Title		
Description of your duties			From (Mo./Yr.)	To (Mo./Yr.)	
			Rate \$ per		
			Reason for Leaving		

Employer		Street Address, City, State, Zip Code		Phone Number ()	
Supervisor (name, title, and telephone number)			Your Job Title		
Description of your duties			From (Mo./Yr.)	To (Mo./Yr.)	
			Rate \$ per		
			Reason for Leaving		

Employer		Street Address, City, State, Zip Code		Phone Number ()	
Supervisor (name, title, and telephone number)			Your Job Title		
Description of your duties			From (Mo./Yr.)	To (Mo./Yr.)	
			Rate \$ per		
			Reason for Leaving		

May we contact your current employer? YES NO

May we contact your past employers? YES NO

May we contact the schools you have attended? YES NO

Do you believe that you can perform the functions of the job for which you are applying? YES NO

FOR LICENSED APPLICANTS ONLY

Have you ever been named as a defendant in a malpractice action? YES NO If yes, explain. _____

Have you ever been sanctioned for misconduct by a professional or trade organization or governmental agency? YES NO

If yes, explain. _____

Have you ever had a license or certification in any jurisdiction limited, revoked, or voluntarily relinquished? YES NO

If yes, explain. _____

Have you ever been licensed or practiced professionally under a different name? YES NO

If yes, what was that name? _____

PLEASE READ CAREFULLY BEFORE SIGNING

"I certify that the information contained in this application is correct to the best of my knowledge and understand that falsification of this information is grounds for refusal to hire, dismissal. I agree that any medical examination and/or drug or alcohol screen required by Warm Springs Medical Center (WSMC) is made with my consent. WSMC will require that applicants and employees submit to a drug and/or alcohol screen if requested to do so. The submission to such testing is a term and condition of employment or of continued employment. This applicant acknowledges and agrees to this term and condition of employment. I authorize any of the persons or organizations referenced in this application to give you any and all information concerning my previous employment, education, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application and release all such parties from any liability for damages that may result from furnishing such information to you. I authorize you to request and receive such information. In consideration for my employment and my being considered for employment by Warm Springs Medical Center, I agree to conform to the rules and regulations of WSMC and acknowledge that these rules and regulations may be changed, interpreted, withdrawn, or added to by WSMC at any time, at WSMC's sole option and without prior notice to me. I understand that no representative of WSMC has any authority to enter into any agreement for employment for any specified period of time or to assure that any other personnel action, either prior to commencement of employment, or make any agreement contrary to the foregoing. I acknowledge that I have been advised that this application will remain active for no more than 90 days from the date it was made. I understand that failure to complete this application will void the application and I will no longer be considered a candidate for the job for which I have applied."

If I am hired as an employee of WSMC, I hereby authorize WSMC to deduct from my paycheck the balance of any financial obligation I owe to and have with WSMC that I have not fulfilled at the time of my separation from employment with WSMC.

Signature of Applicant

CONSUMER REPORT OR INVESTIGATIVE CONSUMER REPORT DISCLOSURE

In compliance with the Fair Credit Reporting Act ("FCRA"), Warm Springs Medical Center notifies you that we may request a consumer report or an investigative consumer report as part of our employment application process. The nature and scope of the consumer report or investigative consumer report Warm Springs Medical Center may request includes information regarding your credit worthiness, credit standing, credit capacity, driving habits and record, character, general reputation, personal characteristics, or mode of living. This report will include information of any criminal record. This information may be gathered through personal interviews with your prior employers, government agencies, courts, law enforcement agencies, departments of motor vehicles, neighbors, friends, associates, others whom you may be acquainted, or other persons who may have knowledge concerning any such information. The interviews, if any, normally will be conducted with only one person at each organization or entity that is contacted for an interview. The questions asked will relate to the information that would be expected to be within the possession of the person or organization being contacted. For example, government agencies, law enforcement agencies, courts and the department of motor vehicles will be asked about criminal records and driving records.

The name and address of the consumer reporting agency providing the consumer report or investigative consumer report is Human Assets South, Inc., 1707 Enterprise Drive, Suite D, Buford, GA 30518, Telephone: 800-553-7276. You may request a copy of this report upon its completion directly from the consumer reporting agency. You have a right to dispute with the consumer reporting agency and inaccurate information by directly contacting the agency.

Warm Springs Medical Center will take no adverse employment action on the basis of any consumer or investigative consumer report unless you have been sent beforehand a copy of the report and a written description of your rights under the FCRA.

CERTIFICATION OF RECEIPT OF DISCLOSURE AND AUTHORIZATION TO OBTAIN A CONSUMER REPORT OR AN INVESTIGATIVE CONSUMER REPORT

I acknowledge that I have received a copy of the above Disclosure and a copy of "A Summary of Your Rights Under the Fair Credit Reporting Act."

I voluntarily authorize Warm Springs Medical Center to obtain a consumer report or an investigative consumer report regarding me in connection with my application for employment or my continuing employment. I understand this consent will apply during the course of my employment with Warm Springs Medical Center, should I obtain such employment. I understand that any and all information contained in my job application or otherwise disclosed to Warm Springs Medical Center by me may be used to obtain a consumer report or investigative consumer report and confirm that all such information is true and correct.

Signature

Date

Print Name (first, middle, last name)

Social Security Number