



Date _____

APPLICATION FOR EMPLOYMENT

Please Answer All Questions. Resumes Are Not A Substitute For A Completed Application.

I UNDERSTAND THAT NEITHER THIS APPLICATION NOR ANY COMMUNICATION BY A MANAGEMENT REPRESENTATIVE IN INTENDED TO CREATE A CONTRACT OF EMPLOYMENT, OFFER, OR PROMISE OF EMPLOYMENT. I ACKNOWLEDGE THAT IF HIRED BY THE COMPANY, EMPLOYMENT IS ON AN AT-WILL BASIS. THIS MEANS THE COMPANY IS FREE TO TERMINATE MY EMPLOYMENT AT ANY TIME, WITH OR WITHOUT CAUSE OR ADVANCE NOTICE, IN ACCORDANCE WITH STATE LAW, AND ACCEPTANCE OF EMPLOYMENT IS NOT A CONTRACT OF EMPLOYMENT FOR ANY SPECIFIED TIME. SIMILARLY, I AM FREE TO TERMINATE MY EMPLOYMENT WITH THE COMPANY AT ANY TIME FOR ANY REASON. THIS AT-WILL PROVISION MAY BE MODIFIED OR WAIVED ONLY IN A WRITTEN AGREEMENT SIGNED BY AN AUTHORIZED REPRESENTATIVE OF THE COMPANY AND ME. I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY, AND I UNDERSTAND THAT THE COMPANY HAS COMPLETE DISCRETION TO MODIFY SUCH RULES AND REGULATIONS AT ANY TIME, EXCEPT THAT IT WILL NOT MODIFY ITS POLICY OF EMPLOYMENT AT-WILL.

We are an equal opportunity employer. Applicants are considered for positions without regard to race, religion, sex, national origin, age, disability, veteran status, sexual orientation or any other consideration made unlawful by applicable federal, state, or local laws.

Position Applied For _____ Social Security Number _____

Name _____ Telephone Number () _____

Present address (Street, Apt. or Unit No.) _____

City / State / Zip _____ Desired Salary _____

Are you able at the time of employment to submit verification of your legal right to work in the U.S.? (*Verification and completion of Form I-9 must be submitted no later than three business days after date hire.*) Yes No

If under the age of 18, can you produce the necessary work certificate at the time of employment? Yes No

Type of employment desired? Full-time Part Time (Specify Hours) _____

Shift desired? Days Evenings Nights (Specify Hours) _____

Are you willing to work overtime? Yes No Date on which you can start _____

Have you ever applied to this company before? Yes No

If yes, when did you apply? _____

How did you hear about the hospital (who referred you)? _____

Within the past (10) years, have you been convicted of a **felony, misdemeanor, or deferred adjudication**? (Criminal convictions/deferred adjudication will not automatically disqualify you from a particular job. The Hospital will consider the nature of the crime, its seriousness, whether the conviction(s) substantially relates to the position's function and qualifications)
 Yes No

If yes, please explain so that individual circumstances can be considered.



Have you ever initiated an act of violence in the workplace? Yes No

If yes, please explain so that individual circumstances can be considered. (A yes answer will not necessarily disqualify you from employment.)

Do you currently hold a current American Heart Association Healthcare Provider Basic Life Support (CPR) Card?

Yes No

List special technical skills or certifications that you feel qualify you for the job for which you are applying (i.e., ACLS, PALS, TNCC, ENPC, CCRN, computer programming/language, software, equipment operation, special tools or machines, etc.):

Education	School Name and Location	Course of study	Graduate?	# of years completed	Degree/Major
High School					
College					
Bus./Tech./Trade or Post College					

Honors Received _____

WORK EXPERIENCE

Start with your present or last place of employment. You may include any verifiable work performed on a volunteer basis, internships, or military service.

Employer

Name *Address* *Type of Business*

Phone (____) _____ Dates Employed From ____/____/____/ To ____/____/____

Job Title _____ Supervisors Name _____

May we contact? Yes ___ No ___ Reason for Leaving _____

Wages Start _____ Final _____ Explain any gap in employment _____

Duties and areas worked _____



WORK EXPERIENCE con't

Employer

Name _____ Address _____ Type of Business _____
 Phone (____) _____ Dates Employed From ____/____/____/ To ____/____/____
 Job Title _____ Supervisors Name _____
 May we contact? Yes ___ No ___ Reason for Leaving _____
 Wages Start _____ Final _____ Explain any gap in employment _____
 Duties and areas worked _____

Employer

Name _____ Address _____ Type of Business _____
 Phone (____) _____ Dates Employed From ____/____/____/ To ____/____/____
 Job Title _____ Supervisors Name _____
 May we contact? Yes ___ No ___ Reason for Leaving _____
 Wages Start _____ Final _____ Explain any gap in employment _____
 Duties and areas worked _____

REFERENCES

Please list the names of additional work-related references we may call. Individuals with no prior work experience may list school or volunteer related references.

NAME	POSITION	COMPANY	WORK RELATIONSHIP i.e., supervisor, co-worker	TELEPHONE #



APPLICANT CERTIFICATION

I understand and agree that if driving is a requirement of the job for which I am applying, my employment and/or continued employment is contingent on possessing a valid drivers license and automobile liability insurance in an amount equal to the minimum required by the state where I reside.

I understand that The Hospital at Westlake Medical Center has, or may establish, a drug-free workplace or drug and/or alcohol testing program consistent with applicable federal, state, and local law. If The Hospital at Westlake Medical Center has such a program and I am offered a conditional offer of employment, I understand that if pre-employment (post-offer) drug and/or alcohol test is positive, the employment offer may be withdrawn. I agree to work under the conditions requiring a drug-free workplace, consistent with the federal, state, and local law. I also understand that all employees of the location, pursuant to The Hospital at Westlake Medical Center's policy and federal, state, and local law, may be subject to urinalysis and/or blood screening or other medically recognized tests designed to detect the presence of alcohol or controlled drugs. If employed, I understand that the taking of alcohol and/or drug tests is a condition of continual employment and I agree to undergo alcohol and drug testing consistent with The Hospital at Westlake Medical Center's policies and applicable federal, state, and local law.

If employed by The Hospital at Westlake Medical Center, I understand and agree that The Hospital at Westlake Medical Center, to the extent permitted by federal, state, and local law, may exercise its right, without prior warning or notice, to conduct investigations of property (including, but not limited to, files, lockers, desks, vehicles, and computers) and, in certain circumstances, my personal property.

I understand and agree that as a condition of employment and to the extent permitted by federal, state, and local law, I may be required to sign a confidentiality, non-compete, and/or conflict of interest statement.

I certify that all the information on this application, my resume, or any supporting documents is complete and accurate to the best of my knowledge. I understand that any **falsification, misrepresentation, or omission** of any information may result in disqualification from consideration for employment or, if employed, disciplinary action, up to and including immediate dismissal.

I authorize The Hospital at Westlake Medical Center or its agents to confirm all statements contained in this application and/or resume as it relates to the position I am seeking and to the extent permitted by federal, state, or local law. I agree to complete any requisite authorization forms for the background investigation.

I authorize the consent to, without reservation, any party or agency contacted by this employer to furnish the above-mentioned information. I hereby release, discharge and hold harmless, to the extent permitted by federal, state, and local law, any party delivering information to The Hospital at Westlake Medical Center or its duly authorized representative pursuant to this authorization from any liability, claims, charges, or causes of action which I may have as a result of delivery or disclosure of the above requested information. I hereby release from liability The Hospital at Westlake Medical Center and its representative for seeking such information and all other persons, corporations, or organizations furnishing such information.

I understand this company hires only individuals who are legally eligible to work in the United States.

Applicant Signature _____ Date _____



Completion of this form is strictly voluntary and is confidential.

The Hospital at Westlake Medical Center provides equal employment opportunity to all qualified applicants and employees by prohibiting discrimination against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, marital status, national origin, age, veteran status or disability.

This information will be used solely to assist us in complying with Federal and State Equal Employment Opportunity and Affirmative Action record keeping requirements. Refusal to provide this information will not adversely affect you.

PLEASE NOTE: This form is **NOT** a part of your official application for employment. This information will be recorded and maintained in a confidential file, separate from all other records.

Applicant Information:

Name: _____ Male _____ Female

Position Applied for: _____

More specific ethnicity information is required for filing EEO-1 reports. Please check the appropriate Equal Opportunity Identification Group. You should only check one of the following ethnicity or race categories:

Ethnicity:

_____ **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Race:

_____ **White (Not Hispanic or Latino)** – A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

_____ **Black or African American (Not Hispanic or Latino)** – A person having origins in any of the black racial groups of Africa.

_____ **Asian (Not Hispanic or Latino)** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

_____ **American Indian or Alaska Native (Not Hispanic or Latino)** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

If you would like to identify as two or more races, please check Two or More Races below, in addition to your one selection above.

_____ **Two or More Races (Not Hispanic or Latino) Comments:** _____

_____ **I choose not to disclose**

VEVRAA Pre-Offer Self-ID Form

The Hospital at Westlake Medical Center is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

- A “disabled veteran” is one of the following:
 - a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
 - a person who was discharged or released from active duty because of a service-connected disability.
- A “recently separated veteran” means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An “active duty wartime or campaign badge veteran” means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An “Armed forces service medal veteran” means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA—the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

I identify as one or more of the classifications of Protected Veterans listed above

I am not a Protected Veteran

I choose not to self-identify my Protected Veteran status

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

YOUR NAME

TODAY'S DATE

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017
Page 1 of 2

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.¹ To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

YOUR NAME

TODAY'S DATE

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017
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Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

ⁱ Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.