

**HARLAN COUNTY HEALTH SYSTEM
APPLICATION FOR EMPLOYMENT (Rev. Jan. 2013)**

Date _____

Last 4-digits of Social Security # XXX-XXX-_____

Position(s) Applying for: 1. _____ 2. _____ 3. _____

I am interested in : Full-Time (36-40hrs/wk) Day
 Part-Time (20-35hrs/wk) I would be available to work: Evening
 Casual/PRN Pool (no benefits) Night

PERSONAL INFORMATION

 Last Name First Name Middle Initial E-mail Address

 Street/Address/Apt. No City State Zip

(____) _____ (____) _____ (____) _____
 Day Phone Number Evening Phone Number Cell Number

Are you 18 years of age or older? Yes No

Have you worked under another name? Yes No If yes, list name (s) _____

Have you worked for Harlan County Health System previously? Yes No
 If yes, what date did you leave employment? _____ Who was your manager? _____

If hired, can you provide proof of your eligibility to be employed in the United States? Yes No

Have you ever been convicted of **ANY** crime within the last seven (7) years? (conviction will not necessarily disqualify applicant from employment) Yes No

Disclose **ALL** misdemeanors and felonies (including Driving Under the Influence (DUI), Minor in Possession (MIP) but you may exclude minor traffic violations)

NOTE: Omitting information or failure to disclose may disqualify you from consideration.

If yes, please explain _____

EDUCATION AND TRAINING RECORD

Circle highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12 G.E.D.

| Name & location of College or Vocational Education | Certificate / Degree Received | Major or Specialty | Graduated | | Dates Attended |
|--|-------------------------------|--------------------|-----------|----|----------------|
| | | | Yes | No | |
| | | | | | |
| | | | | | |
| | | | | | |

PROFESSIONAL LICENSES, REGISTRATIONS AND/OR CERTIFICATIONS (RN, LPN, CNA, ARRT, ASCP, ETC.)

Profession: _____ State Issued: _____ License Number: _____

Certification Number: _____ Registration Number: _____

Has your professional license (in any state) ever been on probation, suspended, revoked, or limited in any way? Yes No
 If yes, give reason _____

HOW WERE YOU REFERRED TO HARLAN COUNTY HEALTH SYSTEM?

- | | |
|---|---|
| <input type="checkbox"/> Employee referral – Name of employee _____ | <input type="checkbox"/> Internet – List site _____ |
| <input type="checkbox"/> Harlan County Journal | <input type="checkbox"/> Job Fair – List location _____ |
| <input type="checkbox"/> Republican Valley Review | <input type="checkbox"/> School |
| <input type="checkbox"/> Oxford Standard | <input type="checkbox"/> Walk - In |
| <input type="checkbox"/> NE Workforce Development | <input type="checkbox"/> Other _____ |

EMPLOYMENT RECORD

List your present or most recent employer **FIRST**. Include U.S. Armed Forces experience. **Account for ALL the time during the past 7 years including period of unemployment. Include any unpaid work experience.** (Attach additional pages as needed.) Omit reasons for leaving if for reasons of health or disability. Resumes are acceptable but may **NOT** be substituted for the following information.

| | |
|---|--|
| Employer _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Address _____ Job Title _____ Primary Duties/Responsibilities _____ _____ _____ Manager _____ Phone # _____ Reason for leaving _____ _____ | <u>Employed</u> From: Mo. Yr. To: Mo. Yr. <hr/> <u>Salary</u> Start: End: <hr/> May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why _____ _____ |
| Employer _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Address _____ Job Title _____ Primary Duties/Responsibilities _____ _____ _____ Manager _____ Phone # _____ Reason for leaving _____ _____ | <u>Employed</u> From: Mo. Yr. To: Mo. Yr. <hr/> <u>Salary</u> Start: End: <hr/> May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why _____ _____ |
| Employer _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Address _____ Job Title _____ Primary Duties/Responsibilities _____ _____ | <u>Employed</u> From: Mo. Yr. To: Mo. Yr. <hr/> <u>Salary</u> Start: End: |

| | |
|--|---|
| <p>_____</p> <p>_____</p> <p>_____</p> <p>Manager _____ Phone # _____</p> <p>Reason for leaving _____</p> <p>_____</p> | <p>May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why _____</p> <p>_____</p> |
| <p>Employer _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time</p> <p>Address _____</p> <p>Job Title _____</p> <p>Primary Duties/Responsibilities _____</p> <p>_____</p> <p>_____</p> <p>Manager _____ Phone # _____</p> <p>Reason for leaving _____</p> <p>_____</p> | <p><u>Employed</u> From: Mo. Yr. To: Mo. Yr.</p> <p><u>Salary</u> Start: End:</p> <p>May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why _____</p> <p>_____</p> |
| <p>Employer _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time</p> <p>Address _____</p> <p>Job Title _____</p> <p>Primary Duties/Responsibilities _____</p> <p>_____</p> <p>_____</p> <p>Manager _____ Phone # _____</p> <p>Reason for leaving _____</p> <p>_____</p> | <p><u>Employed</u> From: Mo. Yr. To: Mo. Yr.</p> <p><u>Salary</u> Start: End:</p> <p>May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why _____</p> <p>_____</p> |

SKILLS

Please list any skills and abilities you wish considered. Include skills with equipment or machines you operate, special computer knowledge, laboratory techniques, etc.

LIST THREE WORK REFERENCES (please do not list relatives)

| Name | Circle One | Daytime Phone Number |
|------|------------------------|----------------------|
| 1. | Co-worker / Supervisor | |
| 2. | Co-worker / Supervisor | |
| 3. | Co-worker / Supervisor | |

EMPLOYMENT AGREEMENT

“I, (applicant), hereby give consent to any and all prior employers of mine to provide information with regard to my employment with prior employers to Harlan County Health System.”

(This reference release is only valid for six (6) months past the date of signature.)

Employment Agreement

I certify the information contained in this application for employment is true to the best of my knowledge and belief. I understand that any omission of facts or misrepresentation is cause for denial of employment and/or dismissal (if hired) regardless of when discovered.

I grant permission for the authorities of **Harlan County Health System** to investigate my work references and release them and any former employer from any and all liability resulting from such investigation. Upon my termination, I authorize the release of reference information on my work.

I agree to submit to a post-offer physical, including drug and/or alcohol screening and recognize employment is contingent upon successfully meeting the post-offer and physical requirements.

I further agree that if I've been convicted of a crime, the authorities of **HCHS** may obtain details of my conviction to determine its relationship to the position I'm applying for as a condition of my employment.

In consideration of my employment, I agree to conform to the rules and regulations of **HCHS**. My employment may be terminated, with or without cause, at any time, at the option of **HCHS** or myself.

Federal law requires evidence of identity and employment eligibility upon hire.

Signature of Applicant _____ Date _____

Harlan County Health System is an EOE/AA Employer

APPLICANT DO NOT WRITE BELOW THIS LINE

| | | | |
|---|--|--|--|
| Job Title: | | Date Position Accepted: | |
| Start Date: | Orientation Date: | <input type="checkbox"/> New Employee <input type="checkbox"/> Rehire/Year | |
| Pay Type: <input type="checkbox"/> FT Hourly <input type="checkbox"/> FT Exempt <input type="checkbox"/> PT FTE: _____ <input type="checkbox"/> Casual Labor | Prime Shift: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd _____ (rate) <input type="checkbox"/> 3 rd _____ (rate) | | Standard Hours Per Day: <input type="checkbox"/> 8 or less <input type="checkbox"/> 10 <input type="checkbox"/> over 40 |
| 1 st Shift Hourly Rate or Annual (if salaried) | Bi-Weekly (if salaried) | Salary Verified With: | Overtime: <input type="checkbox"/> 8/80 <input type="checkbox"/> Over 40 |
| Department Head Signature: | Cost Center/Dept. | Job Code: | Physical Appt Date: |
| Approval Signature: | | | |

Pre-Offer Form
(includes race, gender, veterans inquiry)

APPLICANT INFORMATION FORM

Date: _____ Position Applied For: _____

Print Full Name: _____

Harlan County Health System is an Affirmative Action/Equal Opportunity Employer and does not discriminate on the basis of race, color, religion, sex, age, sexual orientation, gender identity, national origin, disability, veteran status, or any other classification protected by Federal, state, or local law.

This information will be used strictly for statistical record-keeping purposes and will be kept confidential. Providing—or not providing—the gender/race/ethnic/veteran’s status information on this form will neither impact whether or not you are hired, nor will it affect your employment in any manner if you are hired. If you choose not to self-identify, you *must* select the declination box below to move forward with the application process. The person(s) making hiring and personnel decisions will not see this form.

SEX/GENDER: (Please check the appropriate response.)

I decline to self-identify.

Male

Female

RACE/ETHNIC GROUP: (Please check the race/ethnic groups with which you most identify.)

I decline to self-identify.

Hispanic or Latino

Asian (Not Hispanic or Latino)

White (Not Hispanic or Latino)

American Indian or Alaskan Native (Not Hispanic or Latino)

Black or African American (Not Hispanic or Latino)

Two or More Races (Not Hispanic or Latino)

Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)

VETERAN STATUS: (Please check the appropriate response.)

Harlan County Health System is a federal contractor or subcontractor 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 federal contractors/subcontractors 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:

(1) A “disabled veteran” is one of the following:

- a. A veteran of the U.S. military, ground, naval or air force 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

- b. A person who was discharged or released from active duty because of a service-connected disability.
- (2) 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.
- (3) 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.
- (4) 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.

If you believe you are a member of any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a federal contractor or subcontractor subject to VEVRAA, we request this information to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA. Your decision to provide the relevant information is purely voluntary on your part, and refusal to provide such information will not subject you to any adverse treatment. The information will not be used in a manner inconsistent with VEVRAA, as amended.

The information 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.

- I identify as one or more of the classifications of protected veteran status listed above
- I am not a protected veteran
- I decline to self-identify.

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017
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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
- Autism
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Deafness
- Cerebral palsy
- Major depression
- Obsessive compulsive disorder
- Cancer
- HIV/AIDS
- Multiple sclerosis (MS)
- Impairments requiring the use of a wheelchair
- Diabetes
- Schizophrenia
- Missing limbs or partially missing limbs
- Intellectual disability (previously called mental retardation)
- Epilepsy
- Muscular dystrophy

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

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.