



JACKSON
PARK
HOSPITAL AND
MEDICAL CENTER

APPLICATION FOR EMPLOYMENT

STATEMENT OF HOSPITAL POLICY ON EQUAL OPPORTUNITY

It is the policy of Jackson Park Hospital to provide equal opportunity in employment without regard to race, color, religion, creed, sex, pregnancy, national origin, ancestry, physical or mental disability, citizenship, age, marital status, arrest record, sexual orientation, parental status, military status, unfavorable discharge from military service and/or other protected classification in accordance with the requirements of Federal, State and local law.

PLEASE PRINT AND COMPLETE FORM IN DETAIL. PLEASE BE SPECIFIC AND FILL IN ALL APPROPRIATE BLANKS. ALL INFORMATION GIVEN WILL BE HELD IN STRICT CONFIDENCE.

GENERAL INFORMATION

NAME (LAST, FIRST, MIDDLE)			DATE APPLICATION COMPLETED		LAST FOUR DIGITS SOCIAL SECURITY NO.	
ADDRESS				CITY		
STATE		ZIP		HOME PHONE		CELL PHONE
BUSINESS/DAY PHONE NUMBER		IN CASE OF EMERGENCY, CONTACT			RELATIONSHIP	
ADDRESS		CITY		STATE		ZIP
TELEPHONE						
POSITION APPLIED FOR			DATE AVAILABLE	APPLYING FOR: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY		
SHIFT DESIRED: (7-3:30) <input type="checkbox"/> DAYS (3-11:30) <input type="checkbox"/> EVENINGS (11-7:30) <input type="checkbox"/> NIGHTS <input type="checkbox"/> ANY		HAVE YOU BEEN EMPLOYED PREVIOUSLY BY THIS HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHEN?		
DEPARTMENT			JOB TITLE			
REFERRED BY: <input type="checkbox"/> AD <input type="checkbox"/> AGENCY <input type="checkbox"/> EMPLOYEE REFERRAL		(NAME)			<input type="checkbox"/> OWN ACCORD <input type="checkbox"/> OTHER	
FOR PURPOSE OF VERIFYING PAST EMPLOYMENT PLEASE LIST ANY OTHER NAMES UNDER WHICH YOU HAVE BEEN EMPLOYED						
ARE YOU A U.S. CITIZEN OR DO YOU HAVE THE RIGHT TO WORK IN THE U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO EXPLAIN:						
IF HIRED, APPLICANT MAY BE REQUIRED TO SUBMIT PROOF OF U.S. CITIZENSHIP OR VISA PERMITTING APPLICANT TO WORK IN THE UNITED STATES.						
ARE YOU EIGHTEEN YEARS OR OLDER?		(HIRE SUBJECT TO VERIFICATION THAT APPLICANT'S AGE MEETS LEGAL REQUIREMENTS)			IF UNDER EIGHTEEN, CAN YOU, AFTER EMPLOYMENT, SUBMIT A WORK PERMIT?	
<input type="checkbox"/> YES <input type="checkbox"/> NO					<input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU HAVE ANY RELATIVES WHO CURRENTLY WORK AT JACKSON PARK HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, STATE THE RELATIVE'S NAME, POSITION AND RELATION TO YOU. ANSWERING "YES" WILL NOT DISQUALIFY YOU FROM EMPLOYMENT.						

EDUCATION

Type of School	Name and Location of School	Major Subjects Studied	Circle Last Year Completed	Graduate (Yes/No)	List Diploma or Degree
HIGH SCHOOL			1 2 3 4		
COLLEGE OR SCHOOL OF NURSING			1 2 3 4		
COLLEGE OR SCHOOL OF NURSING			1 2 3 4		
OTHER			1 2 3 4		

SPECIAL SKILLS AND TRAINING

PLEASE DESCRIBE ANY SKILLS OR TRAINING YOU POSSESS THAT YOU FEEL HELP QUALIFY YOU FOR THE POSITION FOR WHICH YOU HAVE APPLIED

DO YOU HAVE KNOWLEDGE OF MEDICAL TERMINOLOGY?					
REGISTRY, LICENSE, OR CERTIFICATION HELD		<input type="checkbox"/> CURRENT YEAR		STATE NUMBER	
		<input type="checkbox"/> PERMANENT			
LIST ANY OFFICE EQUIPMENT YOU HAVE EXPERIENCE OPERATING:					

WORK EXPERIENCE (START WITH PRESENT POSITION AND WORK BACK)

NAME OF EMPLOYER		CITY	STATE	
Dates Employed	Position Title		Department	Supervisor
FROM: TO:				
FROM: TO:				
DUTIES:				
REASONS FOR LEAVING:				

NAME OF EMPLOYER		CITY	STATE	
Dates Employed	Position Title		Department	Supervisor
FROM: TO:				
FROM: TO:				
DUTIES:				
REASONS FOR LEAVING:				

NAME OF EMPLOYER		CITY	STATE	
Dates Employed	Position Title		Department	Supervisor
FROM: TO:				
FROM: TO:				
DUTIES:				
REASONS FOR LEAVING:				

By signing this application, I certify:

That this application is complete and accurate to the best of my knowledge and that I have not made any attempt to conceal information and that falsification could be cause for dismissal. Further, Jacksn Park Hospital or its agents may request employment information from my previous employers and that persons or corporations who provide information related to my previous employment will be released from any liability or damage. Also, I understand that an offer of employment may be made contingent upon passing a medical examination conducted by a Hospital designated physician.

DATE _____ APPLICANT'S SIGNATURE _____