



Mendocino Coast District Hospital

700 RIVER DRIVE FORT BRAGG, CALIFORNIA 95437 707 961-1234

APPLICATION FOR EMPLOYMENT

We consider applicants for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, the presence of a non-job-related medical condition or disability, or any other legally protected status.

PERSONAL														
LAST NAME			FIRST NAME			M.I.	e-mail:			DATE				
PERMANENT ADDRESS					CITY		STATE		ZIP		TELEPHONE			
ADDRESS AT WHICH YOU MAY BE REACHED					CITY		STATE		ZIP		TELEPHONE			
ARE YOU LESS THAN 18 YEARS OF AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER NAME(S) UNDER WHICH YOU HAVE BEEN PREVIOUSLY EMPLOYED:					NAMES OF FRIENDS OR RELATIVES EMPLOYED AT THIS HOSPITAL							
HAVE YOU EVER APPLIED AT THIS HOSPITAL BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, GIVE DATE AND POSITION APPLIED FOR:				HAVE YOU EVER BEEN EMPLOYED AT THIS HOSPITAL BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, GIVE DATES OF EMPLOYMENT:						
DO YOU HAVE ANY RESTRICTIONS OR OBLIGATIONS THAT WOULD PREVENT YOU FROM: WORKING OVERTIME? <input type="checkbox"/> YES <input type="checkbox"/> NO WORKING CONSISTENTLY? <input type="checkbox"/> YES <input type="checkbox"/> NO														
HAVE YOU EVER BEEN CONVICTED OF A FELONY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, LIST DATES, OFFENSES AND DISPOSITION (CONVICTIONS ARE NOT AN AUTOMATIC DISQUALIFICATION FROM EMPLOYMENT)												
EMPLOYMENT INTERESTS														
POSITION DESIRED OR AREA OF INTEREST					SECOND CHOICE			DATE AVAILABLE		SALARY EXPECTED				
TYPE OF EMPLOYMENT YOU ARE SEEKING <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> SUMMER					SHIFTS YOU CAN WORK <input type="checkbox"/> DAY <input type="checkbox"/> PM <input type="checkbox"/> NIGHT <input type="checkbox"/> WEEKENDS									
HOW WERE YOU REFERRED TO OUR HOSPITAL? <input type="checkbox"/> ADVERTISEMENT <input type="checkbox"/> OTHER COMPANY <input type="checkbox"/> AGENCY <input type="checkbox"/> EMPLOYMENT SERVICE <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SCHOOL <input type="checkbox"/> SELF <input type="checkbox"/> OTHER					NAME OF REFERRAL SOURCE									
EDUCATION														
			HIGH SCHOOL			UNDERGRADUATE COLLEGE/UNIVERSITY				GRADUATE/ PROFESSIONAL		COURSE OF STUDY: AND HONORS/AWARDS		
SCHOOL NAME AND LOCATION														
CIRCLE LAST YEAR COMPLETED			9	10	11	12	1	2	3	4	1	2	3	4
			DID YOU GRADUATE? <input type="checkbox"/> YES <input type="checkbox"/> NO			DEGREE <input type="checkbox"/> BA <input type="checkbox"/> BS <input type="checkbox"/> AA/AS				<input type="checkbox"/> MA/MS <input type="checkbox"/> PHD				
DESCRIBE ANY SPECIALIZED TRAINING, APPRENTICESHIP, SKILLS AND EXTRA-CURRICULAR ACTIVITIES								TYPING APPROX. WPM 10 KEY CALCULATOR <input type="checkbox"/> YES <input type="checkbox"/> NO WORD PROCESSING SKILL <input type="checkbox"/> YES <input type="checkbox"/> NO						
PLEASE INDICATE ANY FOREIGN LANGUAGES THAT YOU: SPEAK READ WRITE SPEAK READ WRITE														
LIST COMMUNITY AND PROFESSIONAL AFFILIATIONS/OFFICES HELD														

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS (Attach Copy)

ARE YOU CURRENTLY: <input type="checkbox"/> REGISTERED <input type="checkbox"/> LICENSED <input type="checkbox"/> CERTIFIED <input type="checkbox"/> REGISTERED INTERIM PERMITTEE				
IF LICENSED, REGISTERED OR CERTIFIED	TYPE	STATE ISSUED	DATE	NO.
	TYPE	STATE ISSUED	DATE	NO.

REFERENCES				
LIST PEOPLE WE MAY CONTACT WHO ARE QUALIFIED TO EVALUATE YOUR CAPABILITIES (DO NOT INCLUDE RELATIVES)				
NAME	ADDRESS	CITY	STATE	ZIP

EMPLOYMENT HISTORY

GIVE EMPLOYMENT RECORD AS COMPLETELY AS POSSIBLE, LISTING CURRENT OR MOST RECENT EMPLOYER FIRST, SHOW UNEMPLOYED OR SELF-EMPLOYED PERIODS AND INDICATE DATES AND COMMENT ON EACH PERIOD. INCLUDE PART TIME OR SUMMER WORK ONLY IF YOU ARE A RECENT GRADUATE. YOU MAY USE EXTRA SHEETS OR RESUME FOR ADDITIONAL INFORMATION.

COMPANY NAME (CURRENT OR LAST)	ADDRESS	TELEPHONE	DATES EMPLOYED (MONTH/YEAR) FROM: TO:
JOB TITLE	SUPERVISOR'S NAME AND TITLE	TYPE OF BUSINESS	BASE RATE OF PAY (HR/WEEK/MONTH) START: END:
WORK PERFORMED			REASON FOR LEAVING
			MAY WE CONTACT THIS EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
COMPANY NAME	ADDRESS	TELEPHONE	DATES EMPLOYED (MONTH/YEAR) FROM: TO:
JOB TITLE	SUPERVISOR'S NAME AND TITLE	TYPE OF BUSINESS	BASE RATE OF PAY (HR/WEEK/MONTH) START: END:
WORK PERFORMED			REASON FOR LEAVING
COMPANY NAME	ADDRESS	TELEPHONE	DATES EMPLOYED (MONTH/YEAR) FROM: TO:
JOB TITLE	SUPERVISOR'S NAME AND TITLE	TYPE OF BUSINESS	BASE RATE OF PAY (HR/WEEK/MONTH) START: END:
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COMPANY NAME	ADDRESS	TELEPHONE	DATES EMPLOYED (MONTH/YEAR) FROM: TO:
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WORK PERFORMED			REASON FOR LEAVING
COMPANY NAME	ADDRESS	TELEPHONE	DATES EMPLOYED (MONTH/YEAR) FROM: TO:
JOB TITLE	SUPERVISOR'S NAME AND TITLE	TYPE OF BUSINESS	BASE RATE OF PAY (HR/WEEK/MONTH) START: END:
WORK PERFORMED			REASON FOR LEAVING

ADDITIONAL SKILLS OR QUALIFICATIONS RELATED TO EMPLOYMENT WITH THE HOSPITAL

CERTIFICATION — This application is submitted with the understanding that a physical examination satisfactory to the employer must be completed before employment can be secured. I certify that the answers given by me to the foregoing questions and statements are true, correct and without omissions. I authorize the Hospital to investigate the foregoing, and any other information which might assist the Hospital to determine my qualifications for employment. I release the Hospital and my former employers, and all others from my liability for damage which may result from such investigation. If, upon investigation, anything contained in this application is found to be untrue, I understand I will be subject to dismissal at any time during the period of employment. Proof of citizenship or immigration status will be required upon employment.

I CERTIFY THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

DATE _____ SIGNATURE _____

APPLICANT IDENTIFICATION INFORMATION

The information requested on this form is required by the regulations of the Department of Fair Employment and Housing. The employers in California are required to keep these records on file for a period of two years. For your protection, the employers are ordered to store the records in a different location away from your application. The information is for data purposes only, and voluntary on your part.

DATE: _____

NAME: _____ SEX _____

POSITION APPLIED FOR: _____

PLEASE CHECK ONE

RACE/COLOR

- Native American
- Black
- Asian
- Caucasian
- Other

NATIONAL ORIGIN/ANCESTRY

- Hispanic*
- Filipino
- Polynesian
- Mexican American
- Other National Origin

* Hispanic: Those individuals who originate from Mexico, Central American countries, Cuba and Puerto Rico.

Have you served in the United States Armed Forces? Yes No

If yes, dates of enlistment: from _____ to _____