

# DODGE COUNTY HOSPITAL

901 Griffin Avenue  
Eastman, GA 31023-4309  
(478) 448-4106  
(478) 448-4108 (FAX)

Date \_\_\_\_\_

This hospital is an equal opportunity employer. In compliance with provisions of all applicable State and Federal laws, every effort will be made to employ the most qualified individuals without regard to race, color, religion, sex, national origin, age or disability. This application must be completed in its entirety for the application to be considered for employment.

## APPLICATION FOR EMPLOYMENT

(Please Print)

NAME: \_\_\_\_\_  
(Last) (First) (Middle)

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

MAILING ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

SOCIAL SECURITY NUMBER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_  
(Name) (Relation)  
\_\_\_\_\_  
(Address) (Phone Number)

ARE YOU AT LEAST 18 YEARS OLD? Yes  No

ARE YOU A U.S. CITIZEN OR AN ALIEN WHO HAS THE LEGAL RIGHT TO WORK IN THE JOB FOR WHICH YOU ARE APPLYING? Yes  No

(Pursuant to the Immigration Reform & Control Act of 1986, all applicants upon being made an offer of employment, must produce documents which are specified by the federal government, establishing their identity and authorization for employment in the United States.)

DO YOU HAVE A RELIABLE MEANS OF GETTING TO WORK? Yes  No

POSITION(S) DESIRED: \_\_\_\_\_ DATE AVAILABLE: \_\_\_\_\_

SHIFTS YOU CAN WORK: 7AM - 3PM  3PM - 11PM  11PM - 7AM  7AM - 7PM  7PM - 7AM

WOULD YOU ACCEPT PART - TIME WORK? Yes  No  WOULD YOU ACCEPT TEMPORARY WORK? Yes  No

HAVE YOU EVER WORKED FOR DODGE COUNTY HOSPITAL? Yes  No  IF YES, WHEN AND IN WHAT DEPARTMENT? \_\_\_\_\_

WILL YOU WORK OVERTIME? Yes  No  (Hospital operations may require any employee to work weekends, holidays, and any shift.)

ARE YOU ABLE TO PERFORM THE ESSENTIAL JOB RELATED FUNCTIONS OF THE POSITION FOR WHICH YOU ARE APPLYING FOR? Yes  No

SCHOOLS	NAME & LOCATION	DATE ATTENDED		YEARS COMPLETED	DIPLOMA/DEGREE	MAJOR COURSE OF STUDY
		Month/Year	Month/Year			
High School		From	To	9 10 11 12		
College or University		From	To	1 2 3 4		
Post Graduate		From	To	1 2 3 4		
Technical or Business		From	To	1 2 3 4		

(List in order, last or present employer first.)

EMPLOYER	<u>DATES</u> From To	Job Title
ADDRESS		Reason For Leaving
CITY STATE	<u>RATE OF PAY</u> Start Final	Work Performed
PHONE		
SUPERVISOR	May we Contact ? Yes <input type="checkbox"/> No <input type="checkbox"/>	

EMPLOYER	<u>DATES</u> From To	Job Title
ADDRESS		Reason For Leaving
CITY STATE	<u>RATE OF PAY</u> Start Final	Work Performed
PHONE		
SUPERVISOR	May we Contact ? Yes <input type="checkbox"/> No <input type="checkbox"/>	

EMPLOYER	<u>DATES</u> From To	Job Title
ADDRESS		Reason For Leaving
CITY STATE	<u>RATE OF PAY</u> Start Final	Work Performed
PHONE		
SUPERVISOR	May we Contact? Yes <input type="checkbox"/> No <input type="checkbox"/>	

HAVE YOU EVER BEEN DISCHARGED FROM A JOB OR BEEN ASKED TO RESIGN? Yes  No

REFERENCES:

NAME \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
 NAME \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
 NAME \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

DO YOU HAVE ANY EXPERIENCE IN OTHER FIELDS THAN WHAT YOU HAVE APPLIED FOR?

- Medical Secretary     Switchboard     Maintenance     Word Processor     Lab Assistant     Respiratory Therapy  
 Nurse Assistant     Receptionist     Food Service     PC     X Ray     Medical Terminology  
 Insurance/Billing     Credit/Collection     Dictaphone     Transcription     Medical Assistant     Other

PROFESSIONAL LICENSES AND CERTIFICATES:

TYPE	STATE	ISSUED	DATE	NUMBER

Do you understand that due to the nature of the service we provide, an exceptional record of attendance, promptness, and dependability is required of all employees? Yes  No

Do you understand that employment is contingent upon passing a Health Screening Examination, and satisfactory education, prior employment, and reference certification? Yes  No

I certify that the information I have provided is true and complete, and I understand that any misrepresentation or omission of fact is cause for the rejection of my application and my immediate discharge from employment. In making this application for employment, I understand that an investigative consumer report may be made, whereby information may be obtained through personal interviews with friends, neighbors, and others with whom I am acquainted. This inquiry includes information as to my character, general reputation, personal characteristics, and mode of living,. I understand that I have a right to make a written request within a reasonable time to receive additional, detailed information about the nature and scope of this investigative consumer report. In the event of work injury, the Hospital has my consent for such medical treatment or procedures as its staff and employees may deem necessary in emergency situations in an emergency unit. In the event I am photographed during the course of my employment, the Hospital has my permission to use any and all photos for various Hospital relations' purposes. I have read and understand the above statement.

Signature: \_\_\_\_\_

To Whom It May Concern:

I authorize Dodge County Hospital to contact my former employers and all other sources they see fit in order to verify the facts and information furnished with regard to my character and qualifications. I hereby release such employer or persons from any and all liability whatever nature on account of furnishing such information. I realize that I will not view or be informed of any portion of your reply.

---

Signature of Applicant

---

Date