

## **PLEASE READ THE FOLLOWING BEFORE COMPLETING OUR APPLICATION BLANK:**

- 1) There is no guarantee of a job offer or a job interview in completing our application blank. Your application blank will be considered with others who have submitted applications and decisions about interviews will be based on this comparison.
- 2) Our application blank must be completely filled out in order for it to be considered for employment.
- 3) If the information provided on our application can not be satisfactorily verified by employment reference checks, your application could be considered incomplete.
- 4) Applications are filed according to job title. Be as specific as possible in stating the job applying for: "ANY" position is not an acceptable response on our application blank.
- 5) Due to the large number of applications we receive and the competitive nature of our employment process, specific reasons for employment decisions will not be released.
- 6) In completing our application blank, you will be subject to the following checks:
  - EMPLOYMENT REFERENCE CHECK FROM FORMER EMPLOYERS
  - CRIMINAL RECORD CHECK
  - DRUG SCREEN

\_\_\_\_\_, I have read the above statements.  
(Signature of Applicant)



# APPLICATION FOR EMPLOYMENT

PLEASE READ CAREFULLY – WRITE CLEARLY – ANSWER ALL QUESTIONS

**1400 West Main Street • P.O. Box 8004  
Bellevue, Ohio 44811**

**FEDERAL AND STATE LAWS PROHIBIT DISCRIMINATION IN EMPLOYMENT  
BECAUSE OF RACE, COLOR, SEX, DISABILITY, NATIONAL ORIGIN, AGE (40 AND  
OLDER), ANCESTRY, RELIGION AND MILITARY STATUS.**

<b>NAME &amp; LOCATION</b>	(LAST NAME)		(FIRST NAME)		(MIDDLE NAME)	APPLICATION DATE		
	CURRENT ADDRESS (NUMBER & STREET)			HOME PHONE	CELL PHONE	PHONE NO. FOR MESSAGE		
	CITY, STATE, ZIP				SOCIAL SECURITY NUMBER			
<b>EMPLOYMENT DESIRED</b>	FIRST CHOICE		EXPERIENCE?		SECOND CHOICE		EXPERIENCE?	
	HAVE YOU WORKED FOR OUR HOSPITAL BEFORE? YES <input type="checkbox"/> NO <input type="checkbox"/>			( IF YES, STATE DATE LEFT)		WILL YOU ACCEPT PART TIME WORK?		WILL YOU ACCEPT TEMPORARY WORK?
	HAVE YOU WORKED FOR OUR HOSPITAL BEFORE UNDER ANOTHER NAME? YES <input type="checkbox"/> NO <input type="checkbox"/>			(IF YES, STATE NAME)		SHIFT OR HOURS YOU CAN WORK		OTHER
<p>ARE YOU EITHER A UNITED STATES CITIZEN OR AN ALIEN WHO HAS THE LEGAL RIGHT TO WORK IN THE JOB FOR WHICH YOU ARE APPLYING? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>PURSUANT TO THE IMMIGRATION REFORM AND 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. THESE DOCUMENTS MUST BE PRODUCED NO LATER THAN SEVENTY-TWO HOURS AFTER COMMENCEMENT OF EMPLOYMENT. YOU WILL ALSO BE REQUIRED TO SIGN FORM I-9 (ISSUED BY THE FEDERAL GOVERNMENT), VERIFYING UNDER OATH, YOUR EMPLOYMENT AUTHORIZATION.</p>				<p>HAVE YOU SERVED IN THE U.S. MILITARY? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>PLEASE LIST JOB-RELATED SKILLS OR EXPERIENCE</p>				
<b>PERSONAL</b>	HAVE YOU EVER SINCE THE AGE OF 18, BEEN CONVICTED OF A FELONY? YES <input type="checkbox"/> NO <input type="checkbox"/>			<b>NOTE: A CONVICTION WILL NOT NECESSARILY BAR YOU FROM EMPLOYMENT</b>				
	HAVE YOU EVER BEEN INVOLUNTARILY DISCHARGED? IF YES, PLEASE EXPLAIN - GIVE DATES YES <input type="checkbox"/> NO <input type="checkbox"/>							
	HAVE YOU EVER BEEN SANCTIONED BY THE MEDICARE OR MEDICAID PROGRAM? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE EXPLAIN.							
	NAMES	COMPLETE ADDRESSES OF SCHOOLS			ACADEMIC MAJOR	NUMBER OF YEARS ATTENDED	DIPLOMA?	
	LAST ELEMENTARY SCHOOL							
LAST HIGH SCHOOL								
JR. COLLEGE, COLLEGE OR UNIVERSITY								
TECHNICAL OR VOCATIONAL SCHOOL								
OTHER DETAILS OF EXPERIENCE OR TRAINING, INCLUDING INFORMATION ON ADULT EDUCATION PROGRAMS WHICH HAVE A DIRECT BEARING ON THE JOB WHICH YOU ARE SEEKING?		SCHOOL	COURSE	DIPLOMA OR CERTIFICATE	DATE COMPLETED			

**REFERENCE**

GIVE NAME(S) OF PERSONS WE MAY CONTACT TO VERIFY YOUR QUALIFICATIONS FOR THIS POSITION:

NAME	OCCUPATION	ORGANIZATION
	PHONE	ADDRESS
NAME	OCCUPATION	ORGANIZATION
	PHONE	ADDRESS
NAME	OCCUPATION	ORGANIZATION
	PHONE	ADDRESS

**EXPERIENCE**

GIVE A COMPLETE RECORD OF ALL EMPLOYMENT AND REASONS FOR PERIODS UNEMPLOYED DURING PAST TEN YEARS. START WITH MOST RECENT EMPLOYMENT, GIVE U.S. EXPERIENCE ONLY.

LAST EMPLOYMENT FIRST TO				EMPLOYER'S NAME, ADDRESS, TELEPHONE NUMBER, FAX NUMBER	LAST SALARY AND POSITION(S) HELD	REASON FOR LEAVING
MO.	YR.	MO.	YR.	EMPLOYER	SALARY	
				NO. & STREET	POSITION	
				CITY, STATE, ZIP PHONE FAX	SUPERVISION	
				EMPLOYER	SALARY	
				NO. & STREET	POSITION	
				CITY, STATE, ZIP PHONE FAX	SUPERVISION	
				EMPLOYER	SALARY	
				NO. & STREET	POSITION	
				CITY, STATE, ZIP PHONE FAX	SUPERVISION	
				EMPLOYER	SALARY	
				NO. & STREET	POSITION	
				CITY, STATE, ZIP PHONE FAX	SUPERVISION	

MAY WE CONTACT YOUR PRESENT EMPLOYER FOR REFERENCES? YES  NO

LIST OFFICE MACHINES YOU CAN USE NOT APPLICABLE

PLEASE LIST WHAT OTHER EQUIPMENT YOU CAN OPERATE REPAIR YES  NO  SETUP? YES  NO

**PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS**

**VERIF.**

TYPE	STATE ISSUED	DATE	NO.	
TYPE	STATE ISSUED	DATE	NO.	

I HAVE A CURRENT AND VALID OHIO DRIVER'S LICENSE, (NO.) \_\_\_\_\_ WHICH IS DUE TO EXPIRE (DATE) \_\_\_\_\_  
 YOU MAY CHECK THE OHIO BMV TO CONFIRM YES  NO

**AFFIDAVIT** I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever. I agree that my employer shall not be liable in any respect if my employment is terminated because of the falsity of statements, answers or omissions made by me in this questionnaire. I authorize the employers, companies, schools or persons named above to give any information regarding my employment, together with any information they may have regarding me whether or not it is in their records. I hereby release said employers, companies, schools or persons from all liability for any damage, both legal and otherwise, for issuing this information. I also understand an offer of employment will be conditioned on results of a medical examination. In addition, if accepted for employment, I hereby agree to abide by the rules and policies of my employer.

Further, I understand that any employment is not for a stated period of time and may be terminated with or without cause, at any time, at the option of either myself or my employer.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**WE ARE AN EQUAL OPPORTUNITY EMPLOYER – A COPY OF THIS APPLICATION IS AVAILABLE TO YOU ON REQUEST.**



Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

Print Name of Applicant: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Please accept this as my authorization for The Bellevue Hospital to make a thorough investigation of my work history to verify all data given in my application and/or oral interview and to confirm my satisfactory job performance in my past positions. I release from liability, any person and/or organization giving or receiving this information. I understand that falsification of data discovered as a result of this investigation may prevent my being hired, or if hire, may subject me to dismissal. I understand that this is an application for employment and no employment contract is offered. I also understand that if I am employed, such employment is for an indefinite period of time and that the Hospital may change wages, benefits and conditions of work at any time. I have read and understand all of the above.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**(Applicant – do not complete below this line)**

**The applicant below has applied for employment with The Bellevue Hospital. Please fill out the following information and return it to us in the enclosed envelope. Thank you for your assistance in evaluating this applicant.**

**Employer Reference**

Name of Organization \_\_\_\_\_  
 Date of Employment \_\_\_\_\_ to \_\_\_\_\_  
 Position Held \_\_\_\_\_  
 Reason for Leaving \_\_\_\_\_

Would you re-employ?  Yes  No  
 If no, please explain \_\_\_\_\_  
 \_\_\_\_\_

**Personal Reference**

Name \_\_\_\_\_  
 Relationship to Applicant \_\_\_\_\_  
 \_\_\_\_\_  
 Length of Relationship \_\_\_\_\_

Would you recommend?  Yes  No  
 If no, please explain \_\_\_\_\_  
 \_\_\_\_\_

Please check:	Above Average	Average	Below Average
Quality of Work			
Quantity of Work			
Initiative			
Job Knowledge/skill			
Attendance			
Cooperation			
<b>Attitude Toward:</b>			
Supervisor			
Co-worker			
Patients			

Please check:	Above Average	Average	Below Average
Reliability			
Punctuality			
Honesty			
Trustworthiness			
Attitude			

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

PERSONNEL POLICY # 07.48  
PRE-OFFER DRUG SCREEN  
ADDENDUM A

I understand that this Hospital has a policy which prohibits the possession and/or use of illegal or unauthorized drugs on Hospital premises or which may affect the on-the-job performance of its employees. Pursuant to that policy, all job offers are conditioned on the satisfactory results of a drug screen.

A positive result on the initial EMIT test will require a further test be conducted using gas chromatography-mass spectrometry (GC-MS). No final employment decision will be made until the results of the GC-MS test have been received.

Results of the pre-offer drug screen will be confidential and will be maintained in a separate file in the Human Resources office. Results of the screen will be reviewed with me by the VP of Human Resources.

I understand that if I refuse the pre-offer drug screen, I will cease to be considered for employment. I also understand that if I fail to satisfy the screening parameters, I will not be employed. My employment date will not be established prior to a successful completion of the pre-offer drug screen requirements.

I hereby agree to this Hospital policy and consent to the requirements of the drug screen.

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(Signature)

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(Date)