



EMPLOYMENT APPLICATION

PERSONAL INFORMATION:

In considering your application for employment, Lakeside Hospital may conduct a detailed and thorough investigation which *may include, but is not limited to, a background check, a criminal record check, interviews and inquiries or prior employers, coworkers, acquaintances, relatives, or friends.*

Last Name		First		Middle	
Social Security Number		Home Phone Number		Other Phone Number	
Email Address		Best Time To Contact You:		Preference Of Contact <input type="checkbox"/> Home Number <input type="checkbox"/> Other Number <input type="checkbox"/> Email	
Present Address		City		State	Zip
Permanent Address		City		State	Zip
Any Previous Name(S) No [] If Yes, Identify All Other Names Under Which You Have Been Employed:					
Position Applied For:		Date Available To Work:		What Is Your Desired Salary Range?	
Are You Applying For: <i>(check one)</i>	Full Time: <input type="checkbox"/>	Part Time: <input type="checkbox"/>	PRN: <input type="checkbox"/>	Temporary: <input type="checkbox"/>	
Would You Consider Working:					
Weekends <input type="checkbox"/> YES <input type="checkbox"/> NO		Holidays <input type="checkbox"/> YES <input type="checkbox"/> NO		Rotating Shifts <input type="checkbox"/> YES <input type="checkbox"/> NO	
On Call <input type="checkbox"/> YES <input type="checkbox"/> NO		Any Shift <input type="checkbox"/> YES <input type="checkbox"/> NO		Shift Preference: <input type="checkbox"/> days <input type="checkbox"/> evenings <input type="checkbox"/> nights	
How Did You Learn About Lakeside:			Did Employee Refer You, If So Who?		
Do You Have Relatives or Friends Employed At Lakeside? <input type="checkbox"/> NO If Yes Who:					
Name:		Department:		Relationship:	
Name:		Department:		Relationship:	
Have You Ever Been Employed at Lakeside Hospital at Bastrop? <input type="checkbox"/> NO If Yes:					
When and What Department:					
Reason for Leaving:					
If you are under 18 years of age, can you provide proof of your eligibility to work? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Are you a United States citizen or alien legally authorized to work in the United States? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(proof of citizenship or immigration status will be required upon employment)</i>					
Have you ever been subjected to any sanctions, penalties, or exclusions from any federal healthcare program (i.e. including but not limited to: Medicare, Medicaid) <input type="checkbox"/> NO If Yes, please explain:					



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Have you ever been convicted of, or pleaded guilty to a crime (*excluding misdemeanor traffic violations*)?
 NO If Yes, please explain:

Have you ever been involved in the substantiated abuse or neglect of children or adults under the laws of this or any other state of the United States?
 NO If Yes, please explain:

If answer is "yes" to either of the above, you will not be automatically disqualified from employment consideration, except as required by state or federal law.

NOTE: Applicants: DO NOT answer this question unless you have been informed about requirements of the job you are applying:
 Are you capable of performing, with or without a reasonable accommodation, the essential functions of the job or occupation for which you have applied?
 YES NO

PERSONAL / PROFESSIONAL REFERENCES:
 Do not include family members or past supervisors:

NAME	Phone Number	Best Time To Call	Occupation
1.			
2.			
3.			

WORK EXPERIENCES:
 Start with your most recent employment. Include any job-related military service assignments and volunteer activities. (*You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities, or other protected status.*)

Employer (Current):	Dates Employed	
	From:	To:
Address:	City:	State, Zip:
Starting Job Title:	Present Job Title:	
Ending Salary: \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Supervisor:	
	Reason for Leaving:	
Work Performed:		
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO Telephone Number (s):		

Employer :	Dates Employed	
	From:	To:
Address:	City:	State, Zip:
Starting Job Title:	Present Job Title:	
Ending Salary: \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Supervisor:	
	Reason for Leaving:	
Work Performed:		
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO Telephone Number (s):		



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Employer :	Dates Employed	
	From:	To:
Address:	City:	State, Zip:
Starting Job Title:	Present Job Title:	
Ending Salary: \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Supervisor:	
Work Performed:	Reason for Leaving:	
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO Telephone Number (s):		

Employer :	Dates Employed	
	From:	To:
Address:	City:	State, Zip:
Starting Job Title:	Present Job Title:	
Ending Salary: \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Supervisor:	
Work Performed:	Reason for Leaving:	
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO Telephone Number (s):		

Have you ever been discharged from any employment or asked to resign? <input type="checkbox"/> NO
If YES, explain:

Please explain in gaps in employment (<i>time between jobs when not employed</i>)

MILITARY EXPERIENCE:

Were you a member of the United States Armed Services: <input type="checkbox"/> NO If YES:		
Branch	Dates of Duty	Type of Discharge
Briefly describe duties and any special training:		



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PROFESSIONAL, TRADE, BUSINESS, OR CIVIC ACTIVITIES:

List professional, trade, business, or civic activities and offices held. *(You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities, or other protected status.)*

Activity:	Office Held:
Activity:	Office Held:
Activity:	Office Held:
Activity:	Office Held:

EDUCATION / SKILLS:

FORMAL EDUCATION	NAME & ADDRESS OF SCHOOL (CITY AND STATE)	COURSE OF STUDY	YEARS COMPLETED	DIPLOMA / DEGREE
HIGH SCHOOL				
UNDERGRADUATE				
COLLEGE				
GRADUATE				
PROFESSIONAL				
OTHER				
OTHER				
OTHER				

SPECIALIZED SKILLS: (skills / equipment / training)

<input type="checkbox"/> PC Terminal	<input type="checkbox"/> Medical Terminology	<input type="checkbox"/> Spreadsheets
<input type="checkbox"/> Typewriter WPM _____	<input type="checkbox"/> Word Processing WPM _____	<input type="checkbox"/> Shorthand WPM _____
<input type="checkbox"/> Transcription	<input type="checkbox"/> Order Entry	<input type="checkbox"/> Email
<input type="checkbox"/> Languages <i>(other than English)</i> that you read, write, or speak:		
<input type="checkbox"/> Other information you feel may be helpful to us in considering your application:		
<input type="checkbox"/> Computer Software Programs <i>(that you feel you have a proficiency in):</i>		



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PROFESSIONAL LICENSES / REGISTRATIONS / CERTIFICATIONS				
TYPE	STATE	DATE	NUMBER	Have you ever been sanctioned or reprimanded by any state or federal healthcare agency or authority <i>(including, but not limited to, a licensing agency)</i>
				<input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE EXPLAIN BELOW

DRIVER'S LICENSE (if driving is required for your position)
For security purposes, we will request this information upon further consideration of employment

I certify that the information contained in this application (and accompanying resume, if any) is true, correct and complete to the best of my knowledge. I also agree that any falsified information or significant omissions may disqualify me from further consideration for employment and may be considered justification for termination if discovered at a later date.

I authorize a thorough investigation of my past employment, education and activities, agree to cooperate in such investigation, and release from all liability or responsibility all persons and / or entities requesting or supplying information from any damages that may result. I authorize Lakeside Hospital at Bastrop to request and receive such information.

I understand that employment with Lakeside Hospital at Bastrop is at-will, which means that I may terminate the employment relationship at any time and for any reason with or without notice, and that Lakeside Hospital has the same right. I understand that no one may alter the at-will nature of my employment except the Chief Executive Officer, or designee, and than only in a written and notarized agreement. I understand that if I am employed, I will conform to the rules and regulations of Lakeside Hospital.

I acknowledge that these rules and regulations may be changed, interpreted, withdrawn, or added to by Lakeside Hospital at any time at the hospital's sole option and without any prior notice by me.

I understand that an offer of employment is contingent upon satisfactory completion / result of the following: a post-offer medical examination (including lab work and drug screening); a reference, background and criminal history check; integrity and / or skills testing; and proof of legal authority to work in the United States under federal immigration laws.

I acknowledge being advised that this application will remain active for no more than 6 months from the date it is made. Submission of this application neither automatically results in an employment interview nor a job offer.

Signing your name below on the signature line is equivalent to signing your name to this document and therefore conveys your acknowledgement and authorization of the above statements.

Signature of Applicant	Date
HR Representative	Date