



Fresno Surgical Hospital Application for Employment

We are an equal opportunity employer and do not unlawfully discriminate in employment. No question on this application is used for the purpose of limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Equal access to employment, services, and programs is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of Fresno Surgical Hospital.

PLEASE PRINT CLEARLY

Date: _____ Social Security #: _____

Applicant name: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Please list other names used in the past: _____

Position(s) applied for or type of work desired: _____

Salary desired: \$_____ per _____

Type of employment desired: Full-time Part-time Per Diem Temporary

Shift/Hours desired: Days Swing Nights 8 hour 10 hour 12 hour

Date available: _____

Are you able to meet the attendance requirements? Yes No

Do you have any objection to working overtime if necessary? Yes No

Can you travel if required by this position? Yes No

Have you ever been previously employed by our organization? Yes No

If yes, when? _____

In what department? _____

Can you submit proof of legal employment authorization and identity? Yes No

Are you related to anyone working in this facility: Yes No

If so, whom? _____

If you are under 18, can you furnish a work permit if it is required? Yes No

During the last seven years, have you been convicted of a crime other than a minor traffic offense? Yes No

If yes, please provide details as in dates and locations of all convictions (a conviction will not necessarily disqualify you for employment): _____

Drivers license number (if driving is an essential job duty): _____

Do you read or speak any foreign languages: Yes No

If yes, what language(s)? _____

How were you referred to us? _____

Employment History

Please provide all employment information for your past three (3) employers starting with the most recent.

FROM		TO		COMPANY:	PHONE # ()	
MO.	YR.	MO.	YR.	STREET ADDRESS:		
SALARY				SUPERVISOR'S NAME	SUPERVISOR'S TITLE	MAY WE CONTACT: <input type="checkbox"/> YES <input type="checkbox"/> NO
START		FINAL OR CURRENT				
JOB TITLE:						
POSITION AND DUTIES:						
REASON FOR LEAVING:						

FROM		TO		COMPANY:	PHONE # ()	
MO.	YR.	MO.	YR.	STREET ADDRESS:		
SALARY				SUPERVISOR'S NAME	SUPERVISOR'S TITLE	MAY WE CONTACT: <input type="checkbox"/> YES <input type="checkbox"/> NO
START		FINAL OR CURRENT				
JOB TITLE:						
POSITION AND DUTIES:						
REASON FOR LEAVING:						

FROM		TO		COMPANY:	PHONE # ()	
MO.	YR.	MO.	YR.	STREET ADDRESS:		
SALARY				SUPERVISOR'S NAME	SUPERVISOR'S TITLE	MAY WE CONTACT: <input type="checkbox"/> YES <input type="checkbox"/> NO
START		FINAL OR CURRENT				
JOB TITLE:						
POSITION AND DUTIES:						
REASON FOR LEAVING:						

Education / Training

SCHOOL	NAME AND LOCATION	ACADEMIC MAJOR	GRADUATED?	DEGREE EARNED
HIGH SCHOOL			<input type="checkbox"/> YES <input type="checkbox"/> NO	
JUNIOR COLLEGE			<input type="checkbox"/> YES <input type="checkbox"/> NO	
COLLEGE/ UNIVERSITY			<input type="checkbox"/> YES <input type="checkbox"/> NO	
VOCATIONAL COLLEGE			<input type="checkbox"/> YES <input type="checkbox"/> NO	
OTHER			<input type="checkbox"/> YES <input type="checkbox"/> NO	

Other Skills and Qualifications

If your profession requires current licensure, registration, or certification, please indicate:

Type: _____ Number: _____ State: _____ Exp. Date: _____

Type: _____ Number: _____ State: _____ Exp. Date: _____

Type: _____ Number: _____ State: _____ Exp. Date: _____

Departmental Experience (if applying for RN position, check all that apply)

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> Acute Care/Hospital | <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> OR /Surgery | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Bariatrics |
| <input type="checkbox"/> Telemetry | <input type="checkbox"/> Med/Surg | <input type="checkbox"/> Catheter Lab | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Gastroenterology |
| <input type="checkbox"/> Other: _____ | | | |

Software/Computer Skills: Please fill in your skill level 0 to 5 (0=no skill 5=advanced skills)

System	Skill (0 to 5)	System	Skill (0 to 5)	System	Skill (0 to 5)
Microsoft Word		Microsoft Outlook		ADP Scheduler	
Microsoft Excel		Microsoft Access		Healthstream	
Microsoft Powerpoint		Meditech		Success Factors	
Microsoft Visio		ADP E-time			
Microsoft Publisher		HRB Solutions			

Summarize any job-related training, skills, licenses, certificates, and/or other qualifications:

References

List three professional references; do not include relatives or friends.

NAME	PHONE NUMBER	YEARS KNOWN

I hereby authorize the potential employer to contact, obtain, and verify the accuracy of information contained in this application from all previous employers, educational institutions, and references. I also hereby release from liability the potential employer and its representatives for seeking, gathering, and using such information to make employment decisions and all other persons or organizations for providing such information.

I understand that any misrepresentation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate termination of employment if I am employed, whenever it may be discovered.

If I am employed, I acknowledge that there is no specified length of employment and that this application does not constitute an agreement or contract for employment. Accordingly, either I or the employer can terminate the relationship at will, with or without cause, at any time, so long as there is no violation of applicable federal or state law.

I understand that it is the policy of this organization not to refuse to hire or otherwise discriminate against a qualified individual with a disability because of that persons need for a reasonable accommodation as required by the ADA.

I also understand that if I am employed, I will be required to provide satisfactory proof of identity and legal work authorization within three days of being hired. Failure to submit such proof within the required time shall result in immediate termination of employment.

I represent and warrant that I have read and fully understand the foregoing, and that I seek employment under these conditions.

Applicant signature: _____ Date: _____

Equal Employment Opportunity Data

____/____/____
Application Date

To be completed by applicant:

Fresno Surgical Hospital is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, the company invites employees to voluntarily self-identify their race or ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Name: _____

Sex: Male Female

- Race/Ethnicity:
- American Indian/Alaskan Native
 - Asian/Pacific Islander
 - Black or African American
 - Hispanic or Latino
 - White
 - Native Hawaiian or other Pacific Islander
 - Two or more races (not Hispanic or Latino)

Government contractors must take affirmative action to employ and advance certain qualified individuals subject to the Rehabilitation Act of 1973 and the Vietnam Era Veterans Readjustment Act of 1974. Completion of the following information is voluntary, and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodation, please check where applicable:

- Vietnam Era Veteran
- Disabled Veteran
- Individual with a Disability

To be completed by employer:

- EEO-1 Category:
- | | |
|---|---|
| <input type="checkbox"/> 1. Executive/Senior Level Officials and Managers | <input type="checkbox"/> 7. Crafts - skilled |
| <input type="checkbox"/> 2. First/Mid-level Officials and Manager | <input type="checkbox"/> 8. Operatives – semi-skilled |
| <input type="checkbox"/> 3. Professionals | <input type="checkbox"/> 9. Laborers – unskilled |
| <input type="checkbox"/> 4. Technicians | <input type="checkbox"/> 10. Service workers |
| <input type="checkbox"/> 5. Sales | |
| <input type="checkbox"/> 6. Office and clerical | |

Employer information completed by:

Name Date
