

JOB DATA

POSITION(S) APPLIED FOR:

DO YOU KNOW OF ANY REASON WHY YOU CANNOT PERFORM THE ESSENTIAL FUNCTIONS OF THE JOB FOR WHICH YOU ARE APPLYING WITH OR WITHOUT REASONABLE ACCOMMODATION? () YES () NO

IF YES, PLEASE EXPLAIN:

HOURLY WAGE EXPECTED: _____

WERE YOU FORMERLY EMPLOYED HERE: () YES () NO

IF YES, WHEN AND IN WHAT JOB:

ARE YOU RELATED TO ANYONE EMPLOYED AT THE GCMH? () YES () NO

IF YES, WHO AND WHAT RELATIONSHIP?

ARE YOU INTERESTED IN FULL-TIME OR PART-TIME WORK? () FULL-TIME () PART-TIME

IF PART-TIME, SPECIFY DAYS AND HOURS AVAILABLE:

WOULD YOU CONSIDER WORKING ANY SHIFT? () YES () NO
IF NO, WHICH SHIFTS WOULD YOU CONSIDER? () 1st () 2nd () 3rd

DATE AVAILABLE FOR WORK:

LONG-RANGE OCCUPATIONAL GOALS:

WILL YOU HAVE RELIABLE TRANSPORTATION TO AND FROM WORK IN ALL WEATHER CONDITIONS? () YES () NO

DO YOU HAVE ANY COMMITMENTS TO ANOTHER EMPLOYER THAT MIGHT AFFECT YOUR EMPLOYMENT WITH US? () YES () NO

IF YES, PLEASE EXPLAIN:

EDUCATION/TRAINING

SCHOOL	NAME AND ADDRESS OF SCHOOL	COURSE OF STUDY	CIRCLE LAST				DID YOU GRADUATE	LIST DIPLOMA OR DEGREE
			YEAR COMPLETED	1	2	3		
HIGH	_____	_____	1	2	3	4	() Yes () No	_____
COLLEGE	_____	_____	1	2	3	4	() Yes () No	_____
COLLEGE	_____	_____	1	2	3	4	() Yes () No	_____

OTHER: BUSINESS COLLEGE, OTHER SPECIAL SOURCES (INCLUDE POST GRADUATE, ETC.)

AREA OF SPECIALIZATION OR MAJOR INTEREST:

LIST HEALTH CARE, BUSINESS OR INDUSTRIAL EQUIPMENT OPERATED:

List any other experience, skills or qualifications which you feel would especially fit you for work with our hospital.

MILITARY EXPERIENCE:

WERE YOU IN THE ARMED FORCES? () YES () NO

IF YES, WHAT BRANCH? _____

DATES OF DUTY: FROM _____ TO _____

RANK AT SEPARATION: _____

BRIEFLY DESCRIBE YOUR DUTIES:

THIS SECTION TO BE COMPLETED BY R.N. & L.P.N. APPLICANTS ONLY

Please check areas in which you have ()CIC ()OR ()MED/SURG () OTHER-Please Specify
experience or a special interest. ()ER ()OB _____

Are you registered/licensed in MD? ()Yes ()No Registration No. _____
Expiration Date _____

If not, have you applied: ()Yes ()No Date of your application _____

THIS SECTION FOR TECHNICIANS, TECHNOLOGISTS AND PARAMEDICAL PROFESSIONALS ONLY

Please list current professional registrations, licenses and/or certifications.

Certifying or Licensing Association	Number	Expiration Date
_____	_____	_____
_____	_____	_____

THIS SECTION FOR CLERICAL AND SECRETARIAL APPLICANTS

Typing Skills () Yes () No Speed _____ WPM Computer Skills _____
Shorthand () Yes () No Speed _____ WPM _____
Office Machines Used _____

WORK EXPERIENCE

Please give accurate, complete full-time and part-time employment record. Start with present or most recent employer.

COMPANY NAME _____	TELEPHONE # _____
ADDRESS _____	EMPLOYED FROM _____ TO _____
NAME OF SUPERVISOR _____	WEEKLY PAY _____
STATE JOB TITLE AND DESCRIBE YOUR WORK _____	REASON FOR LEAVING _____

COMPANY NAME _____	TELEPHONE # _____
ADDRESS _____	EMPLOYED FROM _____ TO _____
NAME OF SUPERVISOR _____	WEEKLY PAY _____
STATE JOB TITLE AND DESCRIBE YOUR WORK _____	REASON FOR LEAVING _____

COMPANY NAME _____	TELEPHONE # _____
ADDRESS _____	EMPLOYED FROM _____ TO _____
NAME OF SUPERVISOR _____	WEEKLY PAY _____
STATE JOB TITLE AND DESCRIBE YOUR WORK _____	REASON FOR LEAVING _____

COMPANY NAME _____	TELEPHONE # _____
ADDRESS _____	EMPLOYED FROM _____ TO _____
NAME OF SUPERVISOR _____	WEEKLY PAY _____
STATE JOB TITLE AND DESCRIBE YOUR WORK _____	REASON FOR LEAVING _____

We may contact the employers listed above unless you indicate those you do not want us to contact.

DO NOT CONTACT EMPLOYER NUMBER(S)

REASON

PERSONAL or PROFESSIONAL REFERENCES

(NOT RELATIVES)

PLEASE GIVE COMPLETE ADDRESS

<u>NAME & OCCUPATION</u>	<u>ADDRESS</u>	<u>PHONE</u>
<u>NUMBER</u>		

1. _____

2. _____

3. _____

PLEASE READ CAREFULLY AND SIGN BELOW

I UNDERSTAND THAT DUE TO THE NATURE OF THE SERVICES WE PROVIDE, AN EXCEPTIONAL RECORD OF ATTENDANCE, PROMPTNESS AND DEPENDABILITY IS REQUIRED OF ALL GARRETT COUNTY MEMORIAL HOSPITAL EMPLOYEES.

I UNDERSTAND THAT EMPLOYMENT IS CONTINGENT UPON PASSING A PRE-PLACEMENT PHYSICAL EXAMINATION AND SATISFACTORY EDUCATION, PRIOR EMPLOYMENT AND REFERENCE VERIFICATIONS.

THE FACTS SET FORTH IN MY APPLICATION ARE TRUE AND COMPLETE. I UNDERSTAND THAT FALSE OR INCOMPLETE INFORMATION, INCLUDING MISSTATEMENTS, MISREPRESENTATIONS, OR OMISSIONS, FURNISHED ON THIS APPLICATION OR ON ANY OTHER FORM USED IN THE HIRING PROCESS SUCH AS FOR EXAMPLE, EMPLOYMENT VERIFICATION FORM I-9 OR PHYSICAL EXAMINATION FORMS, IS SUFFICIENT CAUSE FOR NOT CONSIDERING THE APPLICATION AND FOR TERMINATION FROM EMPLOYMENT IF DISCOVERED AFTER HIRING.

I UNDERSTAND THAT THIS APPLICATION IS NOT INTENDED TO BE A CONTRACT OF EMPLOYMENT, NOR DOES IT OBLIGATE THE GARRETT COUNTY MEMORIAL HOSPITAL IN ANY WAY IF THE GARRETT COUNTY MEMORIAL HOSPITAL DECIDES TO EMPLOY ME.

I UNDERSTAND THAT GARRETT COUNTY MEMORIAL HOSPITAL FOLLOWS THE CONCEPT OF AT-WILL EMPLOYMENT, WHICH MEANS THAT IF EMPLOYED AT THE HOSPITAL, I MAY TERMINATE MY EMPLOYMENT AND THE HOSPITAL MAY TERMINATE MY EMPLOYMENT AT ANY TIME AND FOR ANY REASON.

SIGNATURE: _____

IN MAKING THIS APPLICATION FOR EMPLOYMENT, I AUTHORIZE THE GARRETT COUNTY MEMORIAL HOSPITAL TO CONTACT ANY OF MY SCHOOLS, FORMER EMPLOYERS OR OTHER REFERENCES UNLESS OTHERWISE STATED. I ALSO HEREBY AUTHORIZE MY FORMER EMPLOYERS AND THOSE INDIVIDUALS WHOM I HAVE LISTED ON MY APPLICATION AS REFERENCES TO FURNISH ANY INFORMATION CONCERNING MY PERSONAL CHARACTER, HABITS OR WORK RECORD. I HEREBY RELEASE ALL SUCH PERSONS FROM ANY LIABILITY OR DAMAGE ON ACCOUNT OF HAVING FURNISHED THIS REQUIRED INFORMATION.

SIGNATURE: _____

UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND, AS A CONDITION OF EMPLOYMENT, PROSPECTIVE EMPLOYMENT OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A LIE DETECTOR OR SIMILAR TEST. AN EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT EXCEEDING \$100.

SIGNATURE: _____