

**PHILLIPS COUNTY HEALTH SYSTEMS  
APPLICATION FOR EMPLOYMENT**  
Please fill in all spaces. Enter N/A if item does not apply to you.

**PERSONAL INFORMATION**

Name – Last	First	Middle	Social Security No.	Today's Date
Address – Street				Telephone No.
City		State		Zip
Position Desired	Training For This Position (Formal education shown on other side of form)			
Other Specialized Training or Experience (Not Necessary for this Job)				
Have you ever worked At PCHS before? (Either Acute or LTC)	yes Dates	no (Please circle)	Department Worked In:	Other names worked here under:
Why Do You Choose Hospital Work?				
What Prompted You To Apply Here for Employment?				
Are You Related To Anyone In Our Employ? Who and How?				
Professional License Number	Type		State	
What shifts are you willing to work?	7-3	3-11	11-7	What days are you willing to work?
Hobbies				

**EMPLOYMENT UNDERSTANDING (Please read and sign)**

This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, Vietnam era veteran status or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this institution the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical examination, and such future physical examinations as may be required by this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

I understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form.

If employed, I will be required to complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility for employment.

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

This application will be kept on file for 90 days. If you desire to be considered for a job after 90 days, please contact the business office at Phillips County Health Systems

**EDUCATION**

Name and Location of Schools or Colleges	Did You Graduate?	Type of Degree/Certificate

**EMPLOYERS AND EXPERIENCE (References) Please list present job first. IF MORE ROOM NEEDED PLEASE ATTACH SHEET. IF RESUME ATTACHED, FILL IN ANY BLANKS NOT ANSWERED IN RESUME.**

<b>Present or Last Employer Name</b>				<b>City, State</b>
Dates Worked	From	To	Salary	Reason for Leaving
Supervisor		Phone Number		Other Names Worked Under
<b>Present or Last Employer Name</b>				<b>City, State</b>
Dates Worked	From	To	Salary	Reason for Leaving
Supervisor		Phone Number		Other Names Worked Under
<b>Present or Last Employer Name</b>				<b>City, State</b>
Dates Worked	From	To	Salary	Reason for Leaving
Supervisor		Phone Number		Other Names Worked Under
<b>Personal References list 2 People not related to you.</b>				
Name:	Address:		Phone:	Friend/Coworker
Name:	Address:		Phone:	Friend/Coworker

**Please sign the following release authorizing Phillips County Health Systems to request a personal reference or employment information from your former employer.**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant's Social Security Number \_\_\_\_\_

If your records are under a different name, please indicate that name. \_\_\_\_\_

Were you referred by anyone currently working at Phillips County Health Systems? Yes                      No

If yes, who referred you?

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

Date: \_\_\_\_\_