



Schuylkill Medical Center  
East Norwegian Street  
700 East Norwegian Street  
Pottsville, PA 17901

**HUMAN RESOURCES**  
Telephone: (570) 621-4065  
E-mail: smchreast@schuylkillhealth.com  
Web site: www.schuylkillhealth.com

**APPLICATION FOR EMPLOYMENT**  
*(Remains Active for 6 Months)*

Date \_\_\_\_\_

\*\*\* SCHUYLKILL MEDICAL CENTER EAST NORWEGIAN STREET IS A TOBACCO FREE CAMPUS \*\*\*

All decisions concerning job application procedures, employment, advancement, discharge, compensation, training, and other terms, conditions and privileges, are made regardless of race, color, sex, religion, ancestry, age, national origin, disability or veteran status.

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Present Address \_\_\_\_\_  
(No. Street) (City) (State) (Zip Code)

Telephone Number \_\_\_\_\_ E-mail \_\_\_\_\_

Do you have the legal right to work in the U.S.? Yes \_\_\_\_\_ No \_\_\_\_\_ Social Security No. \_\_\_\_\_

If under 18, state your age: \_\_\_\_\_ Do you use any tobacco products? Yes \_\_\_\_\_ No \_\_\_\_\_

Position(s) applied for: \_\_\_\_\_ Shift Preference \_\_\_\_\_

How were you referred to this facility? \_\_\_\_\_

(Full time \_\_\_\_\_ Part time \_\_\_\_\_ Casual/Per Diem \_\_\_\_\_) (Regular \_\_\_\_\_ Temporary \_\_\_\_\_ Summer \_\_\_\_\_)

Were you previously employed by us? \_\_\_\_\_ If yes, under what name? \_\_\_\_\_

Do you have any relatives employed by the medical center? \_\_\_\_\_ If yes, whom/relationship? \_\_\_\_\_

Have you been convicted of a felony, or any misdemeanor involving theft, distribution of drugs, or acts of violence? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

(Note: A conviction may not necessarily disqualify you from a particular job.)

Have you ever been discharged or asked to resign from a job? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

If selected for employment, on what date would you be available for work? \_\_\_\_\_

High School Diploma: Yes \_\_\_\_\_ No \_\_\_\_\_ If no, number of years completed 1 2 3 4

School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

College: Yes \_\_\_\_\_ No \_\_\_\_\_ Number of years completed 1 2 3 4

School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Major \_\_\_\_\_ Degree Earned \_\_\_\_\_

**Other Training or Degrees:**

School(s) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Major \_\_\_\_\_ Degree Earned \_\_\_\_\_

Current Employment License, Registration or Certificate Number(s) if any: \_\_\_\_\_

**Employment - List most recent employer first. Include U.S. military service. Complete all information requested.**

Start Date Month                      Year	Employer's Name	Position Held
End Date Month                      Year	Address	
Hourly Rate/Salary	City/State/Zip Code	
	Phone Number	Supervisor's Name/Title
Reason for leaving/wanting to leave		
<hr/>		
Start Date Month                      Year	Employer's Name	Position Held
End Date Month                      Year	Address	
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Reason for leaving/wanting to leave		

**NOTE: ALL appropriate spaces must be signed and dated for application to be considered.**

**References** - Give below the name of three persons not related to you, whom you have known at least one year.

NAME	RELATIONSHIP	PHONE #	YEARS ACQUAINTED

Can you, with or without reasonable accommodations, perform the essential functions of the position(s) for which you are applying?

Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please list the reason(s): \_\_\_\_\_

In case of emergency notify \_\_\_\_\_  
(Name)
(Address)
(Phone #)

**Employment is dependent upon passing a pre-employment medical screening, and satisfactory background reference checks.**

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief, and hereby grant medical center permission to verify such answers. **I understand that any false statement on this application will be considered as sufficient cause for rejecting this application or for dismissal if such false statement is discovered subsequent to my employment.** I understand that as a part of the medical center procedure for processing my employment application, an investigation and a report may be made by a consumer report agency in the process of which information may be obtained through interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom the applicant has been acquainted. This inquiry may include information as to the applicant's character, general reputation, personal characteristics, whichever may be applicable. I understand I have a right to make a written request within a reasonable time for the disclosure of the name and address of the consumer reporting agency so that I may obtain a complete disclosure of the nature and scope of the investigation. I understand that if I am extended an offer of employment, it **will** be conditioned upon my successfully passing a complete pre-employment medical screening, including testing for illegal and/or controlled substances, criminal record check, **and child abuse history clearance if applicable**, which includes a review of Medicare sanctions. I consent to the release of any or all medical information as may be deemed necessary to judge my capability to do the work for which I am applying. **I understand that this application or subsequent employment does not create a contract of employment nor guarantee employment for any definite period of time.**

I have read, understand, and by my signature consent to these statements.

\_\_\_\_\_/\_\_\_\_\_  
(Signature of Applicant)
(Date)

I hereby authorize any individual, medical center, company or institution with whom I have been associated to furnish SCHUYLKILL MEDICAL CENTER EAST NORWEGIAN STREET with any information concerning my employability which they have on record or otherwise. I hereby release any individual, medical center, company or institution and all individuals connected therewith, including Schuylkill Medical Center East Norwegian Street, from all liability for any damages whatsoever incurred in furnishing such information.

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

(For Office Use Only)

**To:**

A former employee has applied for employment as a(n) \_\_\_\_\_ at this medical center. We have obtained written authorization from the applicant to solicit previous employers for employment data. It is understood that information provided by you will be held in the strictest confidence. Thank you for completing the reference form.

Sincerely yours,

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

Name of Applicant \_\_\_\_\_

Social Security No. \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Dates employed \_\_\_\_\_

Position(s) held \_\_\_\_\_

<b>Please Evaluate Applicant</b>	<b>Below Standards</b>	<b>Meets Standards</b>	<b>Above Standards</b>
Performance / Quality			
Performance / Quantity			
Interpersonal Skills			
Motivational Skills			
Leadership Skills			

Reason for leaving: \_\_\_\_\_

Eligible for re-employment? Yes ( ) No ( ) If not, please explain \_\_\_\_\_

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

Was the applicant, with or without reasonable accommodation(s), capable of performing the essential function(s) of the position(s) they held with your organization? \_\_\_\_\_

If not, please list the reason(s): \_\_\_\_\_

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

Title \_\_\_\_\_