



Schuylkill Medical Center
South Jackson Street
420 South Jackson Street
Pottsville, PA 17901

HUMAN RESOURCES

Telephone: (570) 621-5095
E-mail: smchr@south@schuylkillhealth.com
Web site: www.schuylkillhealth.com

APPLICATION FOR EMPLOYMENT
(Remains Active for 6 Months)

Date _____

*** SCHUYLKILL MEDICAL CENTER SOUTH JACKSON 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 | |
| Hourly Rate/Salary | City/State/Zip Code | |
| | Phone Number | Supervisor's Name/Title |
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| 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 | | |

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 SOUTH JACKSON 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 South Jackson 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 _____

| Please Evaluate Applicant | Below Standards | Meets Standards | Above Standards |
|----------------------------------|------------------------|------------------------|------------------------|
| 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 _____