



APPLICATION FOR EMPLOYMENT

Lanier Health Services

4800 48th Street, Valley, AL 36854 (334) 756-9180

PERSONAL INFORMATION

Date: _____ Social Security Number: _____

Name: _____
Last First Middle

Present Address: _____
Street City Zip

Previous Address: _____
Street City Zip

Home/Cell Phone #: (_____) _____
Area Code Names of Relatives Employed By Lanier Health Services: _____

In Case of Emergency, Notify: _____
Name Address Work Phone Home Phone

How did you learn of employment opportunities with Lanier Health Services? _____

Are you eligible for employment in this country? Yes No

Have you ever been convicted of a felony? Yes No If Yes, please explain: _____

EMPLOYMENT DESIRED (You may list more than one position on the same application)

**** (Applications are only accepted for positions currently available) ****

Work Availability

Day Shift (12 Hour) Night Shift (12 Hour)

Full-Time Temporary
 Part-Time Summer Only
 PRN Other _____

Any Shift Evening Shift (8 Hour)
 Day Shift (8 Hour) Night Shift (8 Hour)
 Available on Wknds Other _____

Position: _____

Date You Can Start: _____

Ever Employed by Lanier Health Services Before? Yes No Department: _____ When? _____

Have you ever worked here under a different name? Yes No If so, under what name? _____

Are you employed now? Yes No If so, may we inquire of your present employer? Yes No

Education	NAME AND LOCATION OF SCHOOL	# YEARS ATTENDED	DID YOU GRADUATE?	DEGREE
Grammar School				
High School				
College				
Trade, Business, or Correspondence School				

Post Graduate Work or Areas of Special Study or Research: _____

Professional Licensure or Registration:

State Number Expiration Date

State Number Expiration Date

Clerical Applicants:

Typing Speed: _____ Shorthand Speed: _____

Do you have training or experience with the following:

Dictaphone: Yes No

Data Entry / Computer: Yes No Calculator: Yes No

Have you ever served in the military service? Yes No

Military Branch: _____

Can you furnish a copy of your discharge? Yes No

Type of work in service: _____

EMPLOYMENT RECORD (Start with current or most recent employment) (This page must be completed even if accompanied by resume)

Dates of Employment			Employer's Name	Address		
	MONTH	YEAR	City	State	Zip Code	Area Code/Phone#
FROM			Supervisor or Contact Person	Ext. No.	May We Contact Employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
TO			Position Title & Duties			
Reason For Leaving:						Final Salary:

Dates of Employment			Employer's Name	Address		
	MONTH	YEAR	City	State	Zip Code	Area Code/Phone#
FROM			Supervisor or Contact Person	Ext. No.	May We Contact Employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
TO			Position Title & Duties			
Reason For Leaving:						Final Salary:

Dates of Employment			Employer's Name	Address		
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TO			Position Title & Duties			
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Dates of Employment			Employer's Name	Address		
	MONTH	YEAR	City	State	Zip Code	Area Code/Phone#
FROM			Supervisor or Contact Person	Ext. No.	May We Contact Employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
TO			Position Title & Duties			
Reason For Leaving:						Final Salary:

List other employers and dates of employment:

References: List two persons we may contact for professional references

Name	Address	Phone
1.		
2.		

For use by Personnel Department:

Interviewed By: 1. _____ 2. _____

Remarks: _____

Approved: 1. _____ 2. _____ 3. _____

Supervisor

Department Director

Director of Personnel

I authorize investigation of all statements obtained in this application. I understand that misrepresentation or omission of facts called for is cause for dismissal.

Date

Signature of Applicant



**CERTIFICATION OF PROFESSIONAL LICENSE, REGISTRATION,
CERTIFICATION STATUS**

Please answer each of the following questions completely:

1. Is your professional license (LPN, RN, etc.), registration (RRT, Radiology Tech., etc.) or certification (CNA, etc.) current and in good standing with no restrictions or probation? Yes No
If no, fully explain: _____

2. Has your license, registration, certification ever been suspended? Yes No
If yes, fully explain: _____

3. Have restrictions ever been imposed on your license, registration, or certification? Yes No
If yes, fully explain: _____

4. Have you ever been on professional probation? Yes No
If yes, fully explain: _____

5. Have you ever been denied participation in the Medicare program? Yes No
If yes, please explain: _____

Date of Graduation and Years of Relevant Experience

RN _____ BSN _____ MSN _____ Total Yrs. Experience as RN _____

LPN _____ # Yrs. Experience _____

Radiology Tech _____ # Yrs. Experience _____

Other Degree and Graduation Date _____ # Yrs. Experience _____

I have answered the above questions truthfully and understand that misrepresentations or omission of facts is cause for dismissal.

Signature

Date

Print Name

**Chattahoochee Valley Hospital Society d/b/a
Lanier Health Services
Equal Employment Opportunity Employer**

Dear Applicant:

Lanier Health Services is an Equal Opportunity/Affirmative Action employer and subject to certain reporting and affirmative action requirements. The information asked for on this insert is requested only so that we may meet our Equal Opportunity/Affirmative Action obligations. Your completion of this form is purely voluntary and will not, in any way, affect your consideration for employment. This insert will be separated from your application and will be separately maintained.

How were you referred to our Company?

Ad (Specify) _____
Walk-in _____
Agency (Specify) _____
Employee (Who?) _____
State Employment Service _____
Other _____

SECTION 1

Sex: (please check one): _____ Male _____ Female

SECTION 2

Ethnicity: (please check one):

_____ **Hispanic or Latino** – all persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

****(If you have selected “Hispanic or Latino,” please SKIP SECTION 3.)****

_____ **Not Hispanic or Latino** – everyone who is not “Hispanic or Latino,” as defined above.

SECTION 3

(If you selected “Hispanic or Latino” in Section 2, DO NOT complete this section. Otherwise, please check one of the following:)

Race:

_____ **White** (Not Hispanic or Latino): all persons having origins in any of the original people of Europe, North Africa, or the Middle East

_____ **Black or African American** (Not Hispanic or Latino): All persons having origins in any of the black racial groups of Africa

_____ **Native Hawaiian or Other Pacific Islander** (Not Hispanic or Latino) – any persons having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands

_____ **Asian** (Not Hispanic or Latino) – all persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

_____ **American Indian or Alaskan Native** (Not Hispanic or Latino) - all persons having origins in any of the original peoples of North or South America, and who maintain cultural identification through tribal affiliation or community attachment

_____ **Two or More Races** (Not Hispanic or Latino) – all persons who identify with more than one of the above races

SECTION 4

(If you chose not to complete sections 1, 2, or 3, please complete this Section, and sign where indicated below. If you completed the other sections, please skip this section and sign where indicated below.)

_____ I prefer not to identify my sex, ethnicity, or race at this time.

Thank you.

This information is submitted voluntarily, will be kept confidential, will be exclusively used for statistical gathering and compliance purposes, and will not influence any employment or placement decision.

Print Last Name, First Name

Signature

Date