



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)

Position: _____
Work Availability
 Full-Time Temporary
 Part-Time Summer Only
 PRN Other _____
 Day Shift (12 Hour) Night Shift (12 Hour)
 Any Shift Evening Shift (8 Hour)
 Day Shift (8 Hour) Night Shift (8 Hour)
 Available on Wknds Other _____

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

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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)

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		
	MONTH	YEAR	City	State	Zip Code	Area Code/Phone#
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Reason For Leaving:						Final Salary:

Dates of Employment			Employer's Name	Address		
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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