



Highland Medical Center  
An Equal Opportunity Employer  
**Application for Employment**

Number of attachments \_\_\_\_\_

Current employees and applicants for employment shall be afforded equal opportunity in all aspects of employment without regard to race, color, religion, political affiliation, national origin, disability, marital status, gender, or age. As a means of accommodation to persons with specific disabilities that prevent them from completing this application, confidential assistance in filling out this application may be obtained by calling Highland Medical Center.

Position applied for \_\_\_\_\_ (one per application) Date \_\_\_\_\_

Full legal name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
City State Zip

**EDUCATION**

- a. Highest grade completed
- b. If you did not complete high school, do you have a high school equivalency diploma?  Yes  No
- c. Number of years of post high school education

Name and Location of Institution	Degree Received	Major or Specialty	Minor
1.			
2.			
3.			

- d. If you expect to complete an educational program soon, please indicate what type of degree or program, and expected completion date.

**EXPERIENCE** — Use *Supplementary Experience Form(s)* for additional space. Starting with the most recent, describe ALL paid, military, and applicable voluntary experience. Highlight your knowledge, skills and abilities which best demonstrate your qualifications for this position. You may list significantly different jobs within the same organization as separate items.

May we contact your present supervisor?  No  Yes

a. Position Title \_\_\_\_\_ Type of Business \_\_\_\_\_  
 Immediate supervisor \_\_\_\_\_ Number of employees supervised \_\_\_\_\_  
 Salary (start) \_\_\_\_\_ (finish) \_\_\_\_\_ Dates (mo/yr) \_\_\_\_\_ to (mo/yr) \_\_\_\_\_  
 Reason for leaving \_\_\_\_\_ Full-time  Part-time  Hours/week \_\_\_\_\_  
 Your name if different from present \_\_\_\_\_  
 Duties \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

b. Position Title \_\_\_\_\_ Type of Business \_\_\_\_\_  
 Immediate supervisor \_\_\_\_\_ Number of employees supervised \_\_\_\_\_  
 Salary (start) \_\_\_\_\_ (finish) \_\_\_\_\_ Dates (mo/yr) \_\_\_\_\_ to (mo/yr) \_\_\_\_\_  
 Reason for leaving \_\_\_\_\_ Full-time  Part-time  Hours/week \_\_\_\_\_  
 Your name if different from present \_\_\_\_\_  
 Duties \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

c. Position Title \_\_\_\_\_ Type of Business \_\_\_\_\_  
 Immediate supervisor \_\_\_\_\_ Number of employees supervised \_\_\_\_\_  
 Salary (start) \_\_\_\_\_ (finish) \_\_\_\_\_ Dates (mo/yr) \_\_\_\_\_ to (mo/yr) \_\_\_\_\_  
 Reason for leaving \_\_\_\_\_ Full-time  Part-time  Hours/week \_\_\_\_\_  
 Your name if different from present \_\_\_\_\_  
 Duties \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Use this space for any additional information you think would help us evaluate your application, including training, seminars, workshops, and special achievements or specialized skills: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

License, certificate, or other authorization to practice a trade or profession.

Type	License #	Granted by (licensing board)

**REFERENCES** — List names, phone number, and address of three persons not related to you who know your qualifications:

Name	Phone #	Address

**MISCELLANEOUS**

a. a. Check which job status you would accept:

- Full-time       Part-time (specify)

b. Check which employment status you would accept:

- Salaried (benefits)       Hourly (with benefits)       Part-time hourly

c. Are you willing to accept employment which requires you to travel?

- No       Yes

*If Yes:*       During the day only       Occasionally overnight

d. For purposes of compliance with The Immigration Reform and Control Act, are you legally eligible for employment in the United States?

- No       Yes

Under the Immigration Reform and Control Act of 1986, you will be required to fill out a certification verifying that you are eligible to be employed and verifying your identity. Further, you will be required to provide documentation to that effect should you be employed.

**AVAILABILITY**

When will you be available to start work? \_\_\_\_\_

(No date is necessary if you are available as soon as you give two (2) weeks' notice.)

**CERTIFICATION--Each Application Requires Current Date and Original Signature**

I hereby certify that all entries and attachments are true and complete, and I agree and understand that any falsification of information herein regardless of time of discovery, may cause forfeiture on my part to any employment in the service of the Highland Medical Center. I understand that all information on this application is subject to verification and I consent to criminal history background checks. I also consent to references and former employers and educational institutions listed being contacted regarding this application. I further authorize to rely upon and use, as it sees fit, any information received from such contacts. Information contained on this application may be disseminated to other entities on a need-to-know basis for good cause shown as determined by the Highland Medical Center Chief Executive Officer or designee.

I understand that nothing contained in this employment application or in the granting of an interview is intended to create an employment contract between the company and myself for either employment or for the providing of any benefit. No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon the company unless made in writing. If an employment relationship is established, I understand that I have the right to terminate my employment at any time and that the company retains the same right.

If I am offered employment, I agree to submit to a physical examination whenever requested, and I understand my becoming employed and/or my continued employment are subject to the results of any physical examination related to my job duties in accordance with company policies and procedures.

I understand that if employed, policies, and rules which are issued are not conditions of employment and that the employer may revise policies or procedures in whole or in part, at any time.

I understand that this application will be kept on active file for 365 days from the date completed, after which time I would have to reapply in accordance with established company procedures.

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Date

Applicant Signature

*Supplementary Experience Form*

Position Title \_\_\_\_\_ Type of Business \_\_\_\_\_

Immediate supervisor \_\_\_\_\_ Number of employees supervised \_\_\_\_\_

Salary (start) \_\_\_\_\_ (finish) \_\_\_\_\_ Dates (mo/yr) \_\_\_\_\_ to (mo/yr) \_\_\_\_\_

Reason for leaving \_\_\_\_\_ Full-time  Part-time  Hours/week \_\_\_\_\_

Your name if different from present \_\_\_\_\_

Duties \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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Immediate supervisor \_\_\_\_\_ Number of employees supervised \_\_\_\_\_

Salary (start) \_\_\_\_\_ (finish) \_\_\_\_\_ Dates (mo/yr) \_\_\_\_\_ to (mo/yr) \_\_\_\_\_

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Duties \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_