

*St. Joseph's*  
**HOSPITAL**  
*Where caring is  
our specialty*



Equal Opportunity Employer  
9515 Holy Cross Lane, Breese, IL 62230  
PH: 618-526-4511 FAX: 618-526-8022

## PERSONAL INFORMATION

<p><b>NAME:</b>  <input style="width: 100%;" type="text"/>  <small>LAST                      FIRST                      MIDDLE</small></p> <p><b>PRESENT ADDRESS:</b>  <input style="width: 100%;" type="text"/>  <small>CITY                      STATE                      ZIP CODE</small></p> <p><b>SOCIAL SECURITY NO.:</b>  <input style="width: 100%;" type="text"/></p> <p><b>EMAIL ADDRESS (optional):</b>  <input style="width: 100%;" type="text"/></p> <p><b>TYPE OF EMPLOYMENT:</b>          Full Time <input type="checkbox"/>    Part Time <input type="checkbox"/>    Regular <input type="checkbox"/>    Temporary <input type="checkbox"/></p> <p><b>SHIFT PREFERENCE:</b>          Days <input type="checkbox"/>    Evenings <input type="checkbox"/>    Nights <input type="checkbox"/></p>	<p><b>PREVIOUS NAMES INCLUDING MAIDEN NAME:</b>  <input style="width: 100%;" type="text"/></p> <p><b>PERMANENT ADDRESS:</b>  <input style="width: 100%;" type="text"/>  <small>CITY                      STATE                      ZIP CODE</small></p> <p><b>HOME TELEPHONE NO.:</b>  <input style="width: 100%;" type="text"/>    Best Time To Contact You:</p> <p><b>CONTACT TELEPHONE NO.:</b>  <input style="width: 100%;" type="text"/>    Best Time To Contact You:</p> <p><b>WOULD YOU CONSIDER WORKING:</b></p> <table style="width: 100%;"> <tr> <td>Weekends &amp; Holidays</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>Rotating Shifts</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>On Call</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>Any Shift</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table> <p><b>DATE AVAILABLE TO START:</b>  <input style="width: 100%;" type="text"/></p>	Weekends & Holidays	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rotating Shifts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On Call	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any Shift	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekends & Holidays	Yes <input type="checkbox"/>	No <input type="checkbox"/>											
Rotating Shifts	Yes <input type="checkbox"/>	No <input type="checkbox"/>											
On Call	Yes <input type="checkbox"/>	No <input type="checkbox"/>											
Any Shift	Yes <input type="checkbox"/>	No <input type="checkbox"/>											

<p><b>POSITION APPLIED FOR:</b>  <input style="width: 100%;" type="text"/></p> <p><b>HOW WERE YOU REFERRED TO THIS FACILITY?</b>  <input style="width: 100%;" type="text"/></p> <p><b>RELATIVES OR FRIENDS EMPLOYED WITH THIS FACILITY?</b>          Yes <input type="checkbox"/>    No <input type="checkbox"/>    Name: _____ Dept.: _____ Relationship: _____</p> <p><b>ARE YOU A U.S. CITIZEN OR AN ALIEN LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES?</b>    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p><b>ARE YOU 18 YEARS OF AGE OR OLDER?</b>    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p><b>LONG RANGE OCCUPATIONAL GOALS:</b>  <input style="width: 100%;" type="text"/></p> <p><b>HAVE YOU EVER BEEN CONVICTED OF, OR PLEAD GUILTY TO, A CRIME OTHER THAN MISDEMEANOR TRAFFIC VIOLATIONS?</b>          Yes <input type="checkbox"/>    If yes, which state, and explain: (You are not required to disclose any SEALED or EXPUNGED criminal records.)          No <input type="checkbox"/></p> <p><b>HAVE YOU EVER BEEN INVOLVED IN THE SUBSTANTIATED ABUSE OR NEGLECT OF CHILDREN OR ADULTS UNDER THE LAWS OF THIS OR ANY OTHER STATE OF THE UNITED STATES?</b>          Yes <input type="checkbox"/>    If yes, which state, and explain:          No <input type="checkbox"/></p> <p><b>HAVE YOU EVER BEEN SANCTIONED, CITED, REPORTED, OR EXCLUDED FROM PARTICIPATION IN MEDICARE, MEDICAID, OR ANY OTHER HEALTHCARE RELATED LAW OR REGULATION?</b>          Yes <input type="checkbox"/>    If yes, which state, and explain:          No <input type="checkbox"/></p> <p style="text-align: center;"><b>If your answer is "yes" to any of the above, you will not be automatically disqualified from employment consideration, except as required by state or federal law.</b></p>	<p><b>SALARY DESIRED:</b>  <input style="width: 100%;" type="text"/></p> <p><b>HAVE YOU EVER BEEN EMPLOYED BY THIS FACILITY?</b>          Yes <input type="checkbox"/>    No <input type="checkbox"/>    When? _____</p>
--	--

## EDUCATIONAL INFORMATION

SCHOOL	NAME OF SCHOOL AND ADDRESS	LIST DIPLOMA, DEGREE, OR COURSE OF STUDY	LAST YEAR COMPLETED	DID YOU GRADUATE
HIGH			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO
COLLEGE			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO
COLLEGE			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO
TECHNICAL\ BUSINESS			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER <small>(Including Military, Nursing, and Post Graduate.)</small>			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO

## SKILLS AND PROFESSIONAL LICENSES

LIST OFFICE SKILLS INCLUDING COMPUTER/SOFTWARE EXPERIENCE:

	WORD PROCESSING APPROX. WPM _____
--	-----------------------------------

LIST HEALTH CARE, BUSINESS, OR INDUSTRIAL EQUIPMENT OPERATED:

--

AREA(S) OF SPECIALIZATION OR MAJOR INTEREST:

--

LICENSES:

CURRENTLY LICENSED <input type="checkbox"/>	ELIGIBLE FOR LICENSE <input type="checkbox"/>	TYPE: _____	STATE: _____
CURRENTLY REGISTERED <input type="checkbox"/>	ELIGIBLE FOR REGISTRATION <input type="checkbox"/>	NO.: _____	DATE: _____
CURRENTLY LICENSED <input type="checkbox"/>	ELIGIBLE FOR LICENSE <input type="checkbox"/>	TYPE: _____	STATE: _____
CURRENTLY REGISTERED <input type="checkbox"/>	ELIGIBLE FOR REGISTRATION <input type="checkbox"/>	NO.: _____	DATE: _____

CERTIFICATION:

CURRENTLY CERTIFIED <input type="checkbox"/>	ELIGIBLE FOR CERTIFICATION <input type="checkbox"/>	TYPE: _____	STATE: _____
			DATE: _____
CURRENTLY CERTIFIED <input type="checkbox"/>	ELIGIBLE FOR CERTIFICATION <input type="checkbox"/>	TYPE: _____	STATE: _____
			DATE: _____

## PREVIOUS EXPERIENCE

NAME OF EMPLOYER: _____	ADDRESS: _____	PHONE: _____
JOB TITLE: _____	SUPERVISOR'S NAME: _____	SALARY (Hr/Mo/Yr): _____
JOB DUTIES: _____		
START DATE: _____ END DATE: _____ REASON FOR LEAVING: _____		
MAY WE CONTACT YOUR CURRENT EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>		

NAME OF EMPLOYER: _____	ADDRESS: _____	PHONE: _____
JOB TITLE: _____	SUPERVISOR'S NAME: _____	SALARY (Hr/Mo/Yr): _____
JOB DUTIES: _____		
START DATE: _____ END DATE: _____ REASON FOR LEAVING: _____		
MAY WE CONTACT YOUR CURRENT EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>		

NAME OF EMPLOYER: _____	ADDRESS: _____	PHONE: _____
JOB TITLE: _____	SUPERVISOR'S NAME: _____	SALARY (Hr/Mo/Yr): _____
JOB DUTIES: _____		
START DATE: _____ END DATE: _____ REASON FOR LEAVING: _____		
MAY WE CONTACT YOUR CURRENT EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>		

NAME OF EMPLOYER: _____	ADDRESS: _____	PHONE: _____
JOB TITLE: _____	SUPERVISOR'S NAME: _____	SALARY (Hr/Mo/Yr): _____
JOB DUTIES: _____		
START DATE: _____ END DATE: _____ REASON FOR LEAVING: _____		
MAY WE CONTACT YOUR CURRENT EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>		

## REFERENCES

### WORK OR EDUCATIONAL REFERENCES:

NAME			
OCCUPATION/TITLE			
ADDRESS			
PHONE			

## SIGNATURE

### CAREFULLY READ THIS SECTION PRIOR TO SIGNING BELOW:

I certify that the information I have furnished is correct and complete. I understand that misrepresentation, falsification or omission may result in rejection or dismissal, if employed, even if discovered at a later date. I understand I will be subject to a criminal background check.

I understand that I must meet the health standards established by St. Joseph's Hospital as a condition of initial and continued employment.

I authorize my current employer (if applicable), past employers, schools, other organizations and persons to supply St. Joseph's Hospital and it's affiliate with any requested information regarding my application or suitability for employment. I release them from any and all liability related to the providing or use of such information. Upon my termination of employment, I authorize release of reference information from St. Joseph's Hospital to future potential employers and release St. Joseph's Hospital from any and all liability for reference information it provides.

I understand that completion of this application in no way binds St. Joseph's Hospital to an employment commitment. I understand that if I am employed at St. Joseph's Hospital, the employment relationship can be terminated at will by either party, at any time, for any reason, with or without notice.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_

Have you ever worked under a different name?  NO  YES

NAME(S): \_\_\_\_\_

## OFFICE USE ONLY

STARTING DATE: \_\_\_\_\_ EMPLOYEE NUMBER: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_ DEPARTMENT: \_\_\_\_\_ SALARY/LEVEL: \_\_\_\_\_

SHIFT:  1ST  2ND  3RD  PART TIME  FULL TIME

PRIMARY EMERGENCY CONTACT: \_\_\_\_\_  
NAME ADDRESS PHONE RELATIONSHIP

SECONDARY EMERGENCY CONTACT: \_\_\_\_\_  
NAME ADDRESS PHONE RELATIONSHIP

REQUIRED COPIES OF IDENTIFICATION ACQUIRED?  YES  NO

REFERENCES CHECKED?  YES  NO

INTERVIEWER'S COMMENTS: \_\_\_\_\_

INTERVIEWER'S SIGNATURE: \_\_\_\_\_