DeQuincy Memorial Hospital

APPLICATION FOR EMPLOYMENT

DEQUINCY MEMORIAL HOSPITAL (DQMH) IS AN EQUAL OPPORTUNITY EMPLOYER. All practices of recruiting, hiring, promotion, transfer, wage and salary administration, benefits and terminations are administered without regard to race, color, creed, sex, religion, national origin, disability, age, veteran status or any and all other unlawful biases regarding federal, state or local laws. Further, DQMH is committed to providing a work environment that prohibits, in any form, unlawful harassment. To be considered for employment, all applicants must fill out this form completely. ("See resume" is not an appropriate response). This application will be considered, but its receipt does not imply that the applicant will be employed by the company. This form becomes a part of your permanent employment record if you are hired. This application is valid for 90 days. After that time period, applicants are responsible for reapplying.

PERSONAL INFORMATION (Please Print Full Legal Name)

Last Name _____ First Name _____ Middle Name _____ Social Security Number _____

Current Street Address _____ P.O. Box No. /Apt. No. /Unit No. _____ Area Code – Current Phone Number _____

City _____ State _____ Zip Code _____ Area Code – Secondary Phone Number _____

List all names or aliases ever used: _____

List all addresses for the last 7 years:

Previous Address - Street/P.O. Box No. _____ City/State _____ Zip Code _____

Previous Address - Street/P.O. Box No. _____ City/State _____ Zip Code _____

Previous Address - Street/P.O. Box No. _____ City/State _____ Zip Code _____

TYPE OF WORK DESIRED

Position(s) applying for _____ Salary $_____ Per_____

The following conditions might be required at some point in a job assignment. Do you agree to satisfy the following work schedule?

a. Shift work? ____Yes ____No
b. Overtime work? ____Yes ____No
c. Rotation work? ____Yes ____No
d. Work schedule other than Monday to Friday? ____Yes ____ No
e. Do you agree to work the hours required for your position? ____Yes ____ No
f. Shift desired? ____Day ____Evening ____Night

Status of employment for which you are applying: ____Full-time ____Part-time ____Per Diem (PRN)

GENERAL INFORMATION

Are you are at least 18 years of age or older? ___Yes ___No

As a U.S. citizen or based on immigrant status, do you have legal right to work in the United States? ___Yes ___No

Has DQMH or any of its subsidiaries ever employed you or any of your relatives? If yes, please indicate which subsidiary and dates of employment:

_____

Are you a United States Veteran? ___Yes ___No If yes, please list date of separation:_____

To assist us in our recruitment efforts, please indicate how you were referred to DQMH:

___Walk-in ___Newspaper Ad (please specify):_____

___Job Fair (please specify):_____ ___Website or Internet (please specify):_____

___Employee Referral (please specify):_____ ___Other: (please specify):_____

Do you have a relative that works for DeQuincy Memorial Hospital? If yes, what department? _____

SECURITY DATA

Pursuant to the OIG Compliance Program, Employees convicted of criminal offenses or offenses including fraud and abuse related to health care are prohibited from participating in any portion of the direct or indirect health care delivery process. In the event of any pending charges, current employees may be removed from direct responsibility including patient care or involvement with any Federal health care program.

Have you ever been convicted or plead guilty or no contest to any criminal offense? _____ Yes _____ No
(Criminal convictions are not an automatic ban from employment and will only be considered in relation to specific job requirements.)

Have you ever been convicted of a criminal offense related to health care or listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federal health care programs? _____ Yes _____No

If you answered "yes" to either or the above questions, please briefly describe the circumstances of your conviction indicating the date, nature and place of the offense and disposition of the case.

_____

_____

EDUCATION AND TRAINING Institution Name and Location		No. of Years Completed	Graduated Yes	Graduated No	Type of Degree, Diploma or Certificate and Major Course of Study	Academic Standing
High School						
College/ University						
Graduate School						
Trade School/ OtherTraining						

ACADEMIC ACHIEVEMENTS AND ACTIVITIES:

Please list academic honors, scholarships, or fellowships; memberships in academic honorary societies; or participation in or offices held in extracurricular activities you consider significant. (You may exclude all information of age, sex, race, religion, color, national origin and handicap.)

_____

_____

EMPLOYMENT HISTORY

Please list your employment history for the past 15 years or your last four employers. Start with your current employer. Include U.S. Military Service.

Name of Employer:_____ Area Code & Telephone No. :_____

Address:_____ City/State:_____ Zip:_____

Job Title:_____ Name of Supervisor:_____

Dates of Employment: From_____ To_____ Salary: Starting_____ Ending_____

Duties Performed:_____

Reason for Leaving:_____

May we contact this employer? ____Yes ____No If no, please explain why_____

Name of Employer:_____ Area Code & Telephone No.:_____

Address:_____ City/State:_____ Zip:_____

Job Title:_____ Name of Supervisor:_____

Dates of Employment: From_____ To_____ Salary: Starting_____ Ending_____

Duties Performed:_____

Reason for Leaving:_____

May we contact this employer? ____Yes ____No If no, please explain why_____

Name of Employer:_____ Area Code & Telephone No.:_____

Address:_____ City/State:_____ Zip:_____

Job Title:_____ Name of Supervisor:_____

Dates of Employment: From_____ To_____ Salary: Starting_____ Ending_____

Duties Performed:_____

Reason for Leaving:_____

May we contact this employer? ____ Yes ____ No If no, please explain why_____

Name of Employer:_____ Area Code & Telephone No.:_____

Address:_____ City/State:_____ Zip:_____

Job Title:_____ Name of Supervisor:_____

Dates of Employment: From_____ To_____ Salary: Starting_____ Ending_____

Duties Performed:_____

Reason for Leaving:_____

May we contact this employer? ____ Yes ____ No If no, please explain why_____

Please explain all periods of unemployment:

_____

_____

LICENSED/CERTIFIED APPLICANTS ONLY

	State & License No.	Expires (Date)		State & License No.	Expires (Date)
Registered Nurse			Licensed Social Worker		
LVN / LPN			Speech/Language Pathologist		
Certified Nursing Assistant			Licensed Professional Counselor		
Respiratory Therapist			Recreational Therapist		
Physical Therapist			CPR (BCLS)		
Occupational Therapist			Other (specify)		
Have any disciplinary actions been taken against your license/licenses? If so, explain					

Please indicate any other information you think would be helpful to us in considering you for employment, such as additional work experience, activities, accomplishments, voluntary work experience, and any other languages spoken.

_____

Please list any other professional memberships, organizations or certifications you hold.

_____

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes _____ No_____
If yes, please list
restcrictions:_____ Were the
restrictions : Permanent_____ Temporary_____ Are you currently restricted Yes _____ No _____
What is the medical condition for which you are restricted?
_____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes____ No____
Please list the medical condition being
treated:_____

Doctors Name:_____
Specialty:_____

Doctors
address:_____
3. Have you ever had a job accident? Yes_____ No_____
If you answered yes, please provide the date for each injury and nature of the
injury:_____
_____
How long were you on compensation?_____ Name of employer:_____

4. Has a doctor recommended a surgical procedure, which has not been completed prior to the date, including but not limited to knee, hip or shoulder replacement? Yes_____ No_____
If answered yes, please provide:

Recommended surgery:_____

Approximate date of recommendation:_____

Doctors name:_____
Specialty:_____

Doctors
address:_____

REFERENCES

List at least three references other than relatives or friends.

Name	Address & Phone No.	Occupation	Years Known
1.			
2.			
3.			

READ CAREFULLY BEFORE SIGNING THE APPLICATION FOR EMPLOYMENT:

If employed by DQMH and in consideration thereof, I understand and agree to:

1. I certify that the answers given by me to the forgoing questions and statements on the employment application and or during the employment interview process are true and correct without any consequential omissions of any kind whatsoever. I understand that any misleading or incorrect statements may render this application void and, if employed, would be case for my termination. I further agree that DQMH shall not be liable in any respect if my employment is terminated because of falsity of statements, answers or omissions made by me in this application.
2. I authorize the companies schools, persons or entities given during the employment process or on this employment application as references or past employers or affiliations to give any information regarding my employment, character, qualifications, certifications and licenses and hereby release said companies, schools, persons or entities from all liability for any damage for issuing this information.
3. I understand that I may be required to have a medical examination and/or drug and alcohol test after an offer of employment has been made and prior to the commencement of my employment duties. A favorable result on the medical examination and/or drug and alcohol test would be a condition of my employment or commencement of any employment duties.
4. I understand that my employment is not for a specified or definite term and that I may resign, or I may be discharged, at any time with or without prior notice. I further understand that this policy cannot be changed or amended except by written agreement signed by me and by a corporate officer.
5. My employment shall be in accordance with the terms of this application, all safety and incident reporting rules, all health care industry compliance program requirements and all other DQMH rules, regulations, policies and procedures currently or hereafter in effect.
6. I understand each requirement and certify that I am capable of meeting each and every requirement. I also understand if the position for which I am applying requires licenses and/or certifications; **it is my responsibility and a requirement for continued employment to maintain valid licenses and/or certifications.**

_____ _____

Signature of Applicant Date

Mailing Address:
DeQuincy Memorial Hospital
Attn: Human Resources
P.O. Box 1166
110 West 4th St
DeQuincy, LA 70633,

Phone: 337-786-1200
Fax: 337-786-1219
Website: www.dequincymemorial.com