



# APPLICATION FOR EMPLOYMENT

MILFORD HOSPITAL

We consider applicants for all positions without unlawful discrimination on the basis of protected status including Race, color, religion, sex, national origin, age, marital status, Vietnam Era or disabled veteran status, or disability.

Application must be completed in its entirety  
(PLEASE PRINT)

POSITION(S) APPLIED FOR:

1. \_\_\_\_\_ 2. \_\_\_\_\_

REFERRAL SOURCE: How did you learn about us? (Check one)

- Advertisement – Name of Publication \_\_\_\_\_
- Employment Agency – Name of Agency \_\_\_\_\_
- Employee – Name of Employee \_\_\_\_\_
- Walk-in
- Internet
- Other – Specify \_\_\_\_\_

PERSONAL DATA:

NAME:

\_\_\_\_\_  
LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

ADDRESS:

\_\_\_\_\_  
NUMBER AND STREET TELEPHONE NUMBER (HOME)

\_\_\_\_\_  
CITY, STATE, ZIP DAYTIME NUMBER

If previously employed under a different name, state name: \_\_\_\_\_

Wages expected \_\_\_\_\_

On what date would you be available for work? \_\_\_\_\_

Are you available to work:

Shift Requested:

- Full Time  Part Time  Per Diem  Temporary
- Day  Evening  Night

Are you:

- Yes  No If you are under 18 years of age, can you provide required proof of your eligibility to work?
- Yes  No A U.S. citizen or authorized to work in this country.  
(Proof of citizenship or immigration status will be required upon employment)
- Yes  No A previous applicant?
- Yes  No A previous employee?
- Yes  No On layoff status and subject to recall?

**WORK EXPERIENCE:**

(Please provide the following information. A resume providing this information may be attached only as a supplement)

Note: Start with present or last job. Furnish dates and explanation for each period of unemployment of one month or more.

Employer (Present or Last)		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate / Salary		
		Starting	Final	
Job Title	Supervisor			
Reason for Leaving				

Employer (Present or Last)		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate / Salary		
		Starting	Final	
Job Title	Supervisor			
Reason for Leaving				

Employer (Present or Last)		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate / Salary		
		Starting	Final	
Job Title	Supervisor			
Reason for Leaving				

Employer (Present or Last)		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate / Salary		
		Starting	Final	
Job Title	Supervisor			
Reason for Leaving				

May we contact your present employer?  Yes  No

**EDUCATION AND TRAINING** (Please complete all appropriate items)

SCHOOL NAME AND LOCATION	GRADUATION DATE	DEGREE EARNED	MAJOR AND MINOR FIELDS OF STUDY	SPECIAL AWARDS

**ADDITIONAL QUALIFICATIONS**

What knowledge, special technical or computer skills, and/or capabilities do you have which especially prepare you for the position you have applied for? (Ex: Medical Terminology Course)

\_\_\_\_\_

\_\_\_\_\_

Foreign Language(s): \_\_\_\_\_

Fluency:  Speak  Read  Write

Military:

Branch of Service \_\_\_\_\_ Rank at Discharge \_\_\_\_\_ Dates of Service \_\_\_\_\_

Duties including schools/training:

\_\_\_\_\_

\_\_\_\_\_

List Professional, Trade, Business or Civic Activities and Offices held. Exclude organizations which indicate race, color, religion, gender, national origin, disability or other protected status.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Award(s) Held? \_\_\_\_\_

Current PROFESSIONAL License or Registration Number: \_\_\_\_\_ State: \_\_\_\_\_

If applying for a position as an RN, GN, LPN, GPN, SNI or CNA, please circle those that apply:

- |                      |                              |
|----------------------|------------------------------|
| CPR CERTIFIED        | PACU QUALIFIED (OB/PACU)     |
| HEART SAVER / BLS    | NURSERY QUALIFIED            |
| IV TRAINED           | PEDI QUALIFIED               |
| ACLS CERTIFIED       | FETAL MONITORING COURSE      |
| CRITICAL CARE COURSE | SCRUB QUALIFIED (OR/OB)      |
| TELEMETRY COURSE     | CIRCULATOR QUALIFIED (OR/OB) |
| ARRHYTHMIA COURSE    | C E N                        |
| E.D. COURSE          | C C R N                      |
| DEL ROOM QUALIFIED   | N A A C O G                  |

**PROFESSIONAL REFERENCES**

Please provide complete information for 3 work related references.

Name	Address	Telephone	Relationship
1.		(H) _____ (W) _____	
2.		(H) _____ (W) _____	
3.		(H) _____ (W) _____	

**APPLICANT'S STATEMENT**

I understand that federal law prohibits the employment of unauthorized aliens; all persons hired must submit satisfactory proof of employment authorization and identity; failure to submit such proof will result in denial of employment.

I understand that any offer of employment that may be made by the Milford Hospital, Inc. is conditioned on the results of a post-offer physical examination and drug screening through urinalysis. The medical provider(s) of said examination will be designated by The Milford Hospital, Inc. and will be at the company's expense.

I understand that neither this application nor any handbook or personnel policies manual I receive from The Milford Hospital, Inc. is intended to create a contract for employment for any particular duration or with any particular terms and conditions.

I understand that employment with The Milford Hospital, Inc. is at will and may be terminated at any time by the employer or the employee for any reason not prohibited by law unless different terms and conditions are set forth in a writing signed by the Human Resources Director and the President of The Milford Hospital, Inc.

I hereby agree not to share my assigned User ID/Password with anyone else. Any use or discussion of information on the Hospital Computer Systems or its product must be approved by Department Managers. I will follow any rules set by the M.I.S. Department pertaining to the Information Systems.

I certify that all statements herein are true and I understand that any falsification or willful omission of information in the employment process may result in dismissal or refusal of employment.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(List Employers and Educational Institutions that Milford Hospital may contact.)

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the release of any information in your files concerning my enrollment or employment in your organization to representatives of The Milford Hospital, Inc. and I release any organization or individual providing such information to The Milford Hospital, Inc. representatives from any and all liability for damage resulting therefrom.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE READ CAREFULLY**

**APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION**

Milford Hospital truly welcomes your application. We are proud that our success is the result of the quality and caliber of our employees. You are applying for a position which if accepted will place you in a category of recognized professionals in pursuit of that excellence. We require as a condition of employment and/or continued employment that all applicants consent to and authorize a pre-employment verification of the background information submitted on their application or resumes.

This release and authorization acknowledges that Milford Hospital or a company contracted by Milford Hospital may conduct a background check in to your suitability for employment. This background check may include; a verification of your education, previous employment, work history, military service, credit history, contact of personal or business references, motor vehicle records, any criminal history record information pertaining to you which may be in the files of Federal, State, or Local Criminal Justice Agencies in any State and/or other information as deemed necessary to fulfill the job requirements.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, credit reporting agencies, military agencies to release any information that is requested, and I hereby release all of the persons and agencies providing such information from any and all claims and damages connected with their release of any requested information. I also do hereby agree to forever release and discharge Milford Hospital, their agent Employers Reference Source and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, of any other charge or complaint filed with any agency arising from the retrieving and reporting of information.

According to the Federal Fair Credit Reporting Act, I am entitled to know if employment is denied based on information obtained from Employers Reference Source and to receive upon written request a copy of the consumer report.

**I agree that a copy of this document is as valid as the original.**

**APPLICANT:**

\_\_\_\_\_  
Name Typed or Printed

S.S.#: \_\_\_\_\_

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\*Date of Birth \_\_\_\_\_

Drivers Lic. # \_\_\_\_\_

State Issued \_\_\_\_\_

Have you used any other last name?  Yes  No

High School \_\_\_\_\_

\_\_\_\_\_  
Year Graduated

If yes, what name did you use? \_\_\_\_\_

College \_\_\_\_\_

\_\_\_\_\_  
Year Graduated

Major \_\_\_\_\_

\*Date of birth is being requested only for purposes of identification in obtained accurate retrieval of records, it will not be used for discriminatory purposes.



# APPLICANT CONSENT FOR DRUG TESTING

MILFORD HOSPITAL

**Should an offer of employment be made to me, I understand that it will be a conditional offer. One of those conditions is successful completion of a urinalysis drug test, with a negative test result for illegal drugs or other unauthorized controlled substances. I hereby consent for Milford Hospital, or it's designated agent, to collect a urine sample from me and conduct the necessary tests to determine the presence of illegal drugs or other unauthorized controlled substances.**

I also consent to the release of the test result to the Milford Hospital authorized Medical Review Officer for appropriate review.

It has been recommended to me by an authorized Milford Hospital Human Resources Department representative not to resign any current position until acceptable test results are confirmed.

If employed, I agree to obey Milford Hospital's Rules and Regulations for Safety and General Conduct.

I understand that a positive test result for illegal drugs or other unauthorized controlled substances will render me ineligible for employment at Milford Hospital at this time. Further, I understand that, if I refuse to consent, I will not be eligible for employment at Milford Hospital at this time.

Agreed:

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Human Resources Rep., Signature

\_\_\_\_\_  
Date

Refused:

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Human Resources Rep., Signature

\_\_\_\_\_  
Date