

PERSONAL DATA

Name (last, first, mi)	Social Security Number		
Address	City	State	Zip
Home Phone Number () - () - ()	Alternate Phone Number () - () - ()		
E-mail Address			

Have you ever been employed by Jefferson Memorial Hospital, Jefferson Oaks, Crystal Oaks Skilled Nursing, Residential Care or Wee Care Learning Center? Yes No

If yes, indicate last name used: _____

Are you 16 years of age or older? Yes No

Are you 18 years of age or older? Yes No

Are you employed? Yes No

May we contact your current employer? Yes No

If no, explain why: _____

May we contact you at your current employer to schedule an interview? Yes No

If yes, please provide work phone number: _____

Have you ever pled guilty or been convicted of a felony in the the last 7 years? Yes No

How did you hear about Jefferson Memorial Hospital?

JMH Website Job Board Radio

Other Website Walk-In Newspaper

Job Fair

Employee Referral: _____

Employment Availability

Full-Time Days Weekends

Part-Time Evenings Summer

PRN Nights

Rotation

Job Preference

List job titles in order of preference:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

On what date would you be available to work? _____

What is your desired starting salary? \$ _____ per _____ Negotiable

EDUCATION RECORD

LEVEL	Name / Address of Facility	Course of Study	# of years Completed	Specify Degree Earned
Elementary				
High School				Diploma / GED <input type="checkbox"/> Yes <input type="checkbox"/> No
Undergraduate				<input type="checkbox"/> Associates <input type="checkbox"/> Bachelors
Graduate School				
Post Graduate				
Other (specify)				

EMPLOYMENT HISTORY

(List most recent employment first)

Employer		<u>Dates Employed</u>	Job Title
		FROM TO	
Address			Work Performed
City	State	Zip	
		<u>Hourly Rate/Salary</u>	
		START FINAL	
Phone Number ()	Supervisor's Name		
Reason for Leaving			Indicate last name used if different from current:

Employer		<u>Dates Employed</u>	Job Title
		FROM TO	
Address			Work Performed
City	State	Zip	
		<u>Hourly Rate/Salary</u>	
		START FINAL	
Phone Number ()	Supervisor's Name		
Reason for Leaving			Indicate last name used if different from current:

Employer		<u>Dates Employed</u>	Job Title
		FROM TO	
Address			Work Performed
City	State	Zip	
		<u>Hourly Rate/Salary</u>	
		START FINAL	
Phone Number ()	Supervisor's Name		
Reason for Leaving			Indicate last name used if different from current:

ADDITIONAL INFORMATION

<u>Specialized Skills:</u> <input type="checkbox"/> Data Entry <input type="checkbox"/> Fax <input type="checkbox"/> PC <input type="checkbox"/> Spreadsheet <input type="checkbox"/> Calculator <input type="checkbox"/> PBX System <input type="checkbox"/> Typewriter <input type="checkbox"/> Word Processing	<u>Other Qualifications / Skills:</u> _____ _____ <u>Machinery:</u> _____
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Account for periods of unemployment other than when you were in school: _____

Professional Licensure/Registration: Type: _____ State: _____ Year Received: _____
 License Number: _____
 Is your license in good standing? Yes No



Jefferson Memorial Hospital

RELEASE AUTHORIZATION

I hereby authorize Jefferson Memorial Hospital to contact the employers listed on this application/resume (without liability) in order to obtain information relating to myself and all information relating to my employment, the nature and character of the services rendered by me, the duration of such services, and the cause for my leaving said employment. I further release said person, firm, corporation, or institution furnishing such information from any and all liability in connection with the release of such information.

Signature

Date

I hereby certify that all statements made in this application are correct. I understand that false or misleading information given in my application may cancel any employment between myself and Jefferson Memorial Hospital immediately. I further understand that occasional and permanent reassignments of my work may include, but are not limited to department, shift assignment, and hours of work in order to meet the needs of Jefferson Memorial Hospital.

If I am employed by Jefferson Memorial Hospital, I will conform to the rules and regulations of Jefferson Memorial Hospital and understand that my employment can be terminated, at any time, with or without cause, and with or without notice, by either myself or the Company. I understand that no manager or representative of Jefferson Memorial Hospital other than the Chief Executive Officer has authority to enter into any agreement contrary to the foregoing or for employment for any specified period of time.

My signature verifies that I have executed this employment application as my free and voluntary act in connection with my application for employment at Jefferson Memorial Hospital.

Signature

Date

JEFFERSON MEMORIAL HOSPITAL
P.O. Box 350
Crystal City, MO 63019-0350

It is the policy of Jefferson Memorial Hospital to forbid acts of discrimination in all matters dealing with employees and applicants without regard to race, color, religion, sex, national origin, age, disability, or veteran status, or any other legally protected status.

Human Resources Department
636-933-1148
www.jeffersonmemorial.org

AGREEMENT, AUTHORIZATION, AND CONSENT FOR RELEASE OF BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I, _____
LAST NAME FIRST NAME MIDDLE NAME (PLEASE INCLUDE Jr., Sr., II, III etc.)

understand that in conjunction with my application for employment, work to be performed under contract, promotion, reassignment, and/or retention, **Jefferson Memorial Hospital** will use the services of an outside agency to research and verify the information I have provided on my application for employment including my personal background, character, professional standing, work history and qualifications. This agency will provide a written report of its findings to **Jefferson Memorial Hospital**. **Jefferson Memorial Hospital** uses **Abso**, a consumer-reporting agency, as an agent to perform its employment related background investigations.

Abso will utilize various sources of information it deems appropriate including but not limited to: credit reporting agencies, workers compensation records including any and all injuries in compliance with the Federal ADA Act, department of motor vehicle records, criminal conviction records, current and former employers, military records, education records, professional and personal references. I agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to **Jefferson Memorial Hospital**, and **Abso**.

I agree, authorize and consent to the procurement of a Consumer Report and/or an Investigative Consumer Report and understand that it may contain information about my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. This authorization in original or copy form shall be valid for my term of employment from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by **Jefferson Memorial Hospital** if employment is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to **Jefferson Memorial Hospital**. I further understand that I may request a copy of the report, and that when doing so, proper identification will be required and I should direct my request to: **Abso**, 3000 Lava Ridge Ct., Roseville CA 95661. I understand that residents of all states will automatically receive a copy of the report if an adverse action is taken regarding the employment application, or upon request as outlined herein.

CHECK THIS BOX IF you are applying for work with a California, Minnesota or Oklahoma based employer and you would like a copy of your Consumer Report if one is prepared in the investigation of your background. *CA Codes: 1785.20.5 & 1786.16(a)(5)(b)(1), MN Code 13C Subdivision 2, OK Code 24 O.S. §148.*

LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES FOR POSITIVE IDENTIFICATION PURPOSES REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES.

SIGNED	TODAY'S DATE
PRINTED NAME	POSITION APPLIED FOR
SOCIAL SECURITY NUMBER	DATE OF BIRTH
DRIVER'S LICENSE NUMBER	STATE
OTHER NAMES YOU HAVE USED OR ARE ALSO KNOWN AS	LIST ALL OTHER STATES YOU HAVE LIVED IN DURING THE PAST 7 YEARS

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSEES FOR THE PAST 7 YEARS

M/Y - M/Y

Current:	STREET	CITY	STATE	ZIP	FROM -TO
Previous:	STREET	CITY	STATE	ZIP	FROM -TO
Previous:	STREET	CITY	STATE	ZIP	FROM -TO
Previous:	STREET	CITY	STATE	ZIP	FROM -TO



AUTHORIZATION FOR ELECTRONIC TRANSFER

I hereby authorize Jefferson Memorial Hospital to transfer my application to an electronic format. I understand that this information will not be shared with any individual outside of Jefferson Memorial Hospital.

Signature

Date

Printed Name