APPLICATION FOR EMPLOYMENT

Application Expires in 30 days

900 N. Robert Ave
Arcadia, Fl. 34266

Are you Younger than 17 years of age? Yes No

PERSONAL		
	Last Name First Middle Initial	Application Date:
	Present Address City State Zip Code	Primary Phone Number: ( )
	Previous Address (if less than 7 years at present address)	Emergency Contact Name/Relationship: ( )
	Have you ever been convicted of a felony or have a felony case pending? Yes No Nature: ***(A yes answer will not automatically disqualify you from being considered as a candidate for employment)***	Date: Place:
	Are you bilingual? Yes No Can you communicate by sign language? Yes No	Languages you can speak:
	How many days of work have you missed in the last year?	Pay Expected:
	Do you have adequate transportation to assure arrival for appropriate shift? Yes No	Date available for work:
	Do you have relatives currently employed at DeSoto Memorial Hospital? ***(If so, please indicate relative's name, position, and relationship to you):***	Have you ever worked for DeSoto Memorial Hospital? Yes No If so, when?
	Have you ever previously applied for work with DeSoto Memorial Hospital? Yes No	If so, when?

WORK PREFERENCE AND AVAILABILITY

STATUS:	**SHIFT:**	**AVAILABLE IF REQUIRED:**
Full Time	Day	Weekends
Part Time (under 40 hrs/pay period)	Evening	Over 8 hours/day
Temporary	Night	Over 5 days/week
	Rotation	To work beyond scheduled hours

An affirmation indication of unavailability does not insulate you from being requested to work additional hours or shifts upon reasonable notice.

POSITIONS APPLIED FOR:

1.______________________________ 2.______________________________ 3. ______________________________

How did you learn about this position?

Ad in newspaper _______ DMH Employee _______ Friend ________ Drop in _______

Online (Please Name; Monster, CareerBuilder etc.)____

Please list specific skills/experience which qualify you for employment in the position(s) for which you have applied:

____

____

PROFESSIONAL QUALIFICATIONS (to be completed by applicants requiring State License or Certification)		
LICENSURE OR CERTIFICATION	EXPIRATION DATE	REGISTRATION NUMBER
______________________________	______________________________	______________________________

Community, Civic or school activities which you consider relevant to your ability to perform the position applied for (omit reference to any religious or racial group)

____
____
____

Have you ever been terminated involuntarily from your employment with a prior employer? Yes No
(An affirmation response to this question will not preclude employment)

If your answer is "yes", please explain the details of each involuntary employment termination: ______________________
____
____

PERSONAL REFERENCES (Excluding former employers and relatives)

NAME AND OCCUPATION	ADDRESS	PHONE NUMBER
1.		
2.		
3.		

EDUCATION	School	Name and Location	Course of Study	No. of Years Completed	Did you Graduate?	Degree of Diploma
	Graduate				Yes No	
	College				Yes No	
	Business/Trade/ Technical				Yes No	
	High School				Yes No	
	Hospital Training				Yes No	

We Are an Equal Opportunity Employer

NURSING APPLICANTS ONLY

Please list the number of years experience in each area:
Medical/Surgical___ years Pediatric___ years Operating Room____ years Labor & Delivery____ years Emergency ____________________years Orthopedic___ years Telemetry___________years Recovery Room________years Critical Care__________years Psychiatry____ years Nursery_____________years Neo-Natal____________years Oncology___________years
Other:

____

ALL APPLICANTS

EMPLOYMENT (Please give accurate, complete full-time and part-time employment record. Start with your present or most recent employer)

1	Company Name	Telephone ( )
	Address	Employed (state month and year From To
	Name of Supervisor	Rate of Pay $
	State Job Title and Describe your work duties:	Reason for Leaving:
2	Company Name	Telephone ( )
	Address	Employed (state month and year From To
	Name of Supervisor	Rate of Pay $
	State Job Title and Describe your work duties:	Reason for Leaving:
3	Company Name	Telephone ( )
	Address	Employed (state month and year From To
	Name of Supervisor	Rate of Pay $
	State Job Title and Describe your work duties:	Reason for Leaving:

Name under which you were employed by previous employers if different from that on Page 1 of this application:

____

Occasionally the form of an application makes it difficult for an individual to adequately summarize his/her complete qualifications. Use the space below to summarize any information necessary to describe your full qualifications or any other information you wish us to consider in determining whether to offer you employment at DeSoto Memorial Hospital. ____

____

It is our policy to employ only U.S. Citizens and aliens authorized to work in the U.S. If hired, can you provide proof of eligibility to work in the U.S.? Yes or No

EQUAL EMPLOYMENT OPPORTUNITY

DeSoto Memorial Hospital is an Equal Opportunity Employer. As such, we provide equal employment opportunities in all employment-related matters regardless of race, religion, age, sex, national origin, disability, marital status or veterans' status in accordance with all applicable State and Federal statutes, Executive orders and regulations which prohibit discriminatory employment practices.

____
Applicant initials

POSITION AND SCHEDULE

I acknowledge that if employed, I may in the future be expected to work in a job classification or schedule different from that initially offered by DeSoto Memorial Hospital. Any such change would be in the interest of the Hospital and its patients and would be imposed only after reasonable notice.

____
Applicant initials

EMPLOYMENT AGREEMENT

I understand employment is contingent upon an acceptable physical (including drug screening) and background check including but not limited to: credit check, driving record, criminal record, education and previous employment.

____
Applicant initials

I understand that, if hired, I will be placed on a 90-day probationary period. I further understand that in accordance with Florida Statute Section 443.131(3)(a)(2), if I am terminated for unsatisfactory work performance within the 90-day probation period, the employer's unemployment account shall not be charged for any unemployment benefits paid to me.

____
Applicant initials

I understand and agree that all policies and procedures of DeSoto Memorial Hospital may be modified, amended or deleted by the employer with or without notice to me of such amendment, medication or deletions; that the policies and procedures whether oral or written are to be advisory only, and are not to be interpreted as a contract of employment or to give me any right of continued employment, and that my employment may be terminated at the will of either myself or the Company with or without cause and with or without notice by either party. I also understand any other arrangements, agreements, or understandings regarding the term of employment are hereby canceled and superseded, and that no amendment or exception to this statement is valid unless in writing and signed by a corporate officer of DeSoto Memorial Hospital.

____
Applicant initials

I agree to comply with all rules and regulations; including but not limited to those of DeSoto Memorial Hospital, State, Federal and any other regulatory and accrediting agencies.

____
Applicant initials

I hereby certify that as a condition of prospective employment, all information stated in this application is true and correct. I further acknowledge that any false or inaccurate information stated in this application shall constitute grounds for immediate termination or disqualification from employment with DeSoto Memorial Hospital.

____
Applicant initials

Signature of Applicant: ____ Date: ____________________

FOR INTERNAL USE ONLY

Start Date: ______________ Department: ________________ Position Title: _____________________

Non-Exempt: ☐ Yes ☐ No Exempt: ☐ Yes ☐ No Hours: From________am/pm To__________am/pm

Salary Grade_____Step___________years credit given for previous experience Base Rate $________(Rate waiving benefits $______)

Shift Differential ☐ Yes ☐ No Call Pay ☐ Yes ☐ No Clinical Modality $_____#hrs/pay period ______

☐ Full Time ☐ Part Time eligible ☐ Temp. ☐ Per Diem/Pool ☐ Part time not eligible ☐ Other _____________

Remarks: ____

Department Director/Date____________________________ CNO-CFO/Date _________________________

Human Resources Director/Date _______________________ CEO/Date ____________________________

NOTICE TO APPLICANTS

GENERAL INFORMATION

We are an equal opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, age, disability, handicap, marital status or any other basis protected by law. The opportunity for employment will be based solely upon your qualifications and ability to perform the job for which you are being considered. We also reasonably accommodate individuals with disabilities, handicaps, and bona fide religious beliefs.

We comply with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability to perform job-related functions. You may also be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. Upon request, all entering employees in the same job category will be required to complete the same medical questionnaire and/or examination. All medical information will be kept in confidential files.

We also maintain a Drug-Free Workplace in accordance with the Rules of the State of Florida, Agency for Health Care Administration, Chapter 59A-24, Florida Administrative Code, Drug-Free Workplace Standards, and the Florida Drug-Free Workplace Act, 440.101-102 Florida Statutes, a copy of which is maintained by the employer for review by employees upon request.

PLEASE READ AND INITIAL STATEMENTS BELOW

I understand that in accordance with Florida Statute s443.131 (3) (a) (2), if hired, I will be placed in a 90-day probationary status. I further understand that if I am terminated for unsatisfactory work performance within this 90 day probationary period, the employer may seek to deny any unemployment benefits I might attempt to obtain as a result of my termination.

______(Initials)

I understand, under Rules of the State of Florida for Drug-Free Workplaces, as a condition of my employment, I must take and pass a pre-employment urine and/or blood test at authorized threshold levels for any or all of the drugs or alcohol listed by the employer's Drug-Free Workplace Policy statement, copies of which have been provided to me and a copy, executed by me, returned to the employer.

______(Initials)

I further understand, subject to confidentiality constraints and rights of appeal granted by State and Federal law, if the results of my pre employment drug and/or alcohol tests are POSITIVE (indicating substance abuse) and are received by the employed prior to or within the 90-day probationary employment period, notwithstanding any other disciplinary provisions contained in the employer's Drug-Free Workplace Policy statement, I will be terminated for causes under the provisions of the Florida Drug-Free Workplace Act, 440.102 (7) (b) and the employer may seek to deny any unemployment benefits I might attempt to obtain as a result of my termination.

______(Initials)

I understand and agree that all policies, procedures, whether written, published or orally communicated by the employer may be modified, amended, or deleted by the employer with or without notice to me of such change(s); that the employer's policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment; and if hired, my employment may be terminated at my option or at the option of my employer with or without prior notice to either party. I also agree there are no other written or oral arrangements, agreements, or understandings regarding the terms of my employment and that any amendments or exceptions to this statement must be in writing and signed by a person(s) duly authorized by the employed.

_______(Initials)

See Reverse Side to Complete

I certify that all information given to the employer by me in the form of an employment application, resume', or related papers, or answers given by me during oral interviews, are true and correct. I understand the employer will make a thorough investigation of my past work and personal history. I authorize the giving and receiving of any such information requested by the employer in the course of such investigation and hereby release from liability all persons who provide such information to the employer. I understand that falsification or any derogatory information discovered as a result of investigation may subject me to immediate dismissal for cause and the employer may seek to deny any unemployment benefits I might attempt to obtain as a result of my termination.

_______**(Initials)**

Applicant Signature ____

Applicant Print Name____ **Date**_________________________________

BACKGROUND CHECK RELEASE
(PLEASE READ CAREFULLY AND SIGN BELOW)

I certify the answers given by me on my application and any statements are true and complete to the best of my knowledge. I understand that any false or misleading information in the employment interview, the application, or other required documents may result in rejection of my application or discharge whenever discovered.

I hereby give the Hospital and/or its agents the right to thoroughly investigate my background including, but not limited to, credit, driving record, criminal record, education, and previous employment. I authorize all persons, schools, companies, information service bureaus, governmental agencies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information.

I authorize the Hospital to release to other employers, information service bureaus, and governmental agencies any information regarding me and/or my employment. If required, I agree to complete a medical history form and submit myself upon request for a physical examination by a physician or employee health nurse designated by the Hospital and to future medical examination the Hospital may require as a condition of employment. If required, I am willing to submit to drug testing prior to and during employment.

If employed, I agree to acquaint myself with and abide by all federal, state and local laws, rules and regulations, and policies established or amended by the Hospital. I understand that if employed, my employment and compensation is for an indefinite period of time and can be terminated, with or without prior notice by the hospital or me. I further acknowledge that a telephone facsimile (FAX) or photographic copy shall be as valid as the original.

______________________________ ______________________

Applicant Signature **Date**

____

Applicant Print Name

The Equal Employment Opportunity Commission (EEOC) requires organizations with 100 or more employees to invite applicants to self-identify gender and race and complete an EEO-1 report each year. Completion of this data is voluntary and will not affect your opportunity for employment, or terms or conditions of employment. This form will be used for EEO-1 reporting purposes only and will be kept separate from all other personnel records only accessed by the Human Resources department. Please return completed forms to the HR department.

NAME: ________________________________

JOB TITLE: ______________________________

GENDER:

(Please check one of the options) ______Male ______Female

RACE/ETHNICITY: (Please check one of the descriptions below corresponding to the ethnic group with which you identify.)

____Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

____White (Not Hispanic or Latino): A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

____Black or African American (Not Hispanic or Latino): A person having origins in any of the black racial groups of Africa.

____Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.

____Asian (Not Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

____American Indian or Alaska Native (Not Hispanic or Latino): A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

____Two or more races (Not Hispanic or Latino): All persons who identify with more than one of the above five races.