Bucktail MEDICAL CENTER

APPLICATION FOR EMPLOYMENT

Date:

(Last Name) (First Name) (Middle Initial)

(Address) (City) (State) (Zip)

(Phone Number) (Email Address) (Social Security Number)

In the past 2 years have you lived out of state? Select Answer

POSITION(S) DESIRED:

Physicians/Advanced Care: Advanced Care Careers

Nursing: Nursing Careers

Allied Health: Allied Health Careers

Support Services: Support Services Careers

Administrative/Clerical: Clerical Careers

Other Not Listed:

How did you hear about the position you are applying for? Select Answer

Have you ever applied for employment with Bucktail Medical Center in the past? Select Answer

Were you previously employed by Bucktail Medical Center? Select Answer

If YES, please specify dates and position.

Do you have any relatives employed at Bucktail Medical Center? Select Answer

If YES, please list names and relationships.

Are you 18 years old or older? Select Answer

Are you legally eligible for employment in the United States? Select Answer

*If you need employer sponsorship to work in the United States, you must answer "NO" to this question.

Have you been released, discharged, or laid off from past employment? Select Answer

If YES, please explain.

EDUCATION

List your educational experiences below, starting with your highest degree received.
Please make sure the information presented here matches your resume.

Institution	Location (City, State)	Program/Degree	Graduation Date

PROFESSIONAL REGISTRATIONS, LICENSES, CERTIFICATIONS

Start by entering your most relevant licenses and certifications and continue adding certifications until you have entered all that you feel are important to disclose for this job. Do not list expired licenses or certifications.

License/Certification	Number	Enrollment Date	Expiration Date
Select CPR Type			

Have you ever been convicted, plead guilty, or *no contendere* (no contest) to a felony or misdemeanor crime? Select Answer

If YES, please describe type and date of conviction:

Conviction will not necessarily disqualify an applicant from employment. However, there are specific criminal convictions that prohibit employment under the Pennsylvania Older Adults Protective Services Act and others may relate to your suitability for employment in the position for which you have applied.

Are you currently, or have you ever been, listed on a registry generated by any Local, State, or Federal governmental agency for the purpose of listing individuals that are prohibited from employment with a healthcare provider? Select Answer

If YES, please state the offense and provide a complete detailed description; including date, state, and county of the offense:

(Note: Conviction of a criminal offense will not necessarily preclude your employment)

QUALIFICATIONS/WORK HISTORY

List your work experiences below, starting with your most recent employer. Please make sure the information presented here matches your resume. Attach a separate sheet if needed.

Company Name:	**Job Title:**
City/State:	**Responsibilities:**
Phone Number:	
Dates Employed From: To:	**Reason for Leaving:**
Company Name:	**Job Title:**
City/State:	**Responsibilities:**
Phone Number:	
Dates Employed From: To:	**Reason for Leaving:**
Company Name:	**Job Title:**
City/State:	**Responsibilities:**
Phone Number:	
Dates Employed From: To:	**Reason for Leaving:**

REFERENCES

List three (3) people who are not related to you and who have knowledge of your qualifications for the position for which you are applying.

Name	Phone Number	Company	Occupation
Name	Phone Number	Company	Occupation
Name	Phone Number	Company	Occupation

In case of emergency notification:

Name	Relationship	Phone Number

Voluntary Self-Identification & Disability

Qualified applicants are considered for and treated during employment without regard to race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender expression, gender identity, or marital, familial, or disability status or status as a protected Veteran or any other legally protected group status. Solely to help us comply with federal, state, and local Equal Employment Opportunity record keeping, and other legal requirements, we invite you to complete the following information.

Please note that completion of this information is voluntary. Refusal to complete this information will not subject you to adverse treatment. The information you provide is confidential and will be kept separate from your other applicant information. As mentioned above, this information will be used for data reporting requirements and will not be considered in making any employment decisions.

If you choose to complete this Voluntary Self-Identification & Disability section, please select the appropriate response from each Drop-Down Box

Race

Optional Response

Gender

Optional Respone

Veteran

Optional Respone

Do you consider yourself an individual with a disability or have you had one in the past?

Optional Response

Applications are accepted and employees are chosen based on ability and qualifications without regard to race, color, religion, sex, age, national origin, veteran, or disability status in compliance with federal, state, and municipal laws. The receipt of this application does not mean that a job opening exists and does not obligate Bucktail Medical Center in any way.

EXTERNAL ACKNOWLEDGEMENT

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING THIS APPLICATION. ONLY THOSE APPLICATIONS THAT ARE SIGNED AND DATED WILL BE CONSIDERED.

I certify that the information provided in this application is both accurate and complete. I understand that any misrepresentation, falsification and/or omission of facts requested in this application may result in refusal to hire or, if employed, immediate dismissal from employment.

By submitting this application, if employed, I consent to completing an Employment Verification Form (I-9) and within three (3) days show satisfactory evidence of identity and eligibility for employment.

I authorize Bucktail Medical Center to make any inquiries it considers necessary to verify any information provided in my application of employment and/or resume to determine my job-related qualifications and abilities, which may include prior employers, provided references, educational institutions, and/or any other person or organization that is not a consumer-reporting agency. Inquiries may include employment performance, employment disciplinary actions, information concerning my character, work habits, general reputation, or any other inquiry that may determine my ability to perform the essential functions of the position applied for. I release Bucktail Medical Center and all persons, institutions, organizations, or other entities contacted from all liability or claims for any damage that may arise from the verification of the information provided in my employment application/resume, its determination of my job-related qualifications and abilities, or any other liability arising from supplying, receiving, or acting upon such information.

If I am offered employment, I will be required to produce sufficient and genuine documentation of my identity and the right to work in the United States. In addition, I will be subject to Licensure/Certification Verifications, ACT 33 Child Abuse Clearance, ACT 34 Pennsylvania State Police Criminal History Background Clearance, ACT 73 FBI Fingerprinting Criminal History Record Check, and/or any other clearances considered necessary in connection with the position applied for.

I understand that any offer of employment is contingent upon my consent and successful completion of a job-related medical examination (Employment Physical), Drug Testing, Blood Testing, and any other testing that may be required.

I agree to conform to and abide by the rules, policies, and procedures of Bucktail Medical Center, and to work assigned shifts and/or overtime as required.

I have been provided with a copy of the Job Description for the position or positions for which I am applying, and I certify that I am able to perform the essential functions of the position as listed in the Job Description.

I understand that my employment and compensation can be terminated, with or without cause, at any time, at the option of either Bucktail Medical Center or myself, unless termination is otherwise governed by a collective bargaining agreement.

I have read, understand, and agree with the above statements.

Signature of Applicant

Date