

# APPLICATION FOR EMPLOYMENT



Please read carefully - Write Clearly - Answer All Questions

## Macon Community Hospital Complies With:

Federal and State Laws that Prohibit Discrimination  
 In Employment Because of Race, Color, Creed, Age, Sex,  
 Marital Status, National Origin, Physical Handicap, Medical  
 Condition, Sexual Orientation or Genetic Information.

**Macon Community Hospital**  
**204 Medical Drive**  
**Lafayette, Tennessee 37083**  
**(615) 666-2147**

NAME AND LOCATION			
(Last Name)	(First Name)	(Middle Initial)	Application Date:
Current Address (Number and Street)			Telephone Number:
City, State and Zip			
EMPLOYMENT DESIRED			
First Choice:		Second Choice:	
Have You Worked For Us Before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:	Will You Accept Part-Time Work? Yes <input type="checkbox"/> No <input type="checkbox"/>	Will You Accept Temporary Work? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have You Worked For Us Before Under Another Name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name:	Shift or Hours You Can Work First Shift <input type="checkbox"/> Second Shift <input type="checkbox"/> Third Shift <input type="checkbox"/>		
CITIZENSHIP	U.S. MILITARY SERVICE	STATEMENT OF HEALTH	
Are you either a United States Citizen or an Alien who has the legal right to work in the position for which you are applying? Yes <input type="checkbox"/> No <input type="checkbox"/>  Pursuant to the Immigration Reform and Control Act of 1986, All Applicants, upon being made an offer of employment, must produce documents, which are specified by the Federal Government, establishing their identity and authorization for employment in the United States. These documents must be produced no later than seventy-two (72) hours after commencement of employment. You will also be required to sign Form I-9 (which is issued by the Federal Government).	Have You Served in the U.S. Military? Yes <input type="checkbox"/> No <input type="checkbox"/>  Please list job-related Skills or Experience:	Can You Perform the Essential Functions of the Position for Which You Are Applying Safely? Yes <input type="checkbox"/> No <input type="checkbox"/> , if No, explain:  Are You Willing to Take A Required Pre-Employment Drug Screen? Yes <input type="checkbox"/> No <input type="checkbox"/> , if No, explain:  Are You Willing to Take A Required Pre-Employment Physical? Yes <input type="checkbox"/> No <input type="checkbox"/> , if No, explain:	
PERSONAL			
Have you ever been excluded from or sanctioned by the Medicare Program? Yes <input type="checkbox"/> No <input type="checkbox"/> , if Yes, explain:	Have you ever been discharged from a job? Yes <input type="checkbox"/> No <input type="checkbox"/> , if Yes, explain:	All Applicants are required to have a background check completed prior to commencement of employment.  Do you object to a background check? Yes <input type="checkbox"/> No <input type="checkbox"/> , if Yes, explain	
Have you since the age of 18, ever been convicted of a felony? Yes <input type="checkbox"/> No <input type="checkbox"/> , if Yes, explain			
EDUCATION			
Names	Academic Major	Number of Years Attended	Diploma/Degree?
High School:			
College, University, Technical School:			
College, University, Technical School:			
Other Details or Experience or Training which will have a direct bearing on the position for which you are seeking?			

**REFERENCES - Please give the names of persons we may contact to verify your qualifications**

Name:	Telephone Number:
Name:	Telephone Number:
Name:	Telephone Number:

Dates of Employment				<b>Please Give A Complete Record of All Employment and Reasons Unemployed During Past Ten Years</b> <b>Start with Most Recent Employment</b> <b>ALL INFORMATION MUST BE COMPLETED TO BE CONSIDERED FOR EMPLOYMENT</b>
From		To		
Month	Year	Month	Year	

				Employer Name:	Salary:
				Address:	Telephone:
				Position Held:	Supervisor:
				Reason for Leaving:	

				Employer Name:	Salary:
				Address:	Telephone:
				Position Held:	Supervisor:
				Reason for Leaving:	

				Employer Name:	Salary:
				Address:	Telephone:
				Position Held:	Supervisor:
				Reason for Leaving:	

**PROFESSIONAL LICENSES, REGISTRATION AND/OR CERTIFICATIONS**

Type:	Registration Number:
Type:	Registration Number:
Type:	Registration Number:
Type:	Registration Number:

**AFFIDAVIT:** I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever, I agree that my employer shall not be liable in any respect if my employment is terminated because of the falsity of statements, answers or omissions made by me in this application. I authorize employers, companies, schools, or persons named above to give any information regarding my employment, together with any information they may have regarding me whether or not it is in their records. I hereby release said employees, companies, schools or persons from all liability for any damage, both legal and otherwise, for issuing this information. I also understand a conditional offer of employment may be based on the passing of a pre-employment physical, drug screen and the back ground check Macon Community Hospital will perform. I agree to abide by all of the rules and regulations of all federal, state and local governments. In addition, I hereby agree to abide by the rules and policies of Macon Community Hospital.

Further, I understand that any employment is not for a stated period of time and may be terminated with or without cause, at any time, at the option of either myself or my employer.

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

**WE ARE AN EQUAL OPPORTUNITY EMPLOYER - A COPY OF THIS APPLICATION IS AVAILABLE TO YOU UPON REQUEST**