



Northern Inyo Hospital
 150 Pioneer Lane
 Bishop, CA 93514
 Phone: 760-873-2145
 Fax: 760-873-2108
 www.nih.org

Employment Application
 (Non-Licensed Position)

Northern Inyo County Local Hospital District is an equal opportunity employer. The hospital makes all employment decisions without regard to race, color, religion, sex, sexual orientation, pregnancy, national origin, ancestry, citizenship, age, marital status, military status or obligations, physical or mental disability or mental condition. Notice: There will be a background check verifying past employment, education, court records and inquires will be made to provided personal references.

Personal Information: (Please Print or Type)

Last Name		First Name		M I	
Street Address		City		State	Zip
Mailing Address (if Different From Above)		City		State	Zip
Social Security	Home Phone ()	Cell Phone ()	Office Phone ()		
Position Desired	Date Available	Work Availability – check all that apply.			
		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Per Diem (as needed) <input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Nights			

Have you ever been known by any other name? No _____ Yes _____

If yes, please provide each name and the dates during which you used each name:

_____	_____	_____	_____
Name	Date	Name	Date

Have you ever used any other social security number? No _____ Yes _____

If yes, please provide each social security number and dates when used.

_____	_____	_____	_____
NUMBER	DATES USED	NUMBER	DATES USED

Are you legally authorized to work for the hospital in the job for which you are applying in the U.S. and in the future, without requiring the Hospital to sponsor you for employment visa status? No _____ Yes _____

Have you ever been convicted of a crime? (Do not include any marijuana possession or misdemeanor convictions more than five years old.)
 No _____ Yes _____ If yes, please provide a brief explanation: _____

Note: Admission of a conviction is not an automatic bar to employment. Each case is considered on its own merits.

Are you physically able to perform essential functions of the job as per the job description, with or without a reasonable accommodation? Yes _____ No _____
 If no, please provide a brief explanation: _____

Education:

	Name	Location (City & State)	Academic Major	Graduated			Degree Earned
				Yes	No	GED	
High School							
College University or Technical School							

Experience:

	YEARS EXPERIENCE		YEARS EXPERIENCE		YEARS EXPERIENCE AND SPEED
Bilingual		Medical Terminology		Typing	
Receptionist/Front Office		Medical Insurance Billing		Medical Transcribing	
Switchboard		Hospital Insurance Billing		Shorthand	
Personal Computer Usage		Book Keeping		10-Key Adding Machine	
Mainframe Computer Usage		Cashiering			

Please List any additional competencies you have, including training, education, CPR, computer programs, etc. not mentioned above that are relevant to desired position: _____

References:

Please List **Three** Professional or Personal References *not* including family members:

- 1) _____
NAME RELATIONSHIP TO YOU PHONE NUMBER
- 2) _____
NAME RELATIONSHIP TO YOU PHONE NUMBER
- 3) _____
NAME RELATIONSHIP TO YOU PHONE NUMBER

TO BE REMOVED BY ADMINISTRATION

Employment History:

- 1) State your most recent employment first. 2) Account for periods of unemployment below,
 3) Include all employment for the past 7 years, and all employment relevant to the position for which you are applying (use an attachment if necessary).

Name of Employer	Job Title	Start Date Mo.____ Yr.____	End Date Mo.____ Yr.____
Telephone Number	Description of Duties	Number of Hours Per Week:	
Address of Employer		Reason for Leaving:	
Supervisor's Name and Phone Number		May We Contact? Yes_____ No_____	
Name of Employer	Job Title	Start Date Mo.____ Yr.____	End Date Mo.____ Yr.____
Telephone Number	Description of Duties	Number of Hours Per Week:	
Address of Employer		Reason for Leaving:	
Supervisor's Name and Phone Number		May We Contact? Yes_____ No_____	

Employment History (continued):

Name of Employer	Job Title	Start Date Mo. _____ Yr. _____	End Date Mo. _____ Yr. _____
Telephone Number	Description of Duties	Number of Hours Per Week:	
Address of Employer		Reason for Leaving:	
Supervisor's Name and Phone Number		May We Contact? Yes _____ No _____	
Name of Employer	Job Title	Start Date Mo. _____ Yr. _____	End Date Mo. _____ Yr. _____
Telephone Number	Description of Duties	Number of Hours Per Week:	
Address of Employer		Reason for Leaving:	
Supervisor's Name and Phone Number		May We Contact? Yes _____ No _____	

Please describe unemployment periods of three months or more (give dates and reasons):

I certify the answers I have given to the foregoing question and statements are true and correct without sequential omissions of any kind whatsoever. I agree that my employer shall not be liable in any respect if my employment is terminated because of false or incorrect statements, answers or omissions made by me in this application. I understand that any misstatements or omissions of information are grounds for denial of employment, and if hired, for dismissal. I understand employment is contingent upon verification of information contained herein, as well as my passing, to the Hospital's satisfaction, a post-offer pre-employment physical examination.

I give the Hospital the right to request, and give the listed employers and schools as well as any other persons, schools, companies, credit bureaus, state licensing, law enforcement, and other governmental agencies, the right to give the Hospital (without any further notice to me) any and all information about my background, along with any other pertinent information they may have, personal or otherwise, whether or not it is in their records. I release all parties from all liability, and agree not to file any claims lawsuit or any other cause of action of any kind against any person or entity arising out of the furnishing, receipt or use of such information.

I authorize the Hospital to obtain a consumer report as defined under the Fair Credit Reporting Act in accordance with 15 U.S.C. 1681, et. seq., which includes information on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, criminal record, or mode of living, and to use such information for employment purposes. I understand that if the Hospital relies upon a consumer report, I will be notified about my rights in a separate document.

I AGREE THAT MY EMPLOYMENT WITH THE HOSPITAL WILL BE AT-WILL. THIS MEANS THAT EITHER THE HOSPITAL OR I MAY TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME FOR ANY REASON AT ALL, WITH OR WITHOUT NOTICE. THIS CLAUSE CANNOT BE AMENDED, CHANGED, ALTERED, OR ABOLISHED EXCEPT IN WRITING SIGNED BY THE HOSPITAL ADMINISTRATOR. I ALSO AGREE THAT MY EMPLOYMENT WILL BE GOVERNED BY THE PERSONNEL POLICIES OF NORTHERN INYO HOSPITAL, TO THE EXTENT THESE DOCUMENTS ARE CONSISTENT WITH MY EMPLOYMENT AGREEMENT. THESE DOCUMENTS ARE SUBJECT TO CHANGE FROM TIME TO TIME. 1/03

Signature of Applicant: _____

Date: _____

APPLICANT IDENTIFICATION RECORD

FEDERAL AND CALIFORNIA REGULATIONS REQUIRE EMPLOYERS TO OBTAIN CERTAIN INFORMATION FROM EACH JOB APPLICANT. THIS FORM IS USED TO PROVIDE EACH APPLICANT WITH AN OPPORTUNITY TO FURNISH SUCH INFORMATION *VOLUNTARILY*. ALL INFORMATION THAT IS PROVIDED VOLUNTARILY WILL BE USED ONLY FOR RECORD-KEEPING PURPOSES. FURTHER, SUCH INFORMATION WILL BE KEPT SEPARATE FROM THE APPLICATION AND AN EMPLOYEE'S MAIN PERSONNEL FILE. SUCH INFORMATION WILL NOT BE USED FOR ANY DISCRIMINATORY PURPOSES.

POSITION APPLIED FOR: _____ DATE: _____

SEX: MALE _____ FEMALE _____

PLEASE CHECK ONE

ASIAN _____	FILIPINO _____	NATIVE AMERICAN _____
BLACK _____	HISPANIC* _____	POLYNESIAN _____
CAUCASIAN _____	MEXICAN AMERICAN _____	OTHER _____

*INCLUDES INDIVIDUALS FROM MEXICO, CENTRAL AND SOUTH AMERICAN COUNTRIES, CUBA AND PUERTO RICO

INFO CUBIC

Pre-Employment Reference Checking

Authorization for release of information for employment purposes

Background Screening Disclosure

I hereby authorize Info Cubic, LLC and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include but is not limited to the following areas, names and dates of previous/current employment, work experience, workers compensation claims, criminal history records (from local, state, federal, international and other law enforcement agencies records), sexual offenders list, wants and warrants records, motor vehicle records, military records, educational verification, license verification, credit history, civil cases, OIG?GSA, OFAC/patriots act, any sanction lists. FBI finger printing and drug testing. Upon Request, Info Cubic, LLC will supply a copy of the completed consumer report along with a copy of an individuals rights under the Fair Credit Reporting Act.

Authorization and Release

I, _____ authorize the complete release of these records or data pertaining to me which an individual, company, firm, corporation or public agency may have. I authorize the full release of the information described above, without any reservation, throughout any duration of my employment at Northern, Inyo Hospital. I hereby release Info Cubic, LLC, and its agents, officials, representatives, or assigned agencies, including officers, employees or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may at any time, result to me, my heirs, family or associates because of compliance with this authorization for release of information. I certify that all information provided below and on my resume correct to the best of my knowledge. Any false statements provided in this form and my resume will be considered just cause for the termination of employment at any time. This authorization and consent shall be valid in original, fax, or copy form.

The following information is required by law enforcement agencies and other entities for identification purposes when checking records. It is confidential and will not be used for any other purpose.

Applicants Name (Print Legibly) _____

Maiden/AKA/Previous Names _____

Signature _____ Date _____

Social Security Number _____

Date of Birth _____ 19 ____ Optional (You do not need to give your date of birth until an offer of employment has been made.)

Driver License Number _____ State _____

Current Address _____

Phone _____