



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.

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							

YEARS EXPERIENCE		YEARS EXPERIENCE		YEARS EXPERIENCE AND SPEED	
Bilingual		Medical Terminology		Typing	
Receptionist/Front Office		Medical Insurance		Medical Transcribing	
Switchboard		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	Description of Duties	Start Date	End Date
Telephone Number		Mo. ____ Yr. ____	Mo. ____ Yr. ____
Address of Employer		Number of Hours Per Week:	
Supervisor's Name and Phone Number		Reason for Leaving:	
Name of Employer	Description of Duties	Start Date	End Date
Telephone Number		Mo. ____ Yr. ____	Mo. ____ Yr. ____
Address of Employer		Number of Hours Per Week:	
Supervisor's Name and Phone Number		Reason for Leaving:	
Name of Employer	Description of Duties	Start Date	End Date
Telephone Number		Mo. ____ Yr. ____	Mo. ____ Yr. ____
Address of Employer		Number of Hours Per Week:	
Supervisor's Name and Phone Number		Reason for Leaving:	

Supervisor's Name and Phone Number		May We Contact? Yes _____ No _____
Name of Employer	Description of Duties	Start Date End Date Mo. _____ Yr. _____ Mo. _____ Yr. _____
Telephone Number		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 NORHERN 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