



APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER M/F/D

241 Robert K. Wilson Drive, Carrollton, AL 35447

P. O. Box 478

Email: tabitha.pate@pcmc.care

This application will be active for 90 days

Application Date: _____

PERSONAL DATA

Last Name	First Name	Middle Name	Specific Position Desired
Current Address (Number and Street)			(Check) Full Time () Part Time () Temp ()
City, State and Zip Code			Willing to work shifts: Days Yes () No () Evenings Yes () No () Nights Yes () No ()
Telephone			Willing to work weekends? Yes () No ()
Date of Birth			If offered employment, date you would be available to start work:
Other Names Used:			If a conditional offer of employment is made, will you take a physical examination? Yes () No ()
<p>The Age Discrimination in Employment Act prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age.</p>			SELECTIVE SERVICE DATA Are you currently a member of a reserve unit? Yes () No ()
Professional organizations, interest, hobbies (omit any which might indicate race, religion, color, national origin, disability, age sex or ancestry.)			

EDUCATIONAL DATA

Name and Address of High School	Course or Major	Dates Attended	Graduate?	Diploma or GED
Name at graduation if different than listed above				
Name and Address of College	Course or Major	Dates Attended	Graduate?	Degree
Name at graduation if different than listed above				
Name and Address of Business, Technical, or Professional School(s) attended	Course or Major	Dates Attended	Graduate?	Degree or Diploma
Name of graduation if different than above				

Other Special Training or Certifications

SPECIAL SKILLS AND INTEREST

List Number and Expiration Date of Any Professional or Occupational License _____

State _____

List Any Maintenance or Shop Equipment You Operate	List Any Office Equipment You Operate	List Computer Software Skills
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PERSONAL / PROFESSIONAL REFERENCES: (Other than relatives or previous employers)

Name : _____	Name : _____
Phone: (HM) _____ (WK) _____	Phone: (HM) _____ (WK) _____
E-Mail: _____	E-Mail: _____

Any False statement, misrepresentation or omission will be sufficient cause for revocation of employment offer, if applicable, or termination of employment without notice, at any time.

All previous employment is listed on the application and/or Additional Work History Form. _____ (initials)

EMPLOYMENT DATA

Begin with your most recent job:

DATES OF EMPLOYMENT From ____/____/____ month yr To ____/____/____ month yr	Employer's Name		Salary Starting _____ Ending _____
	Employer's Address		Job Title/Duties
	Supervisor's Name	Phone: _____	
	Reason for Leaving		May we contact this employer? Yes ___ No ___ Full time _____ Part time _____ Per Diem _____

DATES OF EMPLOYMENT From ____/____/____ month yr To ____/____/____ month yr	Employer's Name		Salary Starting _____ Ending _____
	Employer's Address		Job Title/Duties
	Supervisor's Name	Phone: _____	
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	Supervisor's Name	Phone: _____	
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	Employer's Address		Job Title/Duties
	Supervisor's Name	Phone: _____	
	Reason for Leaving		May we contact this employer? Yes ___ No ___ Full time _____ Part time _____ Per Diem _____

Have you ever worked for PCMC before? _____ If yes, Dates: From: _____ To: _____

Name of relatives employed by PCMC. Also list relationship.

MISCELLANEOUS INFORMATION

1. Have you ever been convicted of any crime other than a minor traffic violation? (Check one) Yes ___ No ___ If yes, list offenses: _____
_____. Date of conviction: _____

2. Have you ever been refused a surety bond? Yes () No ()

Note: An answer of yes to either of the above questions does not necessarily disqualify you for employment with PCMC.

3. Are you authorized to work in the U.S.? Yes () No ()

Certification of Applicant

The information provided in this application is given of my own free will and accord and is true and correct to the best of my knowledge and belief. I give my express permission for Pickens County Medical Center to conduct an investigation into my background, experience, qualifications, etc. I fully understand that, as a condition of employment, I will be required to take a physical examination and the interpretation of the results of such examination shall be made by Pickens County Medical Center in accordance with Federal laws. I fully understand that the information contained in the Personal Medical History Form will be kept confidential, except to the extent that disclosure may be required in order to comply with Federal or State law or to ensure my safety or that of other employees. Any false statement provided to Pickens County Medical Center, or any withholding of requested information, whenever discovered, will be sufficient cause for rejection or termination. I further understand and agree that, if employed, my employment will be for an indefinite duration and that my employment may be terminated with or without cause at any time at the will of either myself or Pickens County Medical Center. I further understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by both me and the President/CEO of Pickens County Medical Center.

Signature of Applicant _____ Date _____ Social Security # _____