

EMPLOYMENT HISTORY Begin with your present or most recent employer. Attach additional sheet if necessary.

Name of firm		Position		Supervisor's name/Title		Phone	
Address (street/number)				Work performed			
City/State/Zip							
Phone number		Fax		If you worked under a different name, indicate that name here			
Dates employed (month/year) From _____ to _____		Reason for leaving			May we contact? <input type="checkbox"/> YES <input type="checkbox"/> NO		

If resume available, attach and proceed to personal section

Name of firm		Position		Supervisor's name/Title		Phone	
Address (street/number)				Work performed			
City/State/Zip							
Phone number		Fax		If you worked under a different name, indicate that name here			
Dates employed (month/year) From _____ to _____		Reason for leaving			May we contact? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Name of firm		Position		Supervisor's name/Title		Phone	
Address (street/number)				Work performed			
City/State/Zip							
Phone number		Fax		If you worked under a different name, indicate that name here			
Dates employed (month/year) From _____ to _____		Reason for leaving			May we contact? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Name of firm		Position		Supervisor's name/Title		Phone	
Address (street/number)				Work performed			
City/State/Zip							
Phone number		Fax		If you worked under a different name, indicate that name here			
Dates employed (month/year) From _____ to _____		Reason for leaving			May we contact? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Periods of unemployment	Date (month/year) From To	Date (month/year) From To	Date (month/year) From To	Date (month/year) From To
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PERSONAL

Have you applied here before? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, indicate date. Month _____ Year _____		
Have you ever worked here before? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, indicate dates and the department in which you worked: From ____/____/____ to ____/____/____ Department: _____ Position: _____		

MILITARY SERVICE RECORD

Branch of military service	Date entered service	Date separated from active duty	Date of final discharge	Final rank
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Describe any job related training received in the United States military _____

SPECIAL SKILLS AND TRAINING (Check which skill or training you have in the following areas)

Business	Computers	General	Patient Care
<input type="checkbox"/> Typing _____ wpm	<input type="checkbox"/> Microsoft Word	<input type="checkbox"/> Floor Care (Machines)	<input type="checkbox"/> Sterile Technique
<input type="checkbox"/> Transcription _____ wpm	<input type="checkbox"/> Excel	<input type="checkbox"/> Sterile Processing	<input type="checkbox"/> Vital Signs
<input type="checkbox"/> Medical Terminology	<input type="checkbox"/> Access	<input type="checkbox"/> Sterilization	<input type="checkbox"/> Pre-Op Preps
<input type="checkbox"/> Bookkeeping	<input type="checkbox"/> Power Point	<input type="checkbox"/> Sterilizer (Steam/Gas)	<input type="checkbox"/> Isolation Technique
<input type="checkbox"/> Accounting	<input type="checkbox"/> Meditech	<input type="checkbox"/> Maintenance (General)	<input type="checkbox"/> Catheterization
<input type="checkbox"/> 10-Key Adding	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Driving	<input type="checkbox"/> Charting
<input type="checkbox"/> Calculator	_____	<input type="checkbox"/> Medical Supply Knowledge	<input type="checkbox"/> Monitor
<input type="checkbox"/> Invoicing/Inventory	_____	<input type="checkbox"/> Customer Service	<input type="checkbox"/> Blood Draw
<input type="checkbox"/> Reception	_____	<input type="checkbox"/> Disinfectants (cleaning)	Type _____
<input type="checkbox"/> Phone Switchboard		<input type="checkbox"/> Lifting Techniques	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Insurance billing		<input type="checkbox"/> Inventory/Warehouse	_____
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Food Handling	_____
		<input type="checkbox"/> Other: _____	

OTHER QUALIFICATIONS

Summarize special job-related skills and qualifications acquired from employment or other experience.

What is the minimum period of time that you plan to stay if employed by Mountainview Medical Center? _____

State any additional information you feel may be helpful to us in considering your application for employment _____

An Equal Opportunity Employer

It is Mountainview Medical Center's policy that an individual's race, color, creed, religion, sex, disability, age, national origin, or marital status is not and will not be a factor in any decisions regarding employment opportunity.

I certify that the information set forth in this employment application is true and complete to the best of my knowledge. I understand that, if employed, the falsification or willful omission of information on this application shall be considered sufficient cause for my dismissal.

I understand that my employment shall be contingent upon proof of identity and verification of eligibility for employment in the United States in accordance with the Immigration and Reform Act of 1986. I further understand that my employment is contingent upon satisfactory references.

I understand that my employment shall be contingent upon criminal-history information as required by the Child/Adult Abuse Information Act as well as having and maintaining a record of no violations of Section 1128 and 1156 of the Social Security Act.

I also understand that my name will be checked against the list of Excluded Individuals provided by the Department of Health & Human Services, Office of the Inspector General.

I consent to and authorize Mountainview Medical Center and its Personnel Department to request any information concerning my previous employment record as indicated on this application for employment. I hereby release all parties and persons connected with any request for information and all claims, liabilities and damages for whatever reason arising out of furnishing such job-related information.

Regardless of personal preferences, I must be willing to rotate to a different shift should the needs of Mountainview Medical Center require doing so. Additionally, I will undergo TB skin testing as a condition of employment.

X _____
Signature of Applicant (Required) Date

Thank you for your interest in Mountainview Medical Center. Please feel free to attach your resume or any other additional information, which may be helpful in evaluating your qualifications. **Only those applicants selected for an interview will be notified.**

OPTIONAL INFORMATION

You do **not** need to answer these questions to apply.

Mountainview Medical Center is committed to an affirmative action program which provides for recruitment of women, people with disabilities and members of ethnic minority groups in area work where they may be underrepresented. To more successfully implement this program, Mountainview Medical Center requests that you provide the following information, which will not be used in evaluating your application.

Ethnic Origin – Choose One

- Asian
- American Indian
- African American
- Caucasian
- Hispanic
- Decline to Answer

Veteran / Disabled – Choose all that apply

- Vietnam Veteran
- Disabled Veteran
- Other Veteran
- Disabled

Gender

- Male
- Female
- Decline to Answer