GULF COAST COMMUNITY HEALTH SERVICES, INC.

EMPLOYMENT APPLICATION

AN EQUAL OPPORTUNITY EMPLOYER

PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION
All application with GULF COAST COMMUNITY HEALTH SERVICES, INC. must be made on this form. The entire application must be completed. Incomplete applications cannot be considered. All information submitted is subject to verification. A false or misleading statement may result in disqualification or termination. Please print clearly in ink.

Name: _____
Last First Middle

Date of Birth: _____ Social Security: _____

Address_____
Street City State Zip Code

Phone_____ Email _____

Position Applying For:
1._____ 2. _____

Date Available: _____ ❑Full time ❑Part time Salary Requested: _____

In case of emergency, notify: Name_____ Relationship:_____

Address _____ Phone:_____

List any acquaintances and/or relatives employed by GULF COAST COMMUNITY HEALTH SERVICES, INC.
_____

Who referred you to GULF COAST COMMUNITY HEALTH SERVICES, INC.:
_____
****

Please answer the following questions:
1. ☑Yes ❑No Have you previously been employed by GULF COAST COMMUNITY HEALTH SERVICES, INC.?
2. ❑Yes ☑No Do you authorize us to check previous employment?
3. ❑Yes ☑No Have you ever served in the Military? If yes, Branch: _____;
Discharge Date: _____;
4. ☑Yes ❑No Are you currently in the reserve? If Yes, what Branch _____
5. ☑Yes ❑No Have you ever been convicted of a felony? (If the answer is yes, please explain.) _____
_____

****

EDUCATION

School Level	Name and Location of School	Years Attended	Did you Graduate	Subjects Studied
HIGH SCHOOL				
COLLEGE OR UNIVERSITY				
TECHNICAL OR BUSINESS SCHOOL				

GULF COAST COMMUNITY HEALTH SERVICES, INC.

APPLICANT'S NAME: _____

****

PROFESSIONAL LICENSURE/CERTIFICATION

TYPE: ❒ RN ❒ LVN ❒ CNA ❒PT ❒PTA ❒OT ❒OTA ❒ST ❒STA
❒OTHER: _____

License/Certification #: _____ State: _____ Exp. Date_____

****

TECHNICAL SKILLS

Check all that apply to you:

☐ Typing _____ wpm
❑ Computer Programs: Types? _____
❑ Computers: Type? _____
Foreign Language Spoken? _____
Foreign Language Written? _____

****

EMPLOYMENT HISTORY

List present or most recent position first. Please provide at least 5 years if available.

1. Employment dates from: _____ to _____
   Company: _____ Salary: _____
   Address: _____ Supervisor: _____
   Phone: _____ Job Title: _____
   Job Duties: _____
   Reason for Leaving: _____

****

2. Employment dates from: _____ to _____
   Company: _____ Salary_____
   Address: _____ Supervisor_____
   Phone: _____ Job Title: _____
   Job Duties: _____
   Reason for Leaving: _____

****

3. Employment dates from: _____ to _____
   Company:_____ Salary:_____
   Address:_____ Supervisor:_____
   Phone:_____ Job Title:_____
   Job Duties:_____
   Reason for Leaving: _____

****

4. Employment dates from: _____ to _____
   Company:_____ Salary:_____
   Address:_____ Supervisor:_____
   Phone:_____ Job Title:_____
   Job Duties:_____
   Reason for Leaving: _____

****

REFERENCES

List three persons, not related to you, who have known you for at least one year.

1. Name:_____ Title/Occupation:_____
   Address: _____ Phone Home/Office:_____

2. Name:_____ Title/Occupation:_____
   Address:_____ Phone Home/Office:_____

3. Name:_____ Title/Occupation:_____
   Address:_____ Phone Home/Office:_____

GULF COAST COMMUNITY HEALTH SERVICES, INC.

APPLICANT'S NAME: _____

GULF COAST COMMUNITY HEALTH SERVICES, INC. is an equal opportunity employer, and selects the best matched individual for the job based upon related qualifications, regardless of race, color, creed, sex, national origin, age, handicap or other protected groups under state, federal or local Equal Opportunity Laws.

I UNDERSTAND AND AGREE THAT:

Any material misrepresented or deliberate omission of fact in my application may be justification for refusal of, or if employed termination from employment.

It is my understanding that GULF COAST COMMUNITY HEALTH SERVICES, INC. will make a thorough investigation of my entire work history and may verify all data given in my application for employment, related papers, or oral interview. I authorize such investigation and the giving and receiving of any information requested by GULF COAST COMMUNITY HEALTH SERVICES, INC. and released from liability any person giving or receiving such information. I understand that falsification of data so given or other derogatory information discovered as a result of this investigation may prevent my being hired may subject me to immediate dismissal.

I agree that my employment may be terminated by GULF COAST COMMUNITY HEALTH SERVICES, INC. at any time without liability for wages or salary except such as may have been earned at the date of such termination. If requested by the management at any time, I agree to submit to search of my person or locker that may be assigned to me, and hereby waive all claims of damages on account such examination. I authorize any physician or hospital to release any information which may be necessary to determine my ability to perform the duties of a job l am being considered for prior to employment or in the future during examination by a qualified physician at the discretion of my employer. I understand that the result of my medical exam is the property of GULF COAST COMMUNITY HEALTH SERVICES, INC. and will be kept confidential to the full extent of the law.

Although management makes every effort to accommodate individual preferences, business needs may at time make the following conditions mandatory: overtime, shift work, a rotating work schedule other than Monday through Friday. I understand and accept these as conditions of my continuing employment.

I understand that if I am employed, such employment is for no definite period of time and that association can change wages, benefits, and conditions at any time.

I, the undersigned, certify that l have read and fully comprehend this form in its entirety and that the information provided is true and complete to the best of my knowledge. I understand that should any statement l made prove false, misleading or erroneous, it may result in the rejection of my application. I authorize the Agency to obtain from my present (unless otherwise indicated) and past employers all data needed to support this application. I further understand that this application becomes the property of GULF COAST COMMUNITY HEALTH SERVICES, INC. and will not be returned.

Signature_____Date_____

GULF COAST COMMUNITY HEALTH SERVICES, INC.

APPLICANT'S NAME: _____

DO NOT WRITE ON THIS PAGE
FOR OFFICE USE ONLY

VERIFICATION OF LICENSURE/CERTIFICATION

DATE	TYPE	METHOD (LIST # OR ADDRESS)	RESULTS	VERIFIED BY
	RN LVN CNA Other:	PHONE: FAX: MAIL: WEBSITE:	CURRENT EXPIRED SUSPENDED NO RECORD	

REFERENCE CHECK

DATE	NAME OF REFERENCE	METHOD	RESULTS	VERIFIED BY
		PHONE: FAX: MAIL:		
		PHONE: FAX: MAIL:		
		PHONE: FAX: MAIL:		

DATE	TYPE	METHOD	RESULTS	VERIFIED BY
	CRIMINAL HISTORY	WEBSITE: MAIL:		
	NURSE AIDE REGISTRY	PHONE:		
	MISCONDUCT REGISTRY	PHONE:		

HIRE DATE:	POSITION:	STARTING SALARY/ WAGE:	APPROVED BY: