



DATE

LAST NAME

FIRST NAME

POSITION DESIRED

SHIFT DESIRED

APPLICANT INFORMATION

The following information is provided to assist you in accurate completion of this application for employment.

1. INCOMPLETE OR UNSIGNED APPLICATIONS WILL NOT BE CONSIDERED.
2. ALL INFORMATION MUST BE COMPLETED EVEN IF A RESUME IS ATTACHED.
3. If you become an employee of Twin Creeks Hospital, you will be required to submit acceptable documentation of citizenship or alien status and proof of eligibility to work in the United States as required by the Department of Homeland Security.
4. If you are offered contingent employment you will be required to complete the Post-Contingent Offer Process which includes:
 - a. Submitting and passing a Post-contingent offer of employment Drug Screen.
 - b. Consenting to a routine Criminal Background Investigation to verify information you provided on the employment application. Omissions, falsifications or misrepresentations will constitute grounds for applicant disqualification or termination, if employed.
 - c. Providing routine Employee Health Information and compliance with documentation of such.
 - d. Permitting a Motor Vehicle Report, if driving is a part of the job you have applied for. Driving record issues which prohibit or impede your ability to perform the driving function of the position, for which you are being considered, may constitute applicant disqualification.
5. If you are offered and accept employment, you agree to comply with all Twin Creeks Hospital policies and procedures.
6. All applicants are considered for employment without regard to race, color, religion, gender, sexual orientation, national origin, age, disability, veteran status, or any other characteristic protected under federal, state, or local laws.

EDUCATION

Type of School	School Name	City/State	Circle Years Completed				Graduate?	Degree Obtained
			1	2	3	4		
High School			1	2	3	4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College			1	2	3	4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate School			1	2	3	4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trade School			1	2	3	4	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Describe specialized training skills, professional affiliations and other information relative to the job you are applying for:

Professional License Type & Number Expiration Date

Foreign Language Skills

Language(s) Spoken:	<input type="checkbox"/> Speak
	<input type="checkbox"/> Read
	<input type="checkbox"/> Write

EMPLOYMENT HISTORY

Start with your present or most recent job. Include US Military Services as a position. All information must be provided even if a resume is attached. If you need additional space, please continue on a separate sheet of paper

1.	Employer:	Address, City, State, Zip:				
Title:		Supervisors Name & Title:			Telephone #:	
From:	To:	# of hours per week:	Beginning Salary:		Ending Salary:	
Reason for leaving:						
Describe your job responsibilities in detail:						
May we contact this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						
2.	Employer:	Address, City, State, Zip:				
Title:		Supervisors Name & Title:			Telephone #:	
From:	To:	# of hours per week:	Beginning Salary:		Ending Salary:	
Reason for leaving:						
Describe your job responsibilities in detail:						
May we contact this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						
3.	Employer:	Address, City, State, Zip:				
Title:		Supervisors Name & Title:			Telephone #:	
From:	To:	# of hours per week:	Beginning Salary:		Ending Salary:	
Reason for leaving:						
Describe your job responsibilities in detail:						
May we contact this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						

DISCLOSURE STATEMENT

The information given by me is certified to be true and complete, and may be verified by Twin Creeks Hospital or its designated representative. If I misrepresent information, or provide incomplete or false information, I understand and agree that I may be refused employment, or if employed, I may be terminated.

I understand and agree that employment with the company is at will, and employment may be terminated by the employee or the company at any time with or without cause or notice.

The company has my authorization to thoroughly investigate my work, medical, military and personal history. I will hold no person liable for giving or receiving information in this investigation.

Any doctor, hospital, or testing laboratory may conduct medical and drug tests and may release all information necessary for the company to determine my abilities to perform job duties now or in the future.

The needs of the company may make the following conditions mandatory: overtime, shift work, a rotating work schedule, floating between the nursing and therapy departments as assigned and trained, or a work schedule other than Monday through Friday. I accept these conditions of employment.

If employed, I understand that my employment is for no definite period of time, and if terminated, the company is liable only for wages or salary earned as of the date of termination.

By my signature, I certify, authorize, and acknowledge the above statements.

Applicant Signature

Date

TWIN CREEKS HOSPITAL RELEASE FORM

LEGAL Name as it appears on all identification documents:

FIRST: _____ MIDDLE: _____ LAST: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____ Phone Number _____

How long have you lived at this address? _____

Previous county, state (i.e. Hunt Co, TX): _____

Previous county, state: _____

Previous county, state: _____

Previous county, state: _____

The following personal information requested will not affect you as an applicant. This information will be used to determine if our recruitment efforts are reaching all segments of the community, to meet federal EEO reporting requirements, and to conduct background checks. This information is not communicated in any format to the interviewing manager.

SEX: Male Female

Ethnic Origin: Hispanic or Latino Non-Hispanic or Non- Latino

RACE: Asian American Indian or Alaskan Native Black or African American
 Native Hawaiian or Other Pacific Islander White Other

Driver's License #: _____ State Issued: _____

Date of Birth: _____ SSN: _____

Maiden Name/Alias/Previously used names:

AUTHORIZATION

1. In connection with my application for employment with Twin Creeks Hospital, I understand that an investigative consumer report may be requested that will include information as to my work performance and experience, reasons for termination of past employment, and may include character references. Further, I understand that as directed by company policy and consistent with the job described, Twin Creeks Hospital may request information from public and private sources about my court records and references.
2. According to the fair credit reporting act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency. If so, I will be notified and given the name and address of the agency of the source which provided the information. Information obtained by testing or personal interview services is not considered a consumer report, therefore not subject to the same disclosure, and shall be the full property of Twin Creeks Hospital.
3. I acknowledge that a telephonic facsimile (fax) or photographic copy shall be as binding as the original. This release is valid for most federal, state and county agencies.
4. I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, employer or reference company contacted by Twin Creeks Hospital, or its agent, to furnish the information described in Section 1.

Signature: _____

Today's Date: _____