



An Equal Opportunity Employer

EMPLOYMENT APPLICATION

INSTRUCTIONS: Please provide all information requested on this form. If you wish to supply additional education or work history information, attach a separate sheet. Please type or print clearly all information. We appreciate your interest in working at Boundary Community Hospital and are sincerely interested in your qualifications.

Date: _____

PERSONAL DATA

Name _____
Last First Middle

Present Address _____ ()
Mailing Home Phone Number
_____ ()
City State Zip Cell Phone Number

Permanent Address (If other than above) _____
Mailing ()
City State Zip Permanent Phone Number or
Message Number

POSITION(S) DESIRED

Title: _____ Job # _____ Title: _____ Job # _____
(First Choice) (Second Choice)

Full-time Part-time Occasional

Temporary If temporary, indicate which months available: _____

Please tell us where you heard about the position you are applying for:

- BCH Website Monster.com Personal Referral
- Idaho Commerce & Labor (Job Service) Careerbuilder.com Other: _____
- Bonner County Daily Bee Other Internet Job Board: _____
- Bonner Ferry Herald Healthcare Publication: _____
- Other Newspaper: _____

AVAILABILITY

Indicate shift(s) you are available to work: 1st Shift - days 2nd shift - evenings 3rd shift - nights

First date available for work: _____

Will you rotate shifts? Yes No Will you work weekends? Yes No

Indicate days you are available for work:
 Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Do you have the legal right to be employed in the United States? Yes No

If offered a position, the Immigration Reform & Control Act of 1986 requires you to furnish proof of your employment authorization and your identity before you can begin work.

Do you have any relatives employed here? Yes No If yes, please indicate name(s), relationship and their position.

Have you been previously employed here? Yes No If yes, give dates: _____

Have you previously interviewed for employment here? Yes No If yes, for what position(s) and when:

Have you ever been convicted of a misdemeanor or felony?

Yes No If yes, explain fully: _____

If applying for the position of Registered Nurse, Licensed Practical Nurse, Pharmacist, or Pharmacy Technician please answer the following question:

In the past 3 years, have you ever knowingly used any controlled substances, including narcotics, amphetamines, or barbiturates, other than those prescribed to you by a physician? Yes No

If yes, explain fully: _____

(A "yes" answer to these questions will not necessarily bar the applicant from employment.)

CHECK THE TRAINING AND/OR EXPERIENCE AREAS WHICH MAY QUALIFY YOU FOR THE POSITION(S) DESIRED

BUSINESS/CLERICAL	SERVICE AREAS	PATIENT CARE SKILLS
<input type="checkbox"/> Typing/Keyboard _____ wpm <input type="checkbox"/> Dictaphone <input type="checkbox"/> Medical Terminology <input type="checkbox"/> Data Entry <input type="checkbox"/> Insurance Billing/Collections <input type="checkbox"/> Switchboard <input type="checkbox"/> Information Systems <input type="checkbox"/> Data Based Software <input type="checkbox"/> Spreadsheet Software <input type="checkbox"/> Customer Relations <input type="checkbox"/> Computer Software Proficiency What Programs: _____ _____ _____	<input type="checkbox"/> Floor Care Machines <input type="checkbox"/> Patient Tray Line <input type="checkbox"/> Cafeteria Serving <input type="checkbox"/> Quantity Cooking <input type="checkbox"/> Industrial Washers/Dryers <input type="checkbox"/> Autoclave <input type="checkbox"/> Electrical <input type="checkbox"/> Electronics <input type="checkbox"/> Mechanical <input type="checkbox"/> Plumbing <input type="checkbox"/> Refrigeration <input type="checkbox"/> Carpentry <input type="checkbox"/> Boilers <input type="checkbox"/> HVAC & Controls	<input type="checkbox"/> Infection Control <input type="checkbox"/> Vital Signs <input type="checkbox"/> Bedside testing <input type="checkbox"/> Home Health / Hospice <input type="checkbox"/> Isolation Procedures <input type="checkbox"/> IV Techniques <input type="checkbox"/> Emergency <input type="checkbox"/> Obstetrics <input type="checkbox"/> ICCU <input type="checkbox"/> Med/Surg <input type="checkbox"/> Surgery <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Long-term Care

What are your career goals? _____

PATIENT CARE APPLICANTS PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is your primary focus in Healthcare? _____

Prioritize the importance of these items in your practice (1 = top) _____ Compassion _____ Patient Care
 _____ Critical Thinking _____ Advocacy

WORK EXPERIENCE

LIST MOST RECENT EMPLOYER FIRST AND PROVIDE ALL REQUESTED INFORMATION:

1. Name of employer, address:	Dates employed (month/year) From: _____ To: _____ Final wage \$ _____	Name of supervisor: Phone #: May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Job title & description:	Reason for leaving:	
Job duties and responsibilities:		
2. Name of employer, address:	Dates employed (month/year) From: To:	Name of supervisor: Phone #:
	Final wage \$	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Job title & description:	Reason for leaving:	
Job duties and responsibilities:		
3. Name of employer, address:	Dates employed (month/year) From: To:	Name of supervisor: Phone #:
	Final wage \$	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Job title & description:	Reason for leaving:	
Job duties and responsibilities:		
4. Name of employer, address:	Dates employed (month/year) From: To:	Name of supervisor: Phone #:
	Final wage \$	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Job title & description:	Reason for leaving:	
Job duties and responsibilities:		

Did you work for any of the above employers under a different name? If so, please circle which one: 1 2 3 4

Give your previous name: _____

List any Military experience: N/A

1. Name of employer, address:	Dates employed (month/year) From: To:	Name of supervisor: Phone #:
	Final wage \$	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Job title:		
Job duties and responsibilities:		

EDUCATION

College				
SCHOOL (Circle highest year completed) 1 2 3 4 5 6 7 8 9 10 11 12 / 1 2 3 4 / Other:				
Indicate High School, Vocation School, Business School, School of Nursing, College or University attended:				
Name of School	Location		Course of Study	Degree, Diploma, or Certificate
	City	State		

Do you plan to resume your education? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided	If Yes, when?	Name and location of school:
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PROFESSIONAL REGISTRATION / LICENSURE

Type of Registration or License	State	Number	Date of Expiration

If you do not have a required registration or license, have you applied for one? Yes No
 If an examination is required, what date are you scheduled to take the examination? _____

CERTIFICATIONS

Type of Certificate	State	Date of Certification

PROFESSIONAL REFERENCES

Name	Professional Title	Contact Number

Important: Read Before Signing

I certify that the information on this application is complete and true. I understand that misrepresentation or omission of facts may result in immediate termination of any employment resulting from this application. I further understand that employment is contingent upon satisfactory completion of a criminal background check and requested pre-employment lab tests for controlled substances and that a positive test result will prohibit and/or cancel any offer of employment previously made by an authorized representative of Boundary Community Hospital.

I understand and agree that I shall be subject to immediate termination if it shall be determined that my answers are untrue or that I have failed to disclose a material fact. I understand and agree that the fact that the employer has made or has not made an investigation or the fact that I have performed my work satisfactorily for any period of time to this determination, shall not constitute a waiver, abandonment, or bar of the right of the employer to take such disciplinary action.

I understand that my employment shall be contingent with the Immigration Reform and Control Act of 1986. I further understand that my employment is contingent upon the verification of references furnished by me. I consent to and authorize the hospital and its personnel to request any information concerning my previous employment record as indicated on this application of employment including documentation on performance issues and or discharge notices. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such job related information. In conjunction with my application with Boundary Community Hospital, I understand that investigative background inquiries are to be made on me which may include criminal convictions, motor vehicle and other reports.

Employment at Boundary Community Hospital is at-will. That is, either you or Boundary Community Hospital may terminate the employment relationship at any time, with or without cause. The at-will relationship remains in full force and effect notwithstanding any statements to the contrary made by company personnel or set forth in any documents. This application does not constitute an employment contract.

Signature of Applicant

Date