

# EMPLOYMENT APPLICATION

RETURN COMPLETED APPLICATIONS TO:  
 BOSCOBEL AREA HEALTH CARE  
 205 PARKER STREET  
 BOSCOBEL, WI 53805

FEDERAL LAW PROHIBITS DISCRIMINATION ON THE BASIS OF RACE, CREED, COLOR, NATIONAL ORIGIN, AGE, SEX, MARTIAL STATUS, SEXUAL ORIENTATION, AND PHYSICAL OR MENTAL DISABILITY.
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PLEASE PRINT OR TYPE

POSITION(S) APPLYING FOR:			DATE
NAME: LAST FIRST MIDDLE		SOCIAL SECURITY NUMBER	
ADDRESS: NO. STREET			HOME PHONE NUMBER
CITY STATE ZIP CODE			WORK PHONE NUMBER
ARE YOU OVER 18 YEARS OF AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NOT, WHAT IS YOUR DATE OF BIRTH	WORK PREFERENCE <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> SUMMER	
SHIFT PREFERENCE: <input type="checkbox"/> DAYS <input type="checkbox"/> EVENINGS <input type="checkbox"/> NIGHTS <input type="checkbox"/> ROTATION <input type="checkbox"/> WEEKENDS		DEPARTMENT PREFERENCE	DATE AVAILABLE TO START
WERE YOU PREVIOUSLY EMPLOYED WITH BOSCOBEL AREA HEALTH CARE <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHEN, WHERE AND IN WHAT DEPARTMENT?	
NAME(S) OF RELATIVE(S) EMPLOYED HERE			DEPARTMENT(S) WHERE RELATIVE(S) WORK
WHAT SOURCE/PERSON REFERRED YOU TO US?			
BOSCOBEL AREA HEALTH CARE RESERVES THE RIGHT TO INVESTIGATE ANY PROBABLE RECORD OF CRIMINAL ACTIVITY. HAVE YOU EVER BEEN CONVICTED OF A CRIME? <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU EITHER A U.S. CITIZEN OR AN ALIEN WHO HAS THE LEGAL RIGHT TO WORK IN THE U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, FOR WHAT REASON?			

## NURSING AND OTHER LICENSED CLINICAL PROFESSIONALS

PLEASE LIST CURRENT PROFESSIONAL REGISTRATIONS, LICENSES, OR CERTIFICATIONS.

TYPE	REGISTRATION NUMBER	STATE ISSUED	EXPIRATION DATE
1.			
2.			

HAS YOUR LICENSE/CERTIFICATION EVER BEEN SUSPENDED/REVOKED/RESTRICTED OR HAS A DISCIPLINARY INVESTIGATION EVER BEEN CONDUCTED CONCERNING YOUR PROFESSIONAL ACTIVITIES?  YES  NO

### CLINICAL ARE PREFERRED

1 <sup>ST</sup> CHOICE	2 <sup>ND</sup> CHOICE	3 <sup>RD</sup> CHOICE	
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## APPLICANT DO NOT WRITE BELOW THIS LINE

INTERVIEWS:		JOB TITLE:	
	YES	DATE COMPLETED	STATUS:
PHYSICAL			
TB			
RUBELLA			DEPARTMENT:
EMPLOYMENT DATE:			EXT:
ORIENTATION DATE:			NAME OF SUPERVISOR:
EMPLOYEE NUMBER:			COST CENTER: POSITION CONTROL NO.
SALARY OFFERED:			CREDENTIALS:

## RECORD OF EDUCATION

NAME, ADDRESS AND ZIP CODE OF SCHOOL	COURSE OF STUDY	DID YOU GRADUATE?	DIPLOMA/DEGREE
HIGH SCHOOL			
COLLEGE			
OTHER			

## RECORD OF EMPLOYMENT

List below all employment, beginning with most recent. If not previously employed by **at least two (2) employers**, please include any **volunteer experience and personal References**. (Also, please attach any information you wish to supplement this application, i.e. resume, letters of reference, professional licenses, etc.)

EMPLOYER'S NAME, ADDRESS, ZIP CODE & PHONE NO.	DATES EMPLOYED		JOB TITLE & DUTIES	SUPERVISOR	NO.HRS./WEEK	HOURLY/SALARY	REASON FOR LEAVING
1.	FROM	TO					
2.	FROM	TO					
3.	FROM	TO					

## PERSONAL REFERENCES

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP	LENGTH OF RELATIONSHIP
1.				
2.				
3.				

May we contact employers listed above?  YES  NO If no, indicate by number which one(s) you **DO NOT** wish us to contact:

In order to verify previous work history, have you had any changes of name?  YES  NO If yes, please indicate:

I certify that the preceding statements made by me are true to the best of my knowledge. I understand that if I have made false or misleading statements on the application (and/or accompanying resume), it shall be sufficient cause for ineligibility for employment, or if employed, just cause for dismissal.

I understand that my employment depends upon both receiving favorable employment/personal references and passing the hospital's post job offer physical examination and/or drug test. I also understand that my employment will be on a probationary basis in accordance with applicable Boscobel Area Health Care policies.

I hereby authorize Boscobel Area Health Care to make inquiry of my former employers and references as to my qualifications or other facts related to my previous employment. I understand that any information obtained is considered confidential and hereby release my former employers and/or references from liability for issuing such information.

SIGNATURE OF APPLICANT

DATE