NORTH PHILADELPHIA HEALTH SYSTEM

We care for the community.

APPLICATION FOR EMPLOYMENT

Federal, state, & local laws prohibit discrimination in employment on the basis of race, color, creed, age, sex, sexual orientation, gender identity, marital status, national origin, political affiliation, genetic information, physical handicap, disability or medical condition. We are an Equal Opportunity Employer. A copy of this application is available to you upon request.

PLEASE READ CAREFULLY – PRINT CLEARLY – ANSWER ALL QUESTIONS

EMPLOYMENT DESIRED

POSITION OR TYPE OF WORK:

HOURS:	**SHIFT:**
☐ FULL TIME ☐ PART TIME	☐ DAY ☐ EVENING
☐ FLEX / POOL ☐ TEMPORARY	☐ NIGHT ☐ WEEKEND
DATE OF APPLICATION	**DATE AVAILABLE FOR WORK**

PERSONAL INFORMATION

LAST NAME **FIRST NAME** **MIDDLE NAME**

ADDRESS	**CITY, STATE, ZIP CODE**
HOME PHONE	**ALTERNATE/CELL PHONE**
SOCIAL SECURITY NUMBER	**OTHER NAMES USED**
ARE YOU 18 YEARS OF AGE OR OLDER? ☐ YES ☐ NO	**ARE YOU A U.S. CITIZEN?** ☐ YES ☐ NO (If No, Proof Of Eligibility To Work In The U.S. Will Be Required)

HAVE YOU WORKED FOR N.P.H.S. BEFORE? ☐ YES ☐ NO
IF YES, WHICH LOCATION ☐ GMC ☐ SJH
POSITION _____ **DATES** _____

HAVE YOU EVER BEEN DISCHARGED FROM A JOB? ☐ YES ☐ NO
IF YES, EXPLAIN - GIVE EMPLOYER NAME & DATES:

_____

_____

HOW DID YOU HEAR ABOUT N.P.H.S.?

☐ AD IN _____ ☐ N.P.H.S. ASSOCIATE _____
☐ JOB FAIR AT _____ ☐ MAILING ABOUT _____
☐ WALK-IN _____ ☐ OTHER _____

DOES N.P.H.S. EMPLOY ANY OF YOUR RELATIVES? ☐ YES ☐ NO

IF YES: **NAME** _____ **DEPT** _____ **RELATION** _____
NAME _____ **DEPT** _____ **RELATION** _____
NAME _____ **DEPT** _____ **RELATION** _____

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EDUCATION

HIGH SCHOOL	CITY, STATE	DID YOU GRADUATE? ☐ YES ☐ NO

COLLEGES/ OTHER SCHOOLS	CITY, STATE	DATES ATTENDED	DID YOU GRADUATE?	DIPLOMA, DEGREE, OR CERTIFICATE?	COURSE OF STUDY
			☐ YES ☐ NO		
			☐ YES ☐ NO		
			☐ YES ☐ NO		
			☐ YES ☐ NO		
			☐ YES ☐ NO		

PROFESSIONAL LICENSURE / REGISTRATION / CERTIFICATION

TYPE OF LICENSE, REGISTRY, OR CERTIFICATION	ISSUING STATE OR ORGANIZATION	NUMBER	ISSUED DATE	EXPIRATION DATE

IF NOT LICENSED, REGISTERED, OR CERTIFIED, GIVE DATE OF EXPECTED EXAM: _____
CPR CERTIFICATION: TYPE _____ EXPIRATION DATE _____

SPECIALIZED SKILLS

☐ PERSONAL COMPUTER: SOFTWARE USED _____

☐ WORD PROCESSING ☐ TRANSCRIPTION

☐ TYPING: _____ WPM ☐ SHORTHAND: _____ WPM

☐ MEDICAL TERMINOLOGY ☐ HOSPITAL BILLING

☐ OTHER SPECIAL SKILLS:

_____

_____

_____

_____

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EMPLOYMENT HISTORY

PLEASE LIST JOB HISTORY (INCLUDING MILITARY SERVICE) STARTING WITH PRESENT OR MOST RECENT EMPLOYMENT. MAY ALSO ATTACH RESUME.

FROM (MO/YR) _____ TO (MO/YR) _____ TITLE _____ SALARY _____ STATUS ☐ FT ☐ PT ☐ AS NEEDED	**EMPLOYER (MOST RECENT)** NAME_____ ADDRESS_____ CITY _____ ST _____ ZIP _____ MAY WE CONTACT (if present employer)? ☐ YES ☐ NO	**SUPERVISOR** NAME _____ TITLE _____ PHONE _____
DUTIES AND RESPONSIBILITIES:		
REASON FOR LEAVING:		
FROM (MO/YR) _____ **TO (MO/YR)** _____ **TITLE** _____ **SALARY** _____ **STATUS** ☐ FT ☐ PT ☐ AS NEEDED	**EMPLOYER** NAME_____ ADDRESS_____ CITY _____ ST _____ ZIP _____	**SUPERVISOR** NAME _____ TITLE _____ PHONE _____
DUTIES AND RESPONSIBILITIES:		
REASON FOR LEAVING:		
FROM (MO/YR) _____ **TO (MO/YR)** _____ **TITLE** _____ **SALARY** _____ **STATUS** ☐ FT ☐ PT ☐ AS NEEDED	**EMPLOYER** NAME_____ ADDRESS_____ CITY _____ ST _____ ZIP _____	**SUPERVISOR** NAME _____ TITLE _____ PHONE _____
DUTIES AND RESPONSIBILITIES:		
REASON FOR LEAVING:		

AFFIDAVIT: I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever. I agree that my employer shall not be liable in any respect if my employment is terminated because of the falsity of statements, answers or omissions made by me in this questionnaire. I authorize employers, companies, schools or persons named above to give any information regarding my employment, together with any information they may have regarding me whether or not it is in their records. I hereby release said employers, companies, schools or persons from all liability for any damage, both legal and otherwise, for issuing this information. I also understand an offer of employment will be conditioned on results of a medical examination. In addition, if accepted for employment, I hereby agree to abide by the rules and policies of my employer. Further, I understand that my employment is not for a stated period of time and may be terminated with or without cause, at any time, at the option of either my employer or myself. I also agree that any offer of employment is contingent upon my ability to perform the essential functions of the job. Any demonstration of my inability to perform the essential functions during the probationary period will result in immediate dismissal. In addition, I agree to abide by such established policies as relates to the Drug-Free Workplace Act of 1988.

SIGNED _____ **DATE** _____