



27200 CALAROGA AVENUE
 HAYWARD, CALIFORNIA 94545
 (510) 264-4288
 (510) 264-4033 (Job Hotline)

An Equal Opportunity Employer

Today's Date _____

APPLICATION FOR EMPLOYMENT

NOTE: TO HELP US PROCESS YOUR APPLICATION EFFECTIVELY, PLEASE PRINT ALL INFORMATION FULLY AND ACCURATELY.

PERSONAL INFORMATION

NAME: LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
ADDRESS: NUMBER	STREET	CITY	STATE ZIP CODE
HOME PHONE	MESSAGE/CELL PHONE	E-MAIL ADDRESS	BUSINESS PHONE
HAVE YOU EVER WORKED UNDER ANOTHER NAME? PLEASE LIST:			(For Employment Verification Purposes)
DATE OF PREVIOUS APPLICATION HERE		DATE OF PREVIOUS EMPLOYMENT AT ST. ROSE HOSPITAL	

GENERAL INFORMATION

POSITION(S)/DEPARTMENT DESIRED				2.		
1.		DATE AVAILABLE TO START		CAN YOU WORK WEEKENDS?		SHIFT AVAILABILITY
FULL TIME	PART TIME	PER DIEM/ON CALL		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> DAY <input type="checkbox"/> EVENING <input type="checkbox"/> NIGHT	
CAN YOU ACCEPT CHANGES IN SHIFT WHEN NECESSARY?				CAN YOU ACCEPT CHANGES IN DAYS OFF WHEN NECESSARY?		
<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO		
I AM AVAILABLE FOR WORK AS FOLLOWS:						
HOURS:	AM	TO	AM	DAYS	OF WEEK	
	PM		PM			
NAMES OF RELATIVES EMPLOYED BY ST. ROSE HOSPITAL:				HOW DID YOU FIND OUT ABOUT THE POSITION? Newspaper/Job Hotline/Walk in/Reference. If reference, who?		
ARE YOU OVER 16 YEARS OF AGE?		IF YOU ARE BETWEEN 16 AND 18 YEARS OF AGE CAN YOU PROCUCE A WORK PERMIT?				
HAVE YOU EVER BEEN CONVICTED OF A FELONY?			IF YES, CIRCUMSTANCES			
ARE YOU A U.S. CITIZEN? IF NO, CAN YOU PRESENT AN ALIEN REGISTRATION RECEIPT CARD?						

SKILLS

CHECK ANY OF THE FOLLOWING SKILLS WHICH YOU HAVE AND LIST ANY OTHERS						
<input type="checkbox"/> ACCOUNTING	<input type="checkbox"/> DICTATING (TRANSCRIBING) MACHINES	TYPE _____				
<input type="checkbox"/> BOOKKEEPING	<input type="checkbox"/> COMPUTER/SOFTWARE	TYPE _____				
<input type="checkbox"/> TYPING _____ WPM	<input type="checkbox"/> SHORTHAND _____ WPM	<input type="checkbox"/> WORD PROCESSING _____	<input type="checkbox"/> DATA PROCESSING _____			
RN SPECIALTIES: <input type="checkbox"/> SURGERY <input type="checkbox"/> RECOVERY <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> ADMINISTRATION <input type="checkbox"/> LABOR & DELIVERY <input type="checkbox"/> SKILLED NURSING FACILITY <input type="checkbox"/> CARDIAC REHAB <input type="checkbox"/> CATH LAB						
<input type="checkbox"/> NURSERY <input type="checkbox"/> MEDICAL/SURGICAL <input type="checkbox"/> ICU, CCU <input type="checkbox"/> BCLS _____ EXPIRATION _____	<input type="checkbox"/> ACLS _____ EXPIRATION _____	<input type="checkbox"/> CNRP (NALS) _____ EXPIRATION _____				
OTHERS: _____						
INDICATE ANY FOREIGN LANGUAGE(S) IN WHICH YOU ARE FLUENT: _____						
INDICATE ANY SPECIAL SKILLS OR TRAINING PROGRAMS WHICH MIGHT BE VALUABLE IN YOUR WORK: _____						

LICENSE

PROFESSIONAL LICENSE / REGISTRATION / CERTIFICATE:			
TYPE	STATE	NUMBER	EXPIRATION DATE
VERIFIED BY (FOR INTERVIEWER'S USE ONLY)			

EDUCATION

	SCHOOL NAME	LOCATION	CIRCLE LAST GRADE COMPLETED	MAJOR COURSE	DID YOU GRADUATE?
HIGH SCHOOL			9 10 11 12		
COLLEGE OR UNIVERSITY			1 2 3 4		
GRADUATE SCHOOL			1 2 3 4		
BUSINESS, VOCATIONAL OR NURSING SCHOOL			1 2 3 4		
OTHER SPECIAL EDUCATION (INCLUDE U.S. MILITARY SERVICE SCHOOLS):					

MAY WE CONTACT YOUR PAST/PRESENT EMPLOYER? YES NO

PREVIOUS EMPLOYMENT

LIST ALL PRIOR EMPLOYMENT, INCLUDING MILITARY EXPERIENCE STARTING WITH MOST RECENT EMPLOYMENT FIRST:			
EMPLOYER	DATES OF EMPLOYMENT	POSITION	REASON FOR LEAVING
COMPANY NAME	FROM: MO YR	JOB TITLE	
STREET ADDRESS	TO: MO YR	DUTIES	
CITY AND STATE			
TELEPHONE	SALARY		
SUPERVISOR'S NAME			
COMPANY NAME	FROM: MO YR	JOB TITLE	
STREET ADDRESS	TO: MO YR	DUTIES	
CITY AND STATE			
TELEPHONE	SALARY		
SUPERVISOR'S NAME			
COMPANY NAME	FROM: MO YR	JOB TITLE	
STREET ADDRESS	TO: MO YR	DUTIES	
CITY AND STATE			
TELEPHONE	SALARY		
SUPERVISOR'S NAME			
COMPANY NAME	FROM: MO YR	JOB TITLE	
STREET ADDRESS	TO: MO YR	DUTIES	
CITY AND STATE			
TELEPHONE	SALARY		
SUPERVISOR'S NAME			

St. Rose Hospital is an equal opportunity employer. It is our policy to recruit, hire and promote the best qualified individuals without regard to race, religious creed, color, national origin, ancestry, age, sex, marital status, medical condition or disability which does not impair the individual's ability to do essential job duties.

CERTIFICATION STATEMENT: I hereby certify that all statements made in this application are true. I agree and understand that any omission or misstatement herein of facts will disqualify me from consideration or be cause for termination of employment with St. Rose Hospital. Permission is granted to St. Rose Hospital to investigate employment, education, background, and references. I understand that I will be given a physical examination, and that my employment is contingent upon passing such examination.

DATE: _____ SIGNATURE OF APPLICANT: _____