TOMBIGBEE HEALTHCARE AUTHORITY
Operating Whitfield Regional Hospital

APPLICATION FOR EMPLOYMENT

NAME ____ SOCIAL SECURITY NO. ______________________
Last First Middle

ADDRESS __________________________________ CITY/STATE__________________________ ZIP __________

TELEPHONE: (_________) ____________________ E-MAIL (optional) ________________________________

POSITION APPLIED FOR ____ DATE __________________

PERSONAL INFORMATION

Are you at least 18 years of age? (circle one) Yes No

Are you related to anyone in our employment? Yes No If yes, who and how? ______________________________

Have you ever been convicted of (or pled guilty to) a felony? Yes No

If yes, when and where? ______________________________ What charge? ____________________

Special skills you possess (office/computer equipment, typing, machinery, medical skills/equipment, etc.): ______________________

____

Which shifts would you be available to work? (circle all that apply) 7-3 7a-7p 3-11 11-7 7p-7a 8-5 Flexible/Rotating

Would you be willing to work (circle one): Full time only Part-time only Full-time or part-time

In case of Emergency, Notify:

Name	Address	Phone Number	Relationship
______________________	______________________	__________	______________

EDUCATION

	Name of School (***include dates***)	Location	Did you graduate?	Degree/ Major & Year
High School	______________________	______________________	_____	__________
College	______________________	______________________	_____	__________
Other	______________________	______________________	_____	__________
Other	______________________	______________________	_____	__________

APPLICATION CONTINUED ON BACK SIDE

EMPLOYMENT HISTORY

(List most recent job first)

1) Employer ____ Address ______________________________ Telephone _________________

Position Held ____ Supervisor ____

Dates (From/To) _________________________________ Rate of Pay _________________ Reason for Leaving __________________________

2) Employer ____ Address ______________________________ Telephone _________________

Position Held ____ Supervisor ____

Dates (From/To) _________________________________ Rate of Pay _________________ Reason for Leaving __________________________

3) Employer ____ Address ______________________________ Telephone _________________

Position Held ____ Supervisor ____

Dates (From/To) _________________________________ Rate of Pay _________________ Reason for Leaving __________________________

Are you a former employee of THA and/or Bryan Whitfield Hospital? Yes No

If yes, under what name (if different)? ____

Dates of employment at THA/BWWMH? ____

NOTE: May we contact your present employer? **Yes** **No**

PERSONAL REFERENCES - (List Two - Please Do Not List Relatives or Former Employers)

	Name	Address	Phone Number	Occupation
1)	____________________	____________________	_____________	____________________
2)	____________________	____________________	_____________	____________________

AUTHORIZATION FOR INVESTIGATION AND RELEASE OF INFORMATION

The information contained in this application is given of my own free will and accord, and is true and correct to the best of my knowledge and belief. This is to confirm that the following applicant for employment with the Tombigbee Healthcare Authority authorizes the release of any and all information, which relates to the background of the applicant. This comprises information not only from previous employers, but also the release of police information and any other investigative information that might relate directly or indirectly to the integrity and/or background of the applicant. In order to run a background investigation, it is essential to have the date of birth of the applicant. Release of this information by the applicant shall be voluntary and will be used solely for the purpose as stated.

The following signature provides and acknowledges the right of the Tombigbee Healthcare Authority to acquire the release of said information from any and all sources relating to the background of the applicant/employee, including but not limited to previous employers, current employer, references, acquaintances and/or any law enforcement authority. This signature confirms that the Tombigbee Healthcare Authority and the providing entities will be held harmless and indemnified by the applicant for the provision, receipt and use of the information provided.

______________________________	______________________________	______________________________
Applicant's Signature	Date of Birth	Witness