

EMPLOYMENT HISTORY: Please list your last FIVE employers, starting with your most recent position.

Employer's Name: _____ Phone: _____
Address: _____

Title: _____ Status: Full-Time Part-Time Per Diem
Date of Employment: ____ / ____ / ____ to ____ / ____ / ____ Starting Rate: \$ _____ Ending: \$ _____
Summary of Duties: _____

Reason for Leaving: _____

Employer's Name: _____ Phone: _____
Address: _____

Title: _____ Status: Full-Time Part-Time Per Diem
Date of Employment: ____ / ____ / ____ to ____ / ____ / ____ Starting Rate: \$ _____ Ending: \$ _____
Summary of Duties: _____

Reason for Leaving: _____

Employer's Name: _____ Phone: _____
Address: _____

Title: _____ Status: Full-Time Part-Time Per Diem
Date of Employment: ____ / ____ / ____ to ____ / ____ / ____ Starting Rate: \$ _____ Ending: \$ _____
Summary of Duties: _____

Reason for Leaving: _____

Employer's Name: _____ Phone: _____
Address: _____

Title: _____ Status: Full-Time Part-Time Per Diem
Date of Employment: ____ / ____ / ____ to ____ / ____ / ____ Starting Rate: \$ _____ Ending: \$ _____
Summary of Duties: _____

Reason for Leaving: _____

Employer's Name: _____ Phone: _____
Address: _____

Title: _____ Status: Full-Time Part-Time Per Diem
Date of Employment: ____ / ____ / ____ to ____ / ____ / ____ Starting Rate: \$ _____ Ending: \$ _____
Summary of Duties: _____

Reason for Leaving: _____

Please note any relevant experience such as volunteer service, membership associations, etc:

MISCELLANEOUS INFORMATION:

Have you ever been in the employ of:

- Bertrand Chaffee Hospital
- Jennie B. Richmond Nursing Home
- Primary Care Clinic

No

If YES: Date of Employment: ___/___/___ to ___/___/___
Position: _____

Are you related to anyone who is currently employed by:

- Bertrand Chaffee Hospital
- Jennie B. Richmond Nursing Home
- Primary Care Clinic

No

If YES: Name of Associate(s): _____
Relationship: _____

Can you show proof of your eligibility to work in the United States? Yes No
(Proof will be required upon employment)

EMPLOYMENT REFERENCES: (Must be other than relatives)

Name: _____ Phone: _____
Address: _____
Relationship: _____

Name: _____ Phone: _____
Address: _____
Relationship: _____

Name: _____ Phone: _____
Address: _____
Relationship: _____

I hereby represent that each answer to a question herein and all other information furnished is true and accurate. I further represent that such answers and information constitutes a complete disclosure of my knowledge with respect to the question or subject to which the answer or information relates. I understand that any false statements, incomplete or inaccurate information furnished by me will subject me to discharge at any time. I authorize you to contact my Employment References and investigate any and all information given and release you and my Employment References from any and all liability and responsibility resulting from such investigation.

I consent to any and all medical examinations required by the organization and understand that employment is dependent upon successful completion of a pre-employment physical examination. If employed, I understand that continuance of my employment is contingent upon a favorable report regarding my annual physical examinations.

I understand that this is a non-smoking organization.

Upon termination of employment, I authorize you to release reference information pertaining to my employment.

Signature: _____ Date: _____

**Bertrand Chaffee Hospital, Jennie B. Richmond Nursing Home, and Primary Care Clinic
are an EQUAL OPPORTUNITY EMPLOYER**

Title VII of the Civil Rights Act of 1964 prohibits discrimination in employment because of race, color, creed, religion, sex, or national origin. Federal Law also prohibits other types of discrimination such as age and citizenship. New York State Law prohibits discrimination against any individual because of the age, race, creed, color, national origin, or disability, or marital status of any individual.