

SAN JUAN COUNTY PUBLIC HOSPITAL DIST #1
dba *Inter Island Medical Center*
550 Spring Street
Friday Harbor, WA 98250

APPLICATION FOR EMPLOYMENT

POSITION DESIRED: _____ DATE: _____

NAME: _____ SSN: _____
Last First MI

PREVIOUS NAME(S): _____

ADDRESS: _____
Street City State Zip

PHONE: _____ E-MAIL: _____
Home Cell

EMERGENCY CONTACT: _____
Name Phone # Relationship

- Are you 18 years of age or older? YES NO
- If hired, can you provide written evidence that you are authorized to work in the U.S.? YES NO

EDUCATION

Type: _____ **Name/Location:** _____ **Years completed:** _____ **Degree/Diploma:** _____

High School _____

College: _____

Technical/Other: _____

EMPLOYMENT

Company Name: Dates worked: Type of work: Last rate of pay: Reason for leaving:

1. _____

2. _____

3. _____

4. _____

*If you wish to supply additional education or work history information, include with resume.

REFERENCES:

Name: Address: Phone #: Nature of relationship:

1. _____

2. _____

3. _____

4. _____

How did you learn about this job opening?

Newspaper IIMC Website Employee referral Other _____

Do you have any relatives employed here? YES NO

If yes, please give name(s): _____

Have you previously been employed here? YES NO

If yes, please give dates: _____

Have you been convicted of a criminal offense or been released from prison within the past ten (10) years? YES NO

If yes, please explain fully: _____

Are you able to perform the essential functions of the position for which you have applied, with or without reasonable accommodations? YES NO

Job descriptions are available for review of essential job functions upon request.

WORK SKILLS

(check all that apply)

BUSINESS:

- Typing
- Transcription
- Bookkeeping
- Accounting
- Ten-key
- Accounts Payable
- Accounts Receivable
- Reception
- Switchboard
- Insurance Billing
- Credit/Collections
- Medicare/Medicaid Billing
- Computers
- Word/Excel
- Foreign languages:

MEDICAL:

- Autoclave
- Vital Signs
- Pre-op Prep
- Isolation Technique
- Urinary Catheterization
- Coronary Care
- Charting
- Intensive Care
- Orthopedic
- Geriatric
- Medical/Surgical
- Hospice/Home Health
- Obstetrics
- Oncology
- Emergency Services
- IV Therapy
- Labor & Delivery
- Other: _____

WORK AVAILABILITY: Full time Part time On call

INDICATE THE DAYS YOU ARE AVAILABLE FOR WORK:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

PROFESSIONAL REGISTRATION/LICENSURE:

Type of Registration/License	State	Number
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If you do not have registration or license, have you applied for one? YES NO

If not licensed in Washington, have you applied for reciprocity? YES NO

Have you ever had a professional registration/license revoked, suspended, or restricted? YES NO

If yes, please explain fully:

Has anyone ever complained to a licensing agency or board about you or your work performance? YES NO

Have you ever been sanctioned and/or excluded from participation in Medicare, Medicaid, or other Federal health programs? YES NO

I certify the information set forth in this Application for Employment is true and complete to the best of my knowledge. I understand that, if employed, falsified statements on this application, or failure to furnish all requested information, shall be considered cause for my dismissal.

Employment with Inter Island Medical Center is voluntary and may be terminated, with or without cause, and with or without notice, at any time by you or Inter Island Medical Center. No Clinic representative has the authority to enter into any agreement, either verbal or in writing to the contrary.

I understand my employment shall be contingent upon proof of identity and verification of eligibility for employment in the United States in accordance with the Immigration Reform and Control Act of 1986. I further understand that I will be required to complete a disclosure statement and a Washington State Patrol form under the Washington State Child/Adult Abuse Information Act of 1988. I realize that my employment is contingent upon employment and educational references that are satisfactory to the employer and passing the drug testing requirement, if applicable.

I consent to and authorize Inter Island Medical Center and its personnel to conduct an investigation into my employment and educational history, and to contact any and all of my references. I release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing of such information. If I am employed by Inter Island Medical Center, I release it from any liability for future references it may provide regarding my work history with Inter Island Medical center.

I agree to the above terms:

Printed Name

Date

Signature