

HOSPITAL AUTHORITY OF MILLER COUNTY
MILLER COUNTY HOSPITAL/MILLER NURSING HOME
NEW BEGINNINGS/MILLER COUNTY MEDICAL CENTER

We offer equal employment opportunities to all persons without regard to race, color, religion, sex, age, national origin, disability and veteran status or any other legally protected status.

PERSONAL INFORMATION

Date _____

Last Name _____

First Name _____

Middle Initial _____

Street _____

Apt. Number _____

City _____

State _____

Zip Code _____

Home Phone (include area code) _____

Alternate Phone (include area code) _____

Are you over 18 yrs. old?

Yes No

Are you legally eligible to work in the
United States? Yes No

(Verification will be required upon hire)

WORK STATUS

Position for which you wish to be considered?

1. _____

Full Time

2. _____

Part Time

Date available? _____

Salary desired? _____

Shift desired (please check)

7 a.m. – 3p.m.

3p.m. – 11 p.m.

11p.m. – 7a.m.

12 hours

No Preference

SPECIALIZED SKILLS

List All Specialized Skills: _____

EDUCATION

School Level	Name and Address of School	How many years Attended	Diploma, Degree, or Certificate	Major (Course Of Study)
High School				
College				
Vocation or Business School				

LICENSURE, REGISTRATION AND CERTIFICATION

State or Association	Licensure and/or Registration #	Date Issued	Date Expires

MILITARY SERVICE

Branch of Service: _____ Dates: From: _____ To: _____

Rank at Discharge: _____ Position(s) Held: _____

Specialty Training: _____ Type of Discharge: _____

WORK HISTORY

List your most recent employer first. List all positions held within the last ten (10) years. If you do not have enough space to write please use additional paper. Accuracy of this information is essential. If not completed in full, your application will not be considered.

Name of Previous/Current Employer: _____ Phone No. with Area Code: _____

Address: _____ City: _____ State: _____ Zip: _____

Job Title: _____ Starting Date: _____ Leave Date: _____

Supervisor's Name: _____ Supervisor's Job title: _____

Starting Salary: _____ Final Salary: _____ May we contact your Supervisor? Yes No

Description of Work/Duties: _____

Reason for leaving: _____

Name of Previous/Current Employer: _____ Phone No. with Area Code: _____

Address: _____ City: _____ State: _____ Zip: _____

Job Title: _____ Starting Date: _____ Leave Date: _____

Supervisor's Name: _____ Supervisor's Job title: _____

Starting Salary: _____ Final Salary: _____ May we contact your Supervisor? Yes No

Description of Work/Duties: _____

Reason for leaving: _____

WORK HISTORY

List your most recent employer first. List all positions held within the last ten (10) years. If you do not have enough space to write please use additional paper. Accuracy of this information is essential. If not completed in full, your application will not be considered.

Name of Previous/Current Employer:

Phone No. with Area Code:

Address:

City:

State:

Zip:

Job Title:

Starting Date:

Leave Date:

Supervisor's Name:

Supervisor's Job title:

Starting Salary:

Final Salary:

May we contact your Supervisor? Yes No

Description of Work/Duties:

Reason for leaving:

Name of Previous/Current Employer:

Phone No. with Area Code:

Address:

City:

State:

Zip:

Job Title:

Starting Date:

Leave Date:

Supervisor's Name:

Supervisor's Job title:

Starting Salary:

Final Salary:

May we contact your Supervisor? Yes No

Description of Work/Duties:

Reason for leaving:

Have you ever worked for the Hospital Authority of Miller County or its Entities? Yes No
If yes, when? _____ Position: _____

Name at time of employment: _____

Names of Relatives working at the Hospital Authority of Miller County and its Entities:
_____ Relationship: _____

Names of Friends working at the Hospital Authority of Miller County and its Entities:

In Case of an Emergency, whom should we contact? _____
_____ Phone No.: _____

REFERENCES

Give the names of three non-related persons you have known at least one year.

NAME	ADDRESS	PHONE NUMBER	YEARS ACQUAINTED
1.			
2.			
3.			

Have you ever been convicted of a crime? Yes No
(Conviction will not be an absolute bar to employment.)
If yes, please explain: _____

Have you ever or do you currently have disciplinary action against your
license/certification to practice in this state or any other state? Yes No

Date

Candidate for Employment Signature

Date

Witness

ACKNOWLEDGEMENT OF UNDERSTANDING AND CONSENT

Please Sign the Employment Application Supplement.

The information I have given in this application is true and correct to the best of my knowledge and is subject to validation by the Hospital Authority of Miller County. I understand that any false statements, misrepresentations or omissions on this application may justify refusal or termination of employment.

I understand and agree that, if hired, my employment is at-will meaning that my employment, pay and benefits may be terminated at any time by the Hospital Authority of Miller County and its entities or by me without any prior notice and for any or no reason. I understand that no one other than the Chief Executive Officer/Administrator of the Hospital Authority of Miller County has any authority to enter into any agreement for employment for any specified period of time.

CRIMINAL BACKGROUND CHECK

In keeping with the Hospital Authority of Miller County and its entities commitment to maintain a safe work environment and because of the confidential nature of the business in which the Company is engaged, the Company may conduct background checks on the applicant to determine whether the applicant has had a prior criminal conviction. In that regard, the Hospital Authority of Miller County and its entities asks that you sign the "Consent Form" attached as Exhibit "A".

WORK VERIFICATION ELIGIBILITY

I also understand that employment is contingent upon my providing within three (3) days of employment valid proof of identify and eligibility to work in the U.S. in compliance with the Immigration Reform and Control Act of 1986.

WORK AND PERSONAL REFERENCE CHECK

I authorize the individuals, schools, and employers listed above to provide the Hospital Authority of Miller County and its entities and its authorized agent or representatives with any information that the Hospital Authority of Miller County and entities requires to make an employment decision. I release the Hospital Authority of Miller County and its entities from liability for requesting this information or for using this information when making employment decisions. I release any individual, school, or employer providing such information from liability for issuing/disclosing this information.

CONFIDENTIALITY/SECURITY

If hired, I hereby authorize the Hospital Authority of Miller County and its entities to disclose any information pertaining to my employment with the Hospital Authority of Miller County. If hired, I hereby waive any and all rights and claims against the Hospital Authority of Miller County and its entities, for divulging, disclosing, or providing information during my employment or after my employment terminates, about my employment with the Hospital Authority of Miller County and its entities in response to any request for references or request for information by any entity.

REIMBURSEMENT OF PRE-EMPLOYMENT SCREENING POLICY

The Hospital Authority of Miller County enforces the following policy: Any new employee who voluntarily or un-voluntarily resigns within the first 6 months of employment will have the cost of any pre-employment screening (\$150) deducted from their last paycheck.

HEALTH INSURANCE COVERAGE

The Hospital Authority of Miller County requires all fulltime employees to provide proof of health insurance coverage. Employees who meet eligibility requirements are offered group health insurance coverage through the organization's plan. If the employee is not eligible for the organization's group health insurance plan or chooses not to enroll in the plan, the employee must provide written proof of group health coverage through another company.

Full Name (PRINTED)

Street Address

City, State & Zip Code

Social Security #

Applicant/Employee Signature

EMPLOYEE / APPLICANT CONSENT TO DRUG SCREENING

I, _____, understand that I shall be required to submit to a screening for alcohol, drugs, nicotine, or other controlled substances in connection with my application for employment. I hereby consent for the Hospital Authority of Miller County and its entities, a Collection Facility, and a Reference laboratory to perform appropriate tests or examinations for the presence of alcohol, drugs, nicotine or other chemical substances. Further, I give my consent of the release of the test results, or other medical information to authorized management of the Hospital Authority of Miller County and its entities for appropriate review. I understand that if I refuse to consent, the offer of employment may be withdrawn; I also understand that a positive test result may result in the withdrawal of the offer of employment. I release the Hospital Authority of Miller County and its entities, its employees, management and its designated medical or professional representatives, from any and all claims or causes of action result in from this testing, the release of the results of this testing to authorized persons and any decision resulting therefore. My consent to release the test results to authorized management of the Hospital Authority of Miller County shall be valid for a period of one year from the date written below.

ALCOHOL FREE / DRUG FREE / NICOTINE FREE STATEMENT

The Hospital Authority of Miller County recognizes the health and safety issues of alcohol, nicotine and drug free lifestyles as well as the special responsibility in establishing, maintaining and promoting a healthy and safe environment for patients, family members and employees. Pursuant to this recognition and responsibility, all entities of the Hospital Authority of Miller County require candidates for employment to pass a drug/alcohol/nicotine screening test covering illegal substances and legal substances subject to abuse.

Effective 10/5/2010, the Hospital Authority of Miller County and any of its entities does not hire individuals, including previous employees, who use tobacco or nicotine in any form. As well as any candidates who test positive for illegal substances and legal substances that are subject to abuse.

The Hospital Authority of Miller County and its entities require all candidates for employment to submit to a urine and/or blood test and to sign the attached consent and release statement. Refusal or positive test results will result in disqualification for employment. If hired, employees may also be asked to submit to alcohol, drug, and nicotine testing in accordance with the organization's Drug Free Workplace policy and procedure.

Date

Candidate for Employment Signature

Date

Witness

EXHIBIT A
CRIMINAL HISTORY CONSENT

Georgia State Law requires a criminal history check as a condition for employment for nursing homes. Criminal History checks will be done as a consideration of employment for potential employees of all entities of the Hospital Authority of Miller County Hospital.

I hereby authorize the Hospital Authority of Miller County d/b/a/ Miller County Hospital, Miller Nursing Home, New Beginnings and Miller County Medical Center, PO Box 7, Colquitt, GA 39837 229-758-3385 and any of their representative or agents, to receive any criminal history information pertaining to me which may be in the files of any federal, state, or local criminal justice agency.

I hereby waive any and all rights and claims against, the Hospital Authority of Miller County and its entities and any of their representatives or agents, for seeking, gathering, and using such information in the employment process.

PLEASE HAND-PRINT THE FOLLOWING INFORMATION, DO NOT TYPE.

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Race: _____ Sex: _____

Social Security Number: _____

Signature: _____ Date: _____

Witness: _____ Date: _____