



Little River Memorial Hospital

451 West Locke Street, Ashdown, AR 71822

EMPLOYMENT APPLICATION

Human Resources Department
Hospital (870) 898-5011 ex. 3135
Home Health (870) 898-4120

LAST NAME	FIRST	MIDDLE	DATE OF APPLICATION	DATE AVAILABLE FOR WORK
(1) _____	(2) _____	(3) _____	(FT) _____ (PT) _____ AVAILABILITY	(1) _____ (2) _____ (3) _____
POSITION APPLIED FOR			SHIFT PREFERENCE (Check All That Apply)	

An application is valid for a period of three (3) months. If an applicant wishes to continue to be considered for employment after this time they should notify the Human Resources Department.

All applicants will be considered without regard to race, color, creed, religion, national origin, sex, age, or disability.

Name _____ Social Security # _____
 Last First Middle

How were you referred? _____ Were you ever employed here before? Yes No

If yes, when? _____ Name used if different _____

Present Address _____ Home Phone # _____

_____ Work Phone # _____

_____ May we contact you at work? _____

(City) _____ (State) _____ (Zip) _____ How long have you lived at this address? _____

Previous Address _____

(City) _____ (State) _____ (Zip) _____ How long did you live at this address? _____

Do you have relatives/friends working here? _____ If so, Who? _____ What Department? _____

Are you eligible to work in the Unites States? Yes ___ No ___ Are you over 18 years of age? Yes ___ No ___

In case of emergency, notify: _____ Phone # _____

EDUCATION	Major	
High School Name		If registered or licensed, Please indicate type of Registry/License No. _____ State _____
Address		
College or University Name		
Address		
Professional or Technical		
Address		

Circle Highest Year of Education Completed – 1 2 3 4 5 6 7 8 9 10 11 12 GED 13 14 15 16 Over 16

OFFICE SKILLS
 Typing Speed W.P.M. _____ Word Processing/Data Entry Yes _____ No _____
 Medical Terminology Yes _____ No _____
 List office machines which you can operate: _____

EMPLOYMENT HISTORY (Please list all employers, attach additional sheet if necessary)

Name Used, if different _____

Present or Last Employer _____ Employed From _____ To _____

Address _____ Phone # _____

Starting Rate of Pay _____ Last Rate of Pay _____ Supervisor _____

Give title and describe in detail the work you did _____

Reason for leaving _____

Name Used, if different _____

Present or Last Employer _____ Employed From _____ To _____

Address _____ Phone # _____

Starting Rate of Pay _____ Last Rate of Pay _____ Supervisor _____

Give title and describe in detail the work you did _____

Reason for leaving _____

Name Used, if different _____

Present or Last Employer _____ Employed From _____ To _____

Address _____ Phone # _____

Starting Rate of Pay _____ Last Rate of Pay _____ Supervisor _____

Give title and describe in detail the work you did _____

Reason for leaving _____

PERSONAL REFERENCES (other than relatives)

Name _____ Phone # _____

Address _____

Name _____ Phone # _____

Address _____

Name _____ Phone # _____

Address _____

Military Experience _____ From _____ To _____
Branch Rank

Last Assignment _____

Give title and describe in detail the work you did _____

Have you ever applied here before? _____ If yes, when? _____

Have you ever been convicted of a Misdemeanor? Yes ___ No ___ and / or Felony? Yes ___ No ___

If yes, give date and details _____

1. I certify that the information I have furnished in this application is true and complete to the best of my knowledge, With the understanding that it is subject to verification before and during employment. I grant permission to the Hospital to contact any former employers or any others persons about me and my permission is not limited to those listed on this application. I understand and agree that misrepresentation, falsification or omission of information will be considered sufficient cause for rejection or dismissal, if employed.
2. I understand that regardless of the shift and job I am first assigned, I may be required to accept a change of job or Shift depending on my demonstrated skills after employment and the needs of the Hospital.
3. I understand that I must meet the health standards established by the State Board of Health for health care workers and must Be able to perform essential duties of the position with or without reasonable accommodations as a condition of employment.
4. I understand that if I am employed by the Hospital, the Hospital retains its rights to be an at-will employer and the Employment relationship is for an indefinite period and may be terminated by either party, at any time, with or without cause. I understand that no representative of the Hospital, other than the Administrator or Director of Human Resources, has any authority to enter into any agreement for employment for my specified period of time.

5. REFERENCE CHECK CONSENT FORM

I, _____, HEREBY GIVE CONSENT TO ANY AND ALL PRIOR EMPLOYERS TO PROVIDE INFORMATION WITH REGARD TO MY EMPLOYMENT WITH PRIOR EMPLOYERS TO LITTLE RIVER MEMEORIAL HOSPITAL. THIS CONSENT WILL BE VALID FOR THE LENGTH OF TIME THAT THE APPLICATION IS ACTIVE AND IN NO EVENT LONGER THAN SIX MONTHS. I AUTHORIZE MY PAST EMPLOYERS AND OTHER PERSONS TO SUPPLY ANY INFORMATION THEY HAVE CONCERNING ME OR MY WORK PERFORMANCE AND RELEASE THEM FROM ALL LIABILITY IN CONNECTION THEREWITH.

May we contact your present employer? Yes ___ No ___

Applicant Signature _____ Date _____

LITTLE RIVER MEMORIAL HOSPITAL
IS AN EQUAL OPPORTUNITY EMPLOYER

Drug abuse screening is required prior to and after employment.

FOR HOSPITAL USE ONLY-DON NOT WRITE BELOW THIS LINE

Interviewed by _____ Date _____

Interviewed by _____ Date _____

Starting Date _____ Title _____ Dept. _____ Shift _____

Base Rate \$ _____ PT ___ FT ___ PRN ___ TEMP ___ Approved by _____