



EDUCATION AND TRAINING															
	Elementary School				High School				College/University				Additional Information		
School Name and Location															
Years Completed	4	5	6	7	8	9	10	11	12	1	2	3	4	5+	
					Year: _____				Describe Degree(s) _____				Date: _____		
					<input type="checkbox"/> Diploma _____ <input type="checkbox"/> GED _____				License Type and Expiration Date: _____						
<p>If a license, certificate or registration is required for the position for which you are applying, please answer the following questions:</p> <p>1) Has your license / certificate ever been suspended / revoked?            1-a. <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____            1-b. Why? _____            1-c. When were you or will you be reinstated? _____            1-d. Driver's license: _____            1-e. Expiration date: _____</p> <p>2) Were you sanctioned by Medicare or Medicaid?            2-a. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____            2-b. Describe the circumstances: _____            2-c. Was legal action taken against you? _____            2.d. For what agency or employer were you working at the time of the incident? _____            2.e. When were you or will you be released from this sanction? _____</p> <p>3) I understand that in the event I am sanctioned or have my license / certificate suspended or revoked during my employment with OMH, I am responsible to disclose this information to OMH immediately. I further understand that failure to disclose this information will be grounds for immediate termination and possible legal action against me.</p> <p style="text-align: right;">SIGNED: _____ Date: _____</p>															
Describe any specialized training, apprenticeship, skills, etc:															
ADDITIONAL INFORMATION															
1. To your knowledge, do you have any relatives working for OMH? <input type="checkbox"/> No <input type="checkbox"/> Yes – Give name(s) (Relatives may not work in same department)															
Department: _____															
2. Have you been convicted of a felony? (conviction will not necessarily disqualify an applicant from employment) <input type="checkbox"/> No <input type="checkbox"/> Yes – Give details, including dates: _____															
3. Can you travel if the job requires it? <input type="checkbox"/> Yes <input type="checkbox"/> No (Answer only if job requires travel) Can you work overtime if the job requires it? <input type="checkbox"/> Yes <input type="checkbox"/> No															
4. Do you have any circumstances which would limit your ability to do all the duties of this job on any day on any shift? <input type="checkbox"/> No <input type="checkbox"/> Yes – If so, describe what can be done to accommodate this condition: _____															
5. Have you worked for OMH before? <input type="checkbox"/> No <input type="checkbox"/> Yes – Give dates: From: _____ To: _____															
6. Are you legally able to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (Proof of citizenship or immigration status will be required upon employment.)															
REFERENCES															
Please give the name, address, and telephone number of three persons who are not related to you, and who would have knowledge of your experience and suitability for this position. (Failure to provide such references may disqualify you from further consideration.)															
Name				Address				Phone No.							
Name				Address				Phone No.							
Name				Address				Phone No.							
1. I understand that I may be required to pass an employment physical as a condition of employment, (includes drug-screen) 2. I authorize my previous schools, employers, organizations, and others I have named to furnish OKMULGEE MEMORIAL HOSPITAL, INC. my record and information concerning my suitability for employment. I hereby release them and OKMULGEE MEMORIAL HOSPITAL, INC. from all liability for requesting or releasing this information. 3. Upon my termination from employment with OKMULGEE MEMORIAL HOSPITAL, INC., I authorize release of information regarding my work, and I release OKMULGEE MEMORIAL HOSPITAL, INC. from liability for releasing such information. 4. I hereby certify that statements I have made in this application are true and complete. I understand the reasons for providing this information. I also understand that if I have intentionally made any false statements or withheld information, I may be terminated from my job, and I may be disqualified from re-employment.															
Applicant's Signature										Date					



# SUPPLEMENTAL EMPLOYMENT INFORMATION

This information is being gathered for affirmative action under Section 503 of the Rehabilitation Act of 1973. This information requested is voluntary and will be kept confidential. An applicant will not be subject to any adverse treatment for refusing to complete the questionnaire.

## AFFIRMATIVE ACTION QUESTIONNAIRE

The purpose of this section is to assist in monitoring Affirmative Action Programs and to aid in complying with any required Governing record keeping of periodic reporting. This information is not part of your employment application and will not be considered in the employment / selection process. If you choose to provide the information, please complete the following:

Title of job applied for: \_\_\_\_\_ Sex:  Male  Female

### RACE (check one)

- White – origins in Europe, North Africa, or Middle East
- Asian – origins in Far East, E.S. Asia, India or Pacific Islands
- Black – origins in Africa
- Hispanic – Mexican, Puerto Rican, Cuban, Central or South American
- American Indian – origins in North America, to include Alaska

### VETERANS / U.S. MILITARY STATUS

- (0) Non-Veteran
- (1) Pre-Vietnam Veteran
- (2) Pre-Vietnam Veteran with service incurred disability
- (3) Vietnam Era Veteran (8/5/64 – 5/7/75)
- (4) Vietnam Era Veteran with service incurred disability
- (5) Post Vietnam Veteran
- (6) Post Vietnam Veteran with service incurred disability

### ACTIVE NATIONAL GUARD OR RESERVIST (check one)

- Yes
- No

### PHYSICAL CONDITION

- (1) No Handicap
- (2) Physical Handicapped (No Facility Modification)
- (3) Physical Handicapped (Facility Modification)
- (4) Health Handicapped (Heart Attack, Diabetic, Seizures, etc.)
- (5) Mentally Handicapped (Learning Disability)



# REFERENCE INQUIRY

**TOP PORTION MUST BE FILLED OUT COMPLETELY**

**PLEASE PRINT REFERENCE NAME AND FULL ADDRESS BELOW**

\_\_\_\_\_  
Previous Employer Name

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip

Employment Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

Job Title While Employed: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**You are authorized to furnish Okmulgee Memorial Hospital any information you may have. I release you from liability for damages arising from said information provided either orally or by letter.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

**APPLICANT: DO NOT WRITE BELOW THIS LINE**

**PREVIOUS EMPLOYER:** Please complete the following and return in self-addressed envelope.

Are Employment dates correct?  Yes  No If no, correct dates are: \_\_\_\_\_

Reason for leaving? \_\_\_\_\_

Would you rehire?  Yes  No

If No, why? \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name of Person Completing Form: \_\_\_\_\_

Signature of Person Completing Form: \_\_\_\_\_

Title: \_\_\_\_\_