



CENTRAL FLORIDA HEALTH ALLIANCE

Leesburg Regional Medical Center • The Villages Health System

Employment Application Form

This application is not valid for employment purposes until received and screened by The Central Florida Health Alliance Human Resources Department. Central Florida Health Alliance operates under a Drug-Free Workplace policy. Prior to employment, all final candidates must pass a drug screening.

An Equal Opportunity/Affirmative Action Employer

Applications remain active for 90 days

Social Security Number: _____ - _____ - _____		Application Date: (mm/dd/yy)	
Last Name:		First	Middle
Present Address: Street		City	State Zip Code
Permanent Address: Street		City	State Zip Code
Home Telephone: () -		Business: () -	Cell: () -
E-mail Address: _____			
Are you legally authorized to work in the United States?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will you now or in the future require sponsorship for employment status (e.g., H1B status)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you at least 18 years of age?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How were you referred to Central Florida Health Alliance? <input type="checkbox"/> Job Fair (Date: _____) <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Journal <input type="checkbox"/> Internet <input type="checkbox"/> Radio <input type="checkbox"/> College <input type="checkbox"/> Team Member <input type="checkbox"/> Instructor <input type="checkbox"/> Friend Name of referral source: _____			
Have you been previously employed by Central Florida Health Alliance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dept: _____ From: _____ To: _____ Reason for leaving: _____			
Do you share a household with, or are you related by blood or marriage to anyone currently employed by Central Florida Health Alliance that would either be working in the same department that you have applied for, or would be in a supervisory position over the job you applied for? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, give the names, relationship and department of all such persons:			
Have you filed an application with Central Florida Health Alliance within the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Position Desired		Salary Expected	
Available to begin work on:			
Employment Desired:		<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time <input type="checkbox"/> Temporary <input type="checkbox"/> Pool <input type="checkbox"/> Seasonal
If full-time work is desired but not available, would you consider working part-time?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shifts available to work:		<input type="checkbox"/> 7a-3p <input type="checkbox"/> 3p-11p <input type="checkbox"/> 11p-7a <input type="checkbox"/> 7a-7p <input type="checkbox"/> 7p-7a	<input type="checkbox"/> 8a-5p <input type="checkbox"/> Any
Will you work overtime?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Will you work weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you are hired by Central Florida Health Alliance, your hours of work, shift and schedule may change according to operational requirements. Your signature below indicates you understand and will abide with these guidelines.			
Signature _____		Date _____	

Name

Date

SPECIAL SKILLS, CERTIFICATIONS, LICENSURES

Special knowledge, skills, and abilities you wish to be considered. Include equipment or machines you operate, computer languages, laboratory techniques, etc. If applying for secretarial/typist positions, indicate typing speeds.

List fields of work for which you are licensed, registered, or certified. Please include license numbers, dates, and sources of issuance.

Type	Number	Effective Date	Issuing State/Authority

Are you a veteran? No Yes If YES, indicate dates of military service: _____

Are you a member of the Military Reserves? Yes No

Please list two technical or clinical references we may contact:

Name	Business	Phone Number	Cell Number

EDUCATION AND TRAINING

Circle highest grade completed: **6 7 8 9 10 11 12 GED** College: **1 2 3 4** Grad School: **1 2 2+**

Schools	Name	Location	Graduated?	Major/Minor Course Work	Degree Received
High School			<input type="checkbox"/> Yes <input type="checkbox"/> No		
College(s)/ Universities			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Graduate or Professional			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other educational vocation school Internships, etc.			<input type="checkbox"/> Yes <input type="checkbox"/> No		

Courses, seminars, or training programs you have completed that are relevant to the position(s) you seek:

CRIMINAL HISTORY

Have you ever been convicted of a crime, had adjudication withheld, plead no contest (nolo contendere); or do you have charges pending? (anything other than minor traffic offenses) Yes No

If YES, Date: _____ State: _____

Charge(s): _____

Disposition: _____

A conviction does not mean you cannot be hired. The offense and how recently you were convicted will be evaluated in relation to the job for which you are applying.

EMPLOYMENT

Starting with your present or last position, list all employment during at least the past 10 years and relevant experience beyond 10 years. **To list more employment history, please make copies of this page.** Please account for all periods of unemployment for a minimum of the past 10 years. You may submit a resume as a **supplement but not as a substitute for this section.**

May we contact your present employer? Yes No

Employer			Address			
Job Title			Supervisor's Name		Telephone #	# Supervised by you
Date Employed: (mo/yr)		Starting Salary \$ per	Ending Salary \$ per		Reason for Leaving	
Date Separated: (mo/yr)		Duties				
	Years	Months				
Full Time						
Part Time						
Name while employed:						
Employer			Address			
Job Title			Supervisor's Name		Telephone #	# Supervised by you
Date Employed: (mo/yr)		Starting Salary \$ per	Ending Salary \$ per		Reason for Leaving	
Date Separated: (mo/yr)		Duties				
	Years	Months				
Full Time						
Part Time						
Name while employed:						
Employer			Address			
Job Title			Supervisor's Name		Telephone #	# Supervised by you
Date Employed: (mo/yr)		Starting Salary \$ per	Ending Salary \$ per		Reason for Leaving	
Date Separated: (mo/yr)		Duties				
	Years	Months				
Full Time						
Part Time						
Name while employed:						
Employer			Address			
Job Title			Supervisor's Name		Telephone #	# Supervised by you
Date Employed: (mo/yr)		Starting Salary \$ per	Ending Salary \$ per		Reason for Leaving	
Date Separated: (mo/yr)		Duties				
	Years	Months				
Full Time						
Part Time						
Name while employed:						
Employer			Address			
Job Title			Supervisor's Name		Telephone #	# Supervised by you
Date Employed: (mo/yr)		Starting Salary \$ per	Ending Salary \$ per		Reason for Leaving	
Date Separated: (mo/yr)		Duties				
	Years	Months				
Full Time						
Part Time						
Name while employed:						

UNEMPLOYMENT

Dates		State what you were doing	Personal Reference who will verify this information	
From Mo. Yr.	To Mo. Yr.		Name	Address
				Phone
From Mo. Yr.	To Mo. Yr.		Name	Address
				Phone
From Mo. Yr.	To Mo. Yr.		Name	Address
				Phone

Please return or e-mail to the CFHA Human Resource Office: Email: www.CFHAlliance.org

Leesburg Regional Medical Center
600 East Dixie Avenue
Leesburg, Florida 34748
(352) 323-5360

The Villages Health System
1451 El Camino Real
The Villages, Florida 32159
(352) 751-8856

AGREEMENT

- Initial I certify that the answers given by me for the foregoing questions and statements are true and correct without omissions of any kind whatsoever, and hereby grant the hospital permission to verify such answers. I understand that any false or misleading information furnished by me relative to this application for employment shall be considered rejection of my application for further consideration of employment or sufficient cause for dismissal of employment if such false statement(s) is discovered subsequent to my employment. I agree that the hospital shall not be liable in any respect if my employment is terminated because of the falsification of statements, answers, or omissions made by me in this application.
- Initial I certify that I have not been convicted, plead no contest, been placed on probation or had adjudication withheld for the commission of any crime, other than minor traffic violations, in the United States or any foreign country. I further certify that I do not currently have criminal charges pending against me.
- Initial I authorize the hospitals, companies, schools or persons named in this application to give any information regarding my employment, together with any other information that they may have regarding me whether or not it is in their records. I also understand that an offer of employment will be conditioned upon successfully completing a clear background and criminal investigation, HRS Department report, employment references, and a pre-placement drug screen and health assessment.
- Initial If accepted for employment, I agree to comply with the rules and policies of this hospital and the department or unit to which I am assigned.
- Initial This is to inform you that as part of our procedures for processing your employment application, or for otherwise determining your eligibility for a position with our Company, a consumer report may be obtained for employment purposes. Further information may be obtained through personal/telephonic interviews with third parties, such as previous employers, business associates, financial sources, friends, neighbors, educational institutions or others with whom you are acquainted. This inquiry may include information as to your character, general reputation, personal characteristics, and mode of living, whichever may be acceptable. You have the right to make a written request within a reasonable period of time to a copy of your consumer reports.
- Initial I authorize LRMC/TVRH to conduct background/information checks to verify or obtain additional information as part of recruitment or at established intervals (eg. Consumer reports or government sanctions/exclusive lists.)
- Initial I certify that I am not now excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs; and I have not been convicted of a criminal offense related to provision of health care items or services, or if I have been, I have been reinstated.

Signature: _____

Date: _____

HUMAN RESOURCES

Sent To: _____	Screened: _____	Logged in: _____
_____	Date: _____	_____
_____	Date: _____	_____
_____	Date: _____	_____