



Bibb Medical Center
208 Pierson Avenue
Centreville, AL 35042

APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY EMPLOYER M/F/DISABILITY

APPLICATION DATE: _____

PERSONAL DATA			REFERRED BY		
Last Name	First Name	Middle Name	Position Desired		
Current Address (Number and Street)			(Check) Full Time () Part Time () Temp ()		
City, State, and Zip Code			Willing to work shifts? Evening Yes () No () 3 pm to 11 pm Yes () No () Nights Yes () No () 11 pm to 7 am Yes () No ()		
Telephone			Social Security No.		
Date of Birth			SELECTIVE SERVICE DATA Have you ever been in the U.S. Military Service? Yes () No ()		
Professional Licensure/Registry/Certification Number:			Date of Service From: To:		
Salary Desired:			List Service Schools		
EDUCATIONAL DATA					
Name and Address of High School		Course or Major	Dates Attended	Graduate?	Date
Name and Address of College		Course or Major	Dates Attended	Graduate?	Degree
Name and Address of Business, Technical or Professional School (s) Attended		Course or Major	Dates Attended	Graduate?	Degree or Diploma
Other Special Training					
SPECIAL SKILLS AND INTERESTS					
List Any Maintenance or Shop Equipment or Office Machines You Operate					
Do you type? _____ WPM _____					
I understand that Bibb Medical Center reserves the right to administer a drug test to any applicant or employee at any time and I give my consent to such a test.					
Signature _____					

Professional organizations, interests, hobbies (omit any which might indicate race, religion, color, national origin, or ancestry)

EMPLOYMENT DATA

Begin with your most recent job:

DATES OF EMPLOYMENT (Give Month and Year) FROM TO	Employer's Name	Salary Starting _____ Ending _____
	Employer's Address	Duties
	Supervisor's Name	
	Reason For Leaving	May we contact your current employer? Yes _____ No _____
DATES OF EMPLOYMENT (Give Month and Year) FROM TO	Employer's Name	Salary Starting Salary _____ Ending _____
	Employer's Address	Duties
	Supervisor's Name	
	Reason for Leaving	May we contact your current employer? Yes _____ No _____
DATES OF EMPLOYMENT (Give Month and Year) FROM TO	Employer's Name	Salary Starting Salary _____ Ending _____
	Employer's Address	Duties
	Supervisor's Name	
	Reason for Leaving	May we contact your current employer? Yes _____ No _____

GIVE NAME AND ADDRESS OF PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name Phone Number & Street

City, State and Zip

Have you ever worked at Bibb Medical Center before? _____

If yes, give date: From _____ To _____

Names of relatives employed by Bibb Medical Center: _____

MISCELLANEOUS INFORMATION

1. Have you ever been convicted of a felony or are you currently under investigation for any offense? (Check one) Yes _____ No _____

If yes, list off _____

Date of Conviction (s): _____

2. Have you ever been refused a surety bond? Yes _____ No _____

3. Have you ever been fired or asked to resign? Yes _____ No _____

If yes, please explain: _____

4. Are you currently being investigated by any Board of Nursing or Nurse Aid Registry? Yes _____ No _____

If yes, please explain: _____

5. Have you ever been investigated by the Board of Nursing or Nurse Aid Registry? Yes _____ No _____

If yes, please explain: _____

NOTE: An answer of yes to either question does not necessarily disqualify you for employment at Bibb Medical Center or any of its affiliates.

CERTIFICATION OF APPLICANT

THE INFORMATION GIVEN IN THIS APPLICATION IS GIVEN OF MY OWN FREE WILL AND ACCORD AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS IS MY EXPRESS PERMISSION FOR BIBB MEDICAL CENTER TO CONDUCT AN INVESTIGATION INTO MY BACKGROUND, EXPERIENCE, QUALIFICATIONS, ETC. I FULLY UNDERSTAND THAT, AS A CONDITION OF EMPLOYMENT, I WILL BE REQUIRED TO TAKE A PHYSICAL EXAMINATION AND THE INTERPRETATION OF THE RESULTS OF SUCH EXAMINATION SHALL BE MADE BY BIBB MEDICAL CENTER, IN ACCORDANCE WITH THE REHABILITATION ACT OF 1973. I FULLY UNDERSTAND THAT THE PERSONAL AND FAMILY MEDICAL RECORD FORM WILL BE KEPT CONFIDENTIAL, EXCEPT TO THE EXTENT THAT DISCLOSURE MAY BE REQUIRED IN ORDER TO COMPLY WITH THE REHABILITATION ACT OF 1973 OR ENSURE MY SAFETY OR THAT OF OTHER EMPLOYEES. ANY FALSE STATEMENT HEREON, OR ANY WITHHOLDING OF REQUESTED INFORMATION WILL BE SUFFICIENT CAUSE FOR REJECTION OR TERMINATION. I FURTHER UNDERSTAND THAT THIS STATUS CAN ONLY BE ALTERED BY A WRITTEN CONTRACT OF EMPLOYMENT WHICH IS SPECIFIC AS TO ALL MATERIAL TERMS AND IS SIGNED BY BOTH ME AND THE ADMINISTRATOR OF BIBB MEDICAL CENTER.

SIGNATURE OF APPLICANT _____ DATE _____

NOTICE: Federal law requires all employers to verify the identity and employment eligibility of all persons hired to work in the United States. (Bibb Medical Center utilizes E-Verify for employment verification. Proper identification must be presented if applicant is offered employment.)