



COMMUNITY MEDICAL CENTER
1822 Mulberry Street
Scranton PA 18510

APPLICATION GUIDE

The following information is provided to assist you in completing the Employment Application attached and to provide other information concerning possible employment at Community Medical Center.

www.cmchealthsys.org

1. Please **print** all information.
2. Incomplete or unsigned applications will not be considered.
3. All information must be completed even if a resume is attached.
4. If employed, you will be required to submit documents which confirm your identity and eligibility to work in the United States.
5. Should you be offered employment, you will be required to pass a pre-employment physical.
6. Should you be offered employment, you will be required to comply with all hospital policies work rules and procedures, including, but not limited to, the CMCHS Integrity Plan, compliance with which is a factor considered in performance evaluations.
7. Please give complete information regarding references. (Name, address and phone number).
 - a. Attach three letters of reference with this application or
 - b. Submit three letters of reference to Human Resources for inclusion with your application.
(Blank reference sheets have been attached to this application for your convenience in obtaining work references)
8. The hospital will perform a routine background investigation for the verification of information provided on the employment application. Any omissions, falsifications, or misrepresentations will constitute grounds for applicant disqualification and/or termination should you become employed.
9. Please ask for any assistance needed in completing this application.



COMMUNITY MEDICAL CENTER HEALTHCARE SYSTEM
 1822 Mulberry Street
 Scranton PA 18510
 FAX 570-969-8640

WWW.CMCHEALTHSYS.ORG

EMPLOYMENT APPLICATION

APPLICATION DATE: _____

Please print all information

Incomplete Applications will not be considered

The Community Medical Center Healthcare System is Smoke-Free, Drug-Free Equal Opportunity Employer. Community Medical Center will not discriminate against any person with respect to age, sex, race, color, marital status, religious affiliation, national origin, ancestry, physical/mental disability, veteran status, sexual orientation, gender-identity or on any basis that would be in violation of any applicable Federal, State or local law.

EMPLOYMENT INFORMATION	Position Desired: _____ Position #: _____ SEEKING: <input type="checkbox"/> Full Time <input type="checkbox"/> Day <input type="checkbox"/> Part Time: Specify Hours: _____ <input type="checkbox"/> Evening <input type="checkbox"/> PRN <input type="checkbox"/> Night <input type="checkbox"/> Summer/Temporary <input type="checkbox"/> Rotating <input type="checkbox"/> Weekends Are you available to work weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No Date available for work: _____
PERSONAL INFORMATION	Last: _____ First: _____ Middle: _____ (Include other names by which you are or have been known): _____ Street Address: _____ City: _____ State: _____ ZIP: _____ Phone Number: (____) _____ Alternate Phone Number where you can be reached: (____) _____ Number of years living in PA: _____ Previous State (if less than 10 years) _____ E-mail address: _____ Are you 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you legally eligible for employment in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No List any relatives who are currently employed by CMCHS (<i>hospital policy prohibits the employment of relatives within the same department on the same shift or in a superior/subordinate relationship</i>) Name: _____ Relationship: _____ Department: _____ Name: _____ Relationship: _____ Department: _____ Have you ever been convicted of, or pled guilty to a felony or misdemeanor? (excluding misdemeanor traffic violations)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and describe? _____ Do you have any criminal convictions or any pending criminal charges in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and describe? _____ (A conviction will not automatically disqualify you from being considered as a candidate for employment.) Have you ever been, or are you now excluded from any government program (i.e. Medicare) <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been employed by CMCHS? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where _____ How did you learn about our facility? (Please Specify) <input type="checkbox"/> Newspaper <input type="checkbox"/> Other Publication <input type="checkbox"/> Job Fair/Open House <input type="checkbox"/> School <input type="checkbox"/> Other _____ <input type="checkbox"/> Hospital Employee _____ <div style="text-align:right;">(one name only!)</div>
RESIDENTIAL HISTORY	List Below Starting With The Last Previous Address First. All applicants must account for the last 10 years. City: _____ County: _____ State: _____ Zip: _____ Lived There From: _____ To: _____ City: _____ County: _____ State: _____ Zip: _____ Lived There From: _____ To: _____ City: _____ County: _____ State: _____ Zip: _____ Lived There From: _____ To: _____

PLEASE LIST YOUR JOB HISTORY, STARTING WITH YOUR PRESENT OR MOST RECENT EMPLOYMENT AND NOTING ANY PERIODS IN WHICH YOU WERE NOT EMPLOYED IN THE SECTION MARKED "ADDITIONAL INFORMATION" ON THE FOLLOWING SHEET.

EMPLOYMENT HISTORY	1	Company name: _____ Address: _____ Your Supervisor: _____ Your Job title: _____ Your Job Responsibility: _____ _____	Telephone: (____) _____ Employed (Mo/Yr) From _____ To _____ Rate of pay: Start Rate: _____ Final Rate: _____ Reason for leaving: _____ _____
	2	Company name: _____ Address: _____ Your Supervisor: _____ Your Job title: _____ Your Job Responsibility: _____ _____	Telephone: (____) _____ Employed (Mo/Yr) From _____ To _____ Rate of pay: Start Rate: _____ Final Rate: _____ Reason for leaving: _____ _____
	3	Company name: _____ Address: _____ Your Supervisor: _____ Your Job title: _____ Your Job Responsibility: _____ _____	Telephone: (____) _____ Employed (Mo/Yr) From _____ To _____ Rate of pay: Start Rate: _____ Final Rate: _____ Reason for leaving: _____ _____
	4	Company name: _____ Address: _____ Your Supervisor: _____ Your Job title: _____ Your Job Responsibility: _____ _____	Telephone: (____) _____ Employed (Mo/Yr) From _____ To _____ Rate of pay: Start Rate: _____ Final Rate: _____ Reason for leaving: _____ _____

We may contact your prior employers listed above (including the supervisors and/or managers for those employers) unless you indicate in writing in the box to the right any (or all) of those whom you do not authorize us to contact.

DO NOT CONTACT EMPLOYER NUMBER(S)

REASON: _____

EDUCATIONAL INFORMATION	High school: (Name and City): _____					
	Graduated: <input type="checkbox"/> Yes <input type="checkbox"/> No Course: _____ If GED, Date Received: _____					
	College or other Schools attended	Location City & State	Did you graduate?	Year	Diploma Degree or Cert	Course of Study
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				

PROFESSIONAL LICENSURE REGISTRY, CERTIFICATION	The Commonwealth of Pennsylvania regulations and the mandates of the Joint Commission for Accreditation of Healthcare Organizations require that all registered, licensed and certified employees submit proof of same to his/her employer. Documentation required upon employment.			
	Type of License, Registry Or Certification	Issuing State or Organization	Number	Expiration Date
	Have your Professional Licensees and/or certificates ever been suspended, revoked or restricted, or were you placed on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and for what reason? _____ If not currently registered, licensed or certified, are you eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No When will you/did you sit for your examination? Date: _____			
SPECIAL SKILLS	<input type="checkbox"/> Personal Computer <input type="checkbox"/> Microsoft Word <input type="checkbox"/> Microsoft Excel <input type="checkbox"/> Medical Terminology <input type="checkbox"/> Transcription <input type="checkbox"/> Typing _____ WPM Other Special Skills: _____ _____			
MILITARY EXPERIENCE	U. S. Military Branch: _____ Rank at Discharge: _____ Active Duty Entry Date: _____ Date of Discharge: _____ Training or Specialty: _____ _____			
ADDITIONAL INFORMATION	Please include any additional information that you think would be applicable: e.g., internships, membership in professional organizations, additional relevant employment, and explanation of any gaps in employment. _____ _____ _____ _____			
PERSONAL/PROFESSIONAL REFERENCES	<p style="text-align: center;">List three work references or individuals who can evaluate your work performance (No Relatives).</p> Name: _____ Home Phone: _____ Address: _____ Business Phone: _____ City: _____ State: _____ Zip: _____ Years Acquainted: _____ Occupation: _____			
	Name: _____ Home Phone: _____ Address: _____ Business Phone: _____ City: _____ State: _____ Zip: _____ Years Acquainted: _____ Occupation: _____			
	Name: _____ Home Phone: _____ Address: _____ Business Phone: _____ City: _____ State: _____ Zip: _____ Years Acquainted: _____ Occupation: _____			

**APPLICANT'S CERTIFICATION AND AGREEMENT /
EMPLOYMENT BACKGROUND AUTHORIZATION**

- I hereby affirm that the information provided in this application (and accompanying resume, if any) is true and complete to the best of my knowledge. I also agree that falsified information or significant omissions may disqualify me and may be considered sufficient justification for dismissal if discovered at a later date. When I responded to questions on this application, I continued on a separate sheet of paper and attached it to this application when I required more space to fully answer all questions.
- I understand and agree that all information furnished in this application may be verified by Community Medical Center Healthcare System. I also understand that any employment is subject to satisfactory check of references and satisfactory results of a medical examination. I hereby authorize all individuals and organizations named or referred to in this application and any law enforcement organization to give Community Medical Center Healthcare System all information relative to my employment, work habits, and character and hereby release such individuals, organizations, Community Medical Center Healthcare System, its employees and agents, from any liability for any claim or damage which may result.
- I agree that a photocopy or telephonic facsimile of this authorization shall be valid as the original.
- If hired, I agree to comply with Community Medical Center Healthcare System rules, regulations and policies, and acknowledge that these rules, regulations and policies may be changed, interpreted, withdrawn, or supplemented any time and without prior notice to me.
- Community Medical Center Healthcare System shall not employ or contract individuals who have been convicted of a criminal offense related to healthcare, or who it knows or should have known are, or have been excluded from participation in the Medicare, Medicaid or other federal healthcare programs under Sections 1128, 1128A or 1866 (b)(2) of the Social Security Act. Additionally, if such criminal charges have been filed or are under investigation with respect to an applicant, such applicant is ineligible for employment with CMCHS until such charges or investigation are resolved in favor of applicant.
- If hired, I agree that during my employment with CMCHS if I become excluded from any government program (i.e. Medicare) that it is my obligation to immediately inform the Director of Human Resources of this fact.
- In consideration of my employment, I agree to comply with CMC's rules and regulations, and I agree that as an at-will employee that my employment can be terminated, with or without cause, and with or without notice, at any time, at either my or the organization's option. I also understand and agree that the terms and conditions of my employment may be changed, with or without cause, and with or without notice, at any time by the organization. I understand that no company representative, other than an Administrative Officer, and then only when in writing and signed by the Administrative Officer, has any authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing.
- All phases of employment at Community Medical Center Healthcare System are based strictly upon the qualification of the individual as related to the work requirements of the position
- I understand that an investigative report may be generated on me that may include: information as to my character, work habits, performance and experience, along with reasons for termination of past employment; financial/credit history; criminal history records from any criminal justice agency in any or all-federal, state, city and county jurisdictions; State Department of Motor Vehicle/Drivers' License Records to include traffic citations and registration (where driving is a job-related duty); Military National Personnel Record Center or educational institutions including but not limited to transcripts; any individual, company, firm, corporation, present and/or past employers; public agencies (including the Social Security Administration and the Immigration & Naturalization Service). I fully give my consent to and understand that Community Medical Center may be requesting information from public and private sources about any of the information noted earlier in this paragraph.
- If applicable, all medical and workers' compensation information will be requested in compliance with all Federal and State laws including the Americans with Disabilities Act (ADA).

APPLICANT COMPLETE THE FOLLOWING:

Signature

Today's Date

Please, print full name

If you are an applicant under the age of 18, and not an emancipated minor, a parent or legal guardian's signature is required below

Parent or Legal Guardian signature

Today's Date

Please, print full name

