

**APPLICATION FOR EMPLOYMENT
WINTER HAVEN
AMBULATORY SURGICAL CENTER**

325 Ave. B, N.W.
Winter Haven, Florida 33881
(863) 291-4000

PLEASE PRINT

P E R S O N A L	Name (Last) (First) (Middle) (maiden name)				Date	
	Street Address			Apt. #	Telephone	
	City		State	Zip	Social Security No.	
	Date Available			Salary Requirement		
	How were you referred? Newspaper Ad <input type="checkbox"/> Friend or Relative <input type="checkbox"/> Professional Journal <input type="checkbox"/> Other <input type="checkbox"/>					

J O B I N T E R E S T	Position Applied for	Experience? YES <input type="checkbox"/> NO <input type="checkbox"/>	Do you prefer FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> PRN <input type="checkbox"/>
	Have you ever worked for WHASC? (If yes, state date left) YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you worked for WHASC before under another name? (If yes, state name) YES <input type="checkbox"/> NO <input type="checkbox"/>	
	Have you ever applied for work at WHASC? (If yes, state when) YES <input type="checkbox"/> NO <input type="checkbox"/>	Hours you can work?	
	PLEASE CHECK ANY OF THE FOLLOWING SKILLS WHICH YOU MAY HAVE:		
<input type="checkbox"/> Typing WPM _____ <input type="checkbox"/> Medical Terminology <input type="checkbox"/> Filing <input type="checkbox"/> Shorthand/ Speedwriting WPM _____			<input type="checkbox"/> Transcription <input type="checkbox"/> Data Entry <input type="checkbox"/> Personal Computers <input type="checkbox"/> Bookkeeping <input type="checkbox"/> Other Skills & Machines _____ _____ _____ _____

E D U C A T I O N	SCHOOL	NAME AND LOCATION OF SCHOOL	COURSE OF STUDY	NO. OF YEARS COMPLETED	DID YOU GRADUATE?	YEAR OF GRADUATION	DEGREE OR DIPLOMA
	High School					N.A.	
	College						
	Post Graduate						
	OTHER (Business, Trade, Nursing, Correspondence)						

**AN EQUAL OPPORTUNITY EMPLOYER
A DRUG FREE WORKPLACE**

**MOST RECENT EMPLOYMENT FIRST. COMPLETE FULLY EVEN IF WE HAVE YOUR RESUME
PLEASE EXPLAIN ANY LAPSES IN EMPLOYMENT RECORD**

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1	Employer Name _____	FROM	TO	IMMEDIATE SUPERVISOR	LAST SALARY <small>Hourly, Monthly or Yearly</small>
	Address _____	MO / YR	MO / YR		
	City, State _____ Zip _____	Describe Job Duties _____			
	Phone Number _____				
	Job Title _____				
Reason For Leaving _____					

2	Employer Name _____	FROM	TO	IMMEDIATE SUPERVISOR	LAST SALARY <small>Hourly, Monthly or Yearly</small>
	Address _____	MO / YR	MO / YR		
	City, State _____ Zip _____	Describe Job Duties _____			
	Phone Number _____				
	Job Title _____				
Reason For Leaving _____					

3	Employer Name _____	FROM	TO	IMMEDIATE SUPERVISOR	LAST SALARY <small>Hourly, Monthly or Yearly</small>
	Address _____	MO / YR	MO / YR		
	City, State _____ Zip _____	Describe Job Duties _____			
	Phone Number _____				
	Job Title _____				
Reason For Leaving _____					

4	Employer Name _____	FROM	TO	IMMEDIATE SUPERVISOR	LAST SALARY <small>Hourly, Monthly or Yearly</small>
	Address _____	MO / YR	MO / YR		
	City, State _____ Zip _____	Describe Job Duties _____			
	Phone Number _____				
	Job Title _____				
Reason For Leaving _____					

5	Employer Name _____	FROM	TO	IMMEDIATE SUPERVISOR	LAST SALARY <small>Hourly, Monthly or Yearly</small>
	Address _____	MO / YR	MO / YR		
	City, State _____ Zip _____	Describe Job Duties _____			
	Phone Number _____				
	Job Title _____				
Reason For Leaving _____					

May we contact the employers listed above? YES NO If no, indicate which ones we should not contact and why.

L I C E N S U R E

LICENSURE, CERTIFICATION OR REGISTRATION (Other than Nursing)

Please list any certification, registration or licenses held pertaining to position desired:

Type _____ No. _____ State _____ Year _____

Expiration Date _____ Temporary _____ Permanent _____

Type _____ No. _____ State _____ Year _____

Expiration Date _____ Temporary _____ Permanent _____

NURSING LICENSURE

Licensed in the following states:

State of Florida Year _____ Number _____ Expiration Date _____

State of _____ Year _____ Number _____ Expiration Date _____

State of _____ Year _____ Number _____ Expiration Date _____

Other Nursing Certification (i.e. ANA, CCRN)

C I T I Z E N S H I P

Are you a citizen of the United States? YES NO If yes, can you, upon hire, submit a birth certificate or other proof of U.S. citizenship? YES NO

If not a U.S. citizen, what type of VISA do you possess? Student Permanent Entry USA Other

L A N G U A G E

Language	(Indicate whether slight - fair - fluent)	Speak	Read	Write

M I L I T A R Y

Complete this section if you served in the U.S. Armed Forces	Branch of Service
Describe your duties and any special training	Period of Active Duty
	From _____ To _____
	Type of Discharge
	Date of Final Discharge

O T H E R

Have you ever been convicted of a felony?
YES NO

If yes, explain and give dates:

Have you ever been discharged from a job?
YES NO

If yes, explain:

Have you any relatives employed in our hospital?
YES NO

If yes, give names:

Name _____ Relationship _____

Department _____

H E A L T H

Are you fully able to perform the duties of the position for which you have applied with or without reasonable accommodation?
YES NO

(PLEASE LIST THREE PERSONAL REFERENCES OTHER THAN RELATIVES OR FORMER EMPLOYERS)

REFERENCES	1	Name	Street Address	Apt #	Phone Number
		Occupation	City	State	Zip
	2	Name	Street Address	Apt #	Phone Number
		Occupation	City	State	Zip
	3	Name	Street Address	Apt #	Phone Number
		Occupation	City	State	Zip

APPLICANT'S AGREEMENT AND CERTIFICATION • Please Read Carefully

I certify that the information given by me in this application is true in all respects and that I have not made any willful omissions. I understand that if this application is found to be false in any way, that I will be dismissed without notice. I authorize the use of any information in this application to verify my statements, and I authorize my past employers, doctors, references, and any other person to answer all questions asked concerning my ability, character, reputation, and previous employment record. I release all such person from any liability or damages on account of having furnished such information.

I agree to be employed on a 90 calendar days' probationary period with the understanding that I may be dismissed at any time during this period at the discretion of the employer. If offered employment I agree to submit to a health screening prior to beginning work to verify my fitness and ability to perform the essential functions of the position for which I have been offered. I understand all job offers are conditioned on such verification. If employed, I also agree to submit to whatever health screening as are deemed appropriate. If employed, I agree to abide by all present and subsequently issued personnel policies and procedures.

I understand that I may be dismissed if I, at any time, reveal confidential information concerning the hospital, patients or fellow employees.

I understand and agree that all accounts due WHASC for which I am responsible will be paid prior to my voluntary leaving its employ. In the event I am terminated; I understand and agree that all unpaid wages and salaries can be applied to any account due the Center for which I have assumed responsibility, including any Center property assigned to me; and I further agree that arrangements to liquidate any indebtedness to the Center will be made with the Business Office before I leave the premises.

I understand that anytime during my employment, if reasonable suspicion exists to believe I am under the influence of alcohol, drugs, or hallucinogenic, I will be requested to submit to a blood/urine test; and that refusal or failure to do so will result in immediate discharge. I also understand that if reasonable suspicion exists that I am carrying alcohol and/or illegal drugs, I will be subject to questioning as well as a search of my work area; and that failure to cooperate will result in immediate discharge.

I also agree to comply with all rules and regulations of Winter Haven Ambulatory Surgery Center.

I understand that this employment application and any other WHASC documents are not intended and should not be construed as a contract of employment, either expressed or implied, nor should it be construed to provide any guarantee or assurance of employment. I also understand that any individual who is hired may voluntarily leave employment, and may be terminated by WHASC at any time and for any reason. I understand that any written statements to the contrary are hereby expressly disavowed and should not be relied upon by any prospective or existing employee.*

(Applicant's Signature)

(Date)

*Notice: This application will remain in our active file for a period of 6 months. If you wish to be considered for employment beyond this date, you must personally renew this application in writing.

EQUAL OPPORTUNITY EMPLOYER

SIGNATURE