

# Employment Application

Thank you for your interest in our hospital. Beaufort County Hospital is committed to providing equal employment opportunities to qualified individuals regardless of race, color, sex, religion, disability, national origin, citizenship, age with respect to persons 18 years or older, or any other status protected by law. This application is subject to consideration for thirty (30) days. If you wish to receive further consideration for employment after this 30 day period, it will be necessary for you to submit another application.



*Beaufort Regional Health System*

Beaufort Regional Health System  
628 East 12th Street  
Washington, NC 27889  
Phone: 252.975.4100

AN EQUAL OPPORTUNITY EMPLOYER

Date:

Name:

If employment or education was under a different name, please indicate name below.

Social Security Number:

Address:

State:

Zip/Postal Code:

Home Phone:

Cell Phone:

E-mail address:

Have you ever been convicted of a crime:  yes  no

If yes, please explain below.

Do not include arrests, courts martial or other charges which did not result in a conviction. A conviction does not automatically disqualify you for employment. Relevant factors, such as age, date of conviction and the seriousness and nature of the crime, may be considered

Are you 18 years or older and eligible for employment in the United States?  yes  no

Positions Applied for:

Salary Desired:

Full-Time  part-time  Full or part-time

When available to begin work?

Have you previously been employed at BCH?  yes  no

Are you available to work any shift  yes  no

Any day?  yes  no

Hours Available to Work:

Mon	<input type="text"/>
Tues	<input type="text"/>
Wed	<input type="text"/>
Thurs	<input type="text"/>
Fri	<input type="text"/>
Sat	<input type="text"/>
Sun	<input type="text"/>

## Relatives in our Employment

Name	Relationship
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

## Education

Type of School	Name of School and Complete Mailing Address	No. Years Completed	Major or Degree
High School			
College Bus. or Trade School			
Professional School			
Other			

## Previous Employment

Starting with the most recent, list your last four employers, volunteer activities and/or military experience. Explain any gaps in employment.

**Present Employer:**

**Name of last supervisor:**

**Dates of employment:** From:  To:  **Salary:** From:  To:

**Complete Address:**

**Phone #:**

**Last job title:**

**Reason for Leaving (be specific):**

**List the jobs you held, duties performed, skills used or learned, advancements, or promotions while you worked at this company:**

**May we contact your employer:**  yes  no

**Present Employer:**

**Name of last supervisor:**

**Dates of employment:** From:  To:  **Salary:** From:  To:

**Complete Address:**

**Phone #:**

**Last job title:**

**Reason for Leaving (be specific):**

**List the jobs you held, duties performed, skills used or learned, advancements, or promotions while you worked at this company:**

**Present Employer:**

**Name of last supervisor:**

**Dates of employment:** From:  To:  **Salary:** From:  To:

**Complete Address:**

**Phone #:**

**Last job title:**

**Reason for Leaving (be specific):**

**List the jobs you held, duties performed, skills used or learned, advancements, or promotions while you worked at this company:**

## Special Skills & Qualifications

Summarize special skills and qualifications from employment or other experiences that may qualify you for work with Beaufort County Hospital.

## Professional Licenses, Registrations and/or Certifications

Type	State Issued	Expiration Date	Number

## References

List three business/work references who are not related to you and not previous supervisors. If not applicable, list three school or personal references who are not related to you

Name	Position	Phone	Relationship

## Please Read Carefully Before Signing

I hereby certify that the information provided in this job application is true and complete to the best of my knowledge.

I voluntarily authorize the Hospital to investigate my person, references and employment, and other related matters which may be necessary to verify information related to my application, and to secure the information necessary to make an employment decision. With the submission of this application, I hereby release the Hospital and its employees, representatives and/or agents from all liability of whatever kind or nature for investigating my references, seeking and collecting information related to my application, and making an employment decision based upon such information. I further release from liability all persons, corporations or organizations for furnishing such information. If I am offered employment, I understand that the offer is contingent upon the satisfactory outcome of any reference checks and/or investigation of information related to my application.

I understand and acknowledge that if I have omitted or given false or misleading information in this application, on my resume (if any) or in interview(s), my application may be rejected; and if I am employed, I may be discharged.

In accordance with Hospital policy, if I am offered employment any offer of employment will be contingent upon submission to a pre-employment drug test and a negative result. I hereby voluntarily agree to such testing and release the Hospital from all liability arising from such drug testing and/or any decision made based on such testing.

I understand that my employment is contingent upon my successful compliance with all employment eligibility verification requirements of the Immigration Reform and Control Act of 1986, and, to the extent required, a review of any criminal records.

If I am employed, I understand that my employment is at-will and for no definite period of time. Either the Hospital or I may terminate my employment, at any time with or without cause, including during the initial 90-day probationary period, and with or without notice. I further understand that my employment is at-will regardless of any statements made by a Hospital employee or in a Hospital policy, practice, handbook or in any other oral or written material(s). I understand that no representative of the Hospital, other than the Hospital Administrations by authority of the Board of Trustees in writing, has the authority to make agreement with me concerning the length or terms of my employment.

Signature

Date