

Fold



## EMPLOYMENT APPLICATION

NAME  
(First)  
(Last)

**VALUES STATEMENT**

**COMMITMENT** is to our Customer. Our customer is the patient and resident, family, doctor, client, associate, volunteer and visitor — anyone to whom we provide service.

**ACTIONS** speak louder than words. We act in a professional and timely manner.

**RESPECT** - We treat every person with dignity, honor and appreciation. We avoid every intrusion into their privacy and hold their personal information in confidence.

**EXCELLENCE** - Our System is continuously providing outstanding care and exceptional service.

**SERVICE** - We serve with pride, creating a responsive and healing environment. This is what our team is all about.

Thompson Health is an equal opportunity employer and offers employment opportunity to all persons without regard to age, sex, race, creed, religion, color, national origin, military status, disability, genetic predisposition or carrier status, sexual orientation or marital status. Applicants will be considered on the basis of training, experience, their ability to meet the requirements of the job and their commitment to uphold the values of Thompson Health.

**POSITION**

Position Title applied for: \_\_\_\_\_ Salary Requirements: \_\_\_\_\_

Date Available: \_\_\_\_\_ Today's Date: \_\_\_\_\_

How did you learn of this job?  Ad (where) \_\_\_\_\_

Current Associate (who) \_\_\_\_\_

Other (specify) \_\_\_\_\_

Have you ever been employed here before?  Yes  No List Dates: \_\_\_\_\_

**PERSONAL**

NAME \_\_\_\_\_  
(Last) (First) (Middle)

ADDRESS \_\_\_\_\_  
(Number & Street) (City) (State) (Zip)

Phone: ( ) ( ) ( )  
Home Work Other

E-mail address: \_\_\_\_\_

Is additional information relative to a name change necessary to enable a check of your work or school records?

If yes, state name: \_\_\_\_\_

**WE ARE A HEALTH CARE FACILITY. SMOKING IS NOT PERMITTED.**

350 Parrish Street - Canandaigua, New York 14424 - (585) 396-6680 - FAX (585) 396-6480

www.thompsonhealth.com

**AVAILABILITY**

Are you available to work:  Full Time  Part Time  Per Diem

Are you willing to work overtime?  Yes  No

Indicate shifts available to work  D  E  N

What days of the week can you work?  M  TU  W  TH  F  SA  SU

Comments: \_\_\_\_\_

**PERSONAL**

Do you have the legal right to remain and work in the United States permanently?  Yes  No

Are you 18 years of age or older?  Yes  No

If younger than eighteen (18), do you have proper working papers?  Yes  No

Have you ever been convicted of a crime, other than a minor traffic offense?  Yes  No  
(A yes answer does not automatically disqualify you for consideration.)

If so, please explain and give dates: \_\_\_\_\_

Have you had any findings or convictions of patient/resident abuse, mistreatment, or neglect?  Yes  No  
(A yes answer does not automatically disqualify you for consideration.)

If so, please explain and give dates: \_\_\_\_\_

**EDUCATION / MILITARY**

Circle last grade completed: grade 1 2 3 4 5 6 7 8 9 10 11 12 college 1 2 3 4 5 6 7

School	Name & Address of School	Course of Study or Diploma/Degree	No. of Yrs. Completed	Graduated Yes or No
High School				
Business/Trade				
College/Univer.				
Military Service*	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marines	Service Branch:		Type of Discharge:

\*NOTE: A discharge other than honorable will not necessarily disqualify you for employment, but will be considered with all other factors relating to the job.

**LICENSE**

Professional License Status	License/Registration/Certification Type	Lic/Reg/Certif. Number	Issuance Date	Expiration Date
P <input type="checkbox"/> Permanent T <input type="checkbox"/> Temporary				
P <input type="checkbox"/> Permanent T <input type="checkbox"/> Temporary				

**SKILLS**

List specific skills (office, technical, clinical) whether job related or not.

\_\_\_\_\_

\_\_\_\_\_

**REFERENCES**

Please list former supervisors, or others you have worked with who are familiar with your professional qualifications and technical competence. Do not list relatives or personal friends.

Name _____	Name _____
Address _____	Address _____
How Long Known _____	How Long Known _____
Business/Occupation _____	Business/Occupation _____
Phone (Home/Work) _____	Phone (Home/Work) _____
Alternate Phone (Home/Work) _____	Alternate Phone (Home/Work) _____

**STATEMENT**

I swear, the information provided in this application for employment is true, correct and complete. I understand that, if employed, any information provided to Thompson Health found to be false may subject me to dismissal. I authorize the use of any information in this application to verify my statements, and I authorize past/current employers and personal references to answer all questions concerning my ability to perform the job for which I am applying. I understand that employment at Thompson Health is "at will", and that Thompson Health or I may sever the employment relationship at any time for any reason — with or without cause — unless prohibited by law or bona fide employment contract. If employed, I also agree to abide by all present and subsequently-issued Thompson Health personnel policies and procedures, and further understand that the terms and conditions of my job may be changed from time to time, as deemed appropriate by Thompson Health, and without prior notice. I also understand that only the Associate Services Department of Thompson Health and its representatives have the authority to enter into an employment agreement, and that any agreement by any other member of management is null and void. After a tentative offer of employment, if requested by the company, I agree to have a job related medical exam, including a drug screen, at no personal expense. I authorize the examining physician to disclose the findings to Thompson Health. I understand that any offer of employment is conditional pending job related satisfactory references and criminal background check, medical records review and post-offer pre-employment medical exam (if applicable), professional license certification verification, drivers license verification and safe driving record (if applicable).

Signature \_\_\_\_\_ Date \_\_\_\_\_

Starting with your most recent job, **covering at least the last 10 years**, account for all employment (include summer vacation employment; military service, and while attending school). **Attach your resume, or second sheet if needed.** *You must complete this page even if resume is attached.*

PRIOR EMPLOYMENT

Dates From To	Name, Address & Phone Number of Employer	Rate of Pay	Position Held	Reason for Leaving

Job Responsibilities: \_\_\_\_\_

May we contact for a reference? \_\_\_\_\_ Your Supervisor's name: \_\_\_\_\_

If not, why? \_\_\_\_\_

Dates From To	Name, Address & Phone Number of Employer	Rate of Pay	Position Held	Reason for Leaving

Job Responsibilities: \_\_\_\_\_

May we contact for a reference? \_\_\_\_\_ Your Supervisor's name: \_\_\_\_\_

If not, why? \_\_\_\_\_

Dates From To	Name, Address & Phone Number of Employer	Rate of Pay	Position Held	Reason for Leaving

Job Responsibilities: \_\_\_\_\_

May we contact for a reference? \_\_\_\_\_ Your Supervisor's name: \_\_\_\_\_

If not, why? \_\_\_\_\_

Dates From To	Name, Address & Phone Number of Employer	Rate of Pay	Position Held	Reason for Leaving

Job Responsibilities: \_\_\_\_\_

May we contact for a reference? \_\_\_\_\_ Your Supervisor's name: \_\_\_\_\_

If not, why? \_\_\_\_\_



I authorize Thompson Health to contact my present or previous employers, schools, or references, and authorize them to furnish any information concerning my employment, school record and character. I hereby release from all liability and damages those individuals or companies providing such information.

Applicant's Signature

Date

\*\*\*\*\*  
\*\*\*\*\* FOR OFFICE USE ONLY \*\*\*\*\*

has applied for a position as a/an \_\_\_\_\_  
at Thompson Health. This applicant states that he/she was employed with you from \_\_\_\_\_ to \_\_\_\_\_. We would appreciate the information requested below.

Your reply will, of course, be held in confidence. Thank you for your courtesy in this matter.

Sincerely,

Associate Services

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Employed from \_\_\_\_\_ to \_\_\_\_\_ Job Title \_\_\_\_\_

Employed:  Full Time  Part Time  Per Diem  Other: \_\_\_\_\_

	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Work Performance	_____	_____	_____	_____
Conduct	_____	_____	_____	_____
Attendance	_____	_____	_____	_____
Reliability	_____	_____	_____	_____
Cooperation/Ability to Get Along With Others	_____	_____	_____	_____

Reason for termination \_\_\_\_\_

Would you rehire? \_\_\_\_\_ Comments: \_\_\_\_\_

Reference given by: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Company Name: \_\_\_\_\_

If a telephone discussion would be more convenient, please call us at (585) 396-6680.



**Equal Employment Opportunity Information  
Voluntary Self-Identification**

Thompson Health conducts business with the United States government. In order to comply with government record keeping, reporting and other legal requirements, Thompson Health asks that you complete this self-identification form. This form will be maintained in a separate confidential file. Your participation in this process is entirely voluntary and will not affect your application – completion or non-completion of this form will not subject you to any adverse treatment. You are not required to complete this form to be considered for employment and your response on this form will not affect your application.

Thompson Health is proud to be an Equal Employment Opportunity Employer and conducts all employment-related activities without regard to race, color, sex, sexual orientation, religion, national origin, age, disability, veteran status or any other classification protected by applicable state or federal employment discrimination laws. Thompson Health welcomes diversity in the workplace.

Candidate Name: \_\_\_\_\_

Please check the categories, which apply to you:

**Gender (sex) information:**

- Male
- Female

**Race/Ethnic Information:**

- Black (African American) not of Hispanic Origin
- Asian or Pacific Islander
- American Indian or Alaskan Native
- Hispanic
- White, not Hispanic origin

**Vietnam Veteran Information:**

- Yes
- No



**AUTHORIZATION OF DISCLOSURE AND RELEASE, SEARCH AND EXCHANGE OF INFORMATION.**

My Application for Employment:

I swear that all the information I provided is accurate and true to the best of my knowledge. I understand and agree that if I am not truthful, or fail to supply requested information, I may either not be hired, or may be discharged from my position.

My Background Check:

I voluntarily authorize Thompson Health to receive information and opinions from agents and employees of former employers, schools I attended, and other relevant organizations acting on Thompson's behalf about my:

- educational background and related information
- previous work experience and work-related qualifications
- behavior and character as referenced in school, work, or other relevant records
- financial and credit records available through credit agencies or bureaus
- criminal background inquiries
- driving records

I understand that if I want additional information about the background investigation, I can contact Thompson Health Associate Services at 350 Parrish St. Canandaigua, NY 14424.

I understand that favorable and unfavorable information and opinions about me may be disclosed to Thompson Health. I knowingly and voluntarily release each of my former educators and employers, and their respective agents and employees, from any and all claims and liabilities, including, but not limited to, claims for defamation, retaliation, discrimination, damages, costs and attorney fees, which have arisen or may arise in the future related to the information and opinions provided to Thompson Health.

I understand that my signature on this Authorization of Disclosure and Release, Search and Exchange of Information form is a condition of my being considered for employment and continued employment by Thompson Health. My signature ensures that Thompson Health, my former educators and employers, and other related organizations are free to disclose information and opinions about me.

I hereby authorize Thompson Health to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health, and Thompson Health. This information may be used only by Thompson Health and only for the purpose of determining my suitability for employment in a position involved in resident/patient contact.

I intend that a copy of this Authorization and Release be as valid as the original.

Name (Print)	Date
Applicant's Signature	Current County of Residence
Other last names / Alias / AKA's used in last 7 years	
Previous counties and states of residence within the last 7 years	
Social Security Number	Driver License # and State

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