

EMPLOYMENT APPLICATION



**BROCKIE
HEALTHCARE
INCORPORATED**

NAME / Last, First, Middle

POSITION

DATE

We are an equal opportunity employer with opportunities for all regardless of race, color, sex, handicap or religious affiliations. In order to insure proper evaluation of your qualifications, we encourage you to complete all sections of this form.

PERSONAL					
Last Name	First	Middle	Social Security No.		
Present Address	City	State	Zip	Telephone No. ()	
Permanent Address	City	State	Zip	Telephone No. ()	
Position Applied For				Salary Desired	
How did you hear about this position?				Are you applying for: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Other:	
Do you have any relatives employed at Brockie Healthcare, Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?					
Are you legally entitled to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you 18 years old or younger? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you consider working any shift? 1st Shift <input type="checkbox"/> Yes <input type="checkbox"/> No 2nd Shift <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been employed by Brockie Healthcare, Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		When?			
Were you ever convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain:					

Mandatory Drug Testing and Criminal Background Check Required

EDUCATION/SKILLS					
School Name	Address of School	Course of Study	Circle year completed	Did you Graduate?	List diploma or degree
High:			9 10 11 12	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College:			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College:			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Training or special courses (post graduate, nursing, etc.)					
Area of specialization or major interest			Typing Approx. WPM _____ Shorthand Approx. WPM _____		
List healthcare or industrial equipment operated					
Professional Licenses and/or Certifications					
Are you currently: <input type="checkbox"/> Registered <input type="checkbox"/> Licensed <input type="checkbox"/> Certified					
Eligible for: <input type="checkbox"/> Registration <input type="checkbox"/> Licensure <input type="checkbox"/> Certification					
If licensed, registered, or certified:					
Type:	State Issued:	Date:	Number:		
Type:	State Issued:	Date:	Number:		

Please list and describe any paid or unpaid activities, honors, experience or training that might aid you in performing the job(s) for which you have applied and have not listed otherwise. (You may omit any activities, honors, memberships or other items that tend to identify your race, sex, national origin, age, handicap or other personal traits you prefer not to disclose.)

EMPLOYMENT HISTORY (Begin with most recent employment)

1. Name of Company			Type of Business		
Address			Phone:		
Title	Date	Rate	Starting Title	Date	Rate
Reason for leaving					
Immediate Supervisor Name:			Title:		
Address and Phone Number:			May we communicate with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Description of Duties					

2. Name of Company			Type of Business		
Address			Phone:		
Title	Date	Rate	Starting Title	Date	Rate
Reason for leaving					
Immediate Supervisor Name:			Title:		
Address and Phone Number:			May we communicate with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Description of Duties					

3. Name of Company			Type of Business		
Address			Phone:		
Title	Date	Rate	Starting Title	Date	Rate
Reason for leaving					
Immediate Supervisor Name:			Title:		
Address and Phone Number:			May we communicate with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Description of Duties					

PERSONAL REFERENCES (Please do not include relatives. Include only one previously listed supervisor.)

Name	Address	Phone Number	Years Acquainted

AGREEMENT

I hereby affirm that all statements made herein are true and correct to the best of my knowledge. I authorize Brockie Healthcare, Inc. to conduct whatever evaluation they deem necessary to confirm statements submitted on this application. If the evaluation determines any untrue statements are made, I understand this may be sufficient grounds for immediate dismissal.

I authorize Brockie Healthcare, Inc. and also authorize and request each former employer and person, firm or corporation given as a reference to answer any and all questions that may be sought in connection with this application.

I agree to submit myself, upon request, for a physical examination by Brockie Healthcare, Inc. and understand that employment is subject to meeting medical standards. In addition, a drug screen and criminal background check are required. If accepted for employment I hereby agree to abide by the rules and policies of my employer.

I understand that Brockie Healthcare, Inc. operates 24 hours a day, 7 days per week and that weekends or changes of shifts may be required to provide quality service.

I understand that nothing contained in this employment application is intended to create an employment contract between Brockie Healthcare, Inc. and myself for either employment or the providing of any benefit. No promises regarding employment have been made to me. If an employment relationship is established, I understand that my employment will be at will, and that Brockie Healthcare, Inc. has the right to terminate my employment at any time for any reason.

Date:

Signature:

FOR OFFICE USE ONLY – Staff are not to write above this line.

References checked by whom:

1.

2.

3.

4.

5.

6.

Work permit:

License Verification:

Interviewer's Signature:

Date:

Interviewer's Signature:

Date:

Approval for hire:

 Yes No

Signature:

Attach references and interview questions and answers to this application.