



OFFICE
USE ONLY

COLLEGE HOSPITALS

10802 College Place Cerritos, California 90703
562/924-9581 or 714/826-2140

301 Victoria Street Costa Mesa, California 92627
949/642-2734

APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY EMPLOYER

WHAT IS THE BEST TIME
TO CONTACT BY TELEPHONE?

PLEASE TYPE / PRINT / EMAIL

GENERAL - PERSONAL INFORMATION

Last Name		First	Middle	Telephone
Home Address (Street & Number)		City	State	Zip Code
Previous Residences in the United States				
Social Security Number	Driver's License Number	Are you age 18 or over? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, a work permit will be required prior to employment.		
Parents or Guardian if Minor Applicant (Name & Address)				

Friends or Relatives employed by this Hospital

POSITION DESIRED

(First Choice)	(Second Choice)	Minimum Earnings Required
Date Available for Work	<input type="checkbox"/> Full Time <input type="checkbox"/> Temporary <input type="checkbox"/> Part Time <input type="checkbox"/> On Call	<input type="checkbox"/> Drop-in <input type="checkbox"/> Ad <input type="checkbox"/> Agency <input type="checkbox"/> School <input type="checkbox"/> Other <input type="checkbox"/> Employee _____ NAME
Shift Preferred - 1st Choice	2nd Choice	3rd Choice
Have you ever worked at a College Health Enterprises entity before? Where? When? Under what name?		

Are you able to perform the essential functions of the position for which you are applying, either with or without reasonable accommodations?

Yes No

If necessary, please describe what type(s) of reasonable accommodations are needed:

OFFICE SKILLS (For clerical applicants only)

Typing	<input type="checkbox"/> Yes <input type="checkbox"/> No	WPM	Adding Machine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Calculator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shorthand	<input type="checkbox"/> Yes <input type="checkbox"/> No	WPM	Dictaophone	<input type="checkbox"/> Yes <input type="checkbox"/> No	PBX	<input type="checkbox"/> Yes <input type="checkbox"/> No
Computer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Other			

EDUCATION

	NAME AND LOCATION OF SCHOOLS	Number of Years	GRAD.		Degree	GPA	Major Field of Study
			Yes	No			
High School Last Attended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
College or University	Name		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	City State						
University	Name		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	City State						
Graduate School	Name		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	City State						
Business or Vocational	Name		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	City State						
Other			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

LICENSING

Identify each license or certification held, include serial numbers and expiration dates.

BCLS for Healthcare Providers Yes No Expires _____

MISCELLANEOUS SKILLS OR ACTIVITIES

List special language skills, scholarships or other significant activities (Please omit those indicating race, color, sex, national origin, ancestry, age, the existence of a disability, or any other protected characteristics).

GOALS

Immediate	Long Term

REFERENCES (Other than relatives)

GIVE THREE REFERENCES WHO HAVE KNOWN YOU DURING THE PAST FIVE OR MORE YEARS.

	Name	Position	Address (Include City/State)	Phone Work / Home	Number of years known
1.					
2.					
3.					

PAST EMPLOYMENT

Account for the past ten (10) years. Include periods of unemployment, self-employment, schooling or military service. List present (or most recent) position first. Please include any other name under which such records may appear. Attach supplement sheet if ore space needed.

May we contact your present employer: Yes No

Company Name		Telephone Number		From: mo	yr	Salary per <input type="checkbox"/> Wk. <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.	
Street		City	State	Zip Code	Type of Business		Starting \$
Title/Duties and Responsibilities		Supervisor				Final \$	Other Compensations, i.e., Bonus, Shift Diff., Commissions, Etc. (Specify) per <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.

What did you like most about the work?

What did you like least?

Reason for leaving

Company Name		Telephone Number		From: mo	yr	Salary per <input type="checkbox"/> Wk. <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.	
Street		City	State	Zip Code	Type of Business		Starting \$
Title/Duties and Responsibilities		Supervisor				Final \$	Other Compensations, i.e., Bonus, Shift Diff., Commissions, Etc. (Specify) per <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.

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Street		City	State	Zip Code	Type of Business		Starting \$
Title/Duties and Responsibilities		Supervisor				Final \$	Other Compensations, i.e., Bonus, Shift Diff., Commissions, Etc. (Specify) per <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.

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Street		City	State	Zip Code	Type of Business		Starting \$
Title/Duties and Responsibilities		Supervisor				Final \$	Other Compensations, i.e., Bonus, Shift Diff., Commissions, Etc. (Specify) per <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.

Reason for leaving

SECURITY/RIGHT TO WORK

Do you have the legal right to work and be employed in the U.S.? (Proof of identity and legal authority to work in the U.S. is a condition of employment.)

Yes No

Have you ever been convicted of a crime?

Yes No

(Please exclude misdemeanor convictions for marijuana-related offenses more than two years old; convictions that have been sealed, expunged, or legally eradicated; and misdemeanor convictions for which probation was successfully completed or otherwise discharged and the case was judicially dismissed.)

If yes, briefly describe the nature of crime(s), the date and place of conviction(s), and the legal disposition of the case(s).

The Hospital will not deny employment to any applicant solely because he or she has been convicted of a crime. Each case will be evaluated based on its own facts and merits.

If you are seeking a position with regular access to patients, have you ever been arrested for a sex-related offense specified in Section 290 of the California Penal Code?

Yes No

If you are seeking a position that would present you with access to drugs and medications, have you ever been arrested for any drug related offense specified in Health and Safety Code Section 11590?

Yes No

If you answered yes to either of the two questions above, please explain the date of the arrest, the facts involved, and the court, if any, in which the matter was resolved.

Have you ever been bonded? Yes No

Have you ever been refused a bond? Yes No

MEDICAL EXAMINATIONS

The Hospital requires you to take a post-offer pre-placement medical examinations, and a yearly examination after hire at Hospital expense.

OTHER INFORMATION

Please indicate additional information relevant to your application which may be helpful to us.

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and agree to have any of the statements checked by the Hospital unless I have indicated to the contrary. I authorize the references listed above, as well as all other individuals whom the Hospital contacts, to provide the Hospital any and all information concerning my previous employment and any other pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to the Hospital as well as from any use or disclosure of such information by the Hospital or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or, if I am hired, my immediate dismissal from employment.

In consideration of my employment, I agree to conform to the rules and standards of the Hospital. I further agree that my employment and compensation can be terminated at will, with or without cause, and with or without notice, at any time, either at my option or at the option of the Hospital. I understand that no employee or representative of the Hospital, other than its president, has the authority to enter into any agreement for employment for any specified period of time, or to make any express or implied agreement contrary to the foregoing. Further, the president of the Hospital may not alter the at-will nature of the employment relationship or enter into any employment agreement for a specified time unless the president and I both sign a written agreement that clearly and expressly specifies the intent to do so. I agree that this shall constitute a final and fully binding integrated agreement with respect to the at-will nature of my employment relationship and that there are no oral or collateral agreements regarding this issue.

I also understand that all offers of employment are conditioned on the Hospital's receipt of satisfactory responses to reference requests and the provision of satisfactory proof of an applicant's identity and legal authority to work in the United States. Offers of employment are also conditioned on the satisfactory completion of a post-offer medical examination.

SIGNATURE _____

DATE _____

COLLEGE HOSPITAL
Voluntary Self-Identification Form

College Hospital is subject to certain governmental recordkeeping and reporting requirements of the administration of civil rights laws and regulations. In order to comply with these laws, College Hospital invites employees to voluntarily self-identify their race and ethnicity. **Submission of this Information is voluntary and refusal to provide it will not subject you to any adverse treatment.** The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify a specific individual. This form will be kept separate from your personnel file.

I am:

- Hispanic or Latino: a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.
- Not Hispanic or Latino

If you checked "Not Hispanic or Latino", please check one of the following racial/ethnic categories:

- American Indian or Alaska Native: a person having origins in any of the original peoples of North, South and Central America, and who maintain cultural identification through tribal affiliation or community attachment.
- Asian: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: a person having origins in any of the Black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White: a person having origins in any of the original peoples of Europe, the Middle East or North Africa.
- Two or More: a person who identifies with more than one of the above five races.

I am: Female Male

Name: _____ Date: _____

Position: _____