APPLICATION FOR EMPLOYMENT

CPH provides equal opportunity for all team members and applicants and guarantees that conditions of employment are made without regard to sex, race, color, national origin, age, religion, disability, or any other characteristic protected by law.

PERSONAL INFORMATION

Date___________________

NAME		AT LEAST 18 YRS OF AGE?	
PRESENT ADDRESS	CITY	STATE	ZIP CODE
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
CELL PHONE #	EMAIL ADDRESS(Required)	REFERRED BY	

EMPLOYMENT DESIRED

POSITION	WHAT STATUS? FT, PT, or PRN?	DAY OR NIGHT SHIFT?	OTHER: ex: weekend only, MWF only, etc.	
DESIRED SALARY	WHEN CAN YOU START?	HAVE YOU EVER BEEN CONVICTED OF A FELONY?	MAY WE CONTACT YOUR CURRENT EMPLOYER?	ARE YOU LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES?
EVER APPLIED TO THIS COMPANY BEFORE?	**CLINICAL LICENSE #**		**LICENSING BOARD NAME**	
DO YOU HAVE ANY RELATIVES THAT WORK, HAVE WORKED OR ON THE BOARD FOR THE COMPANY?	IF SO, WHO ARE THEY AND WHAT DEPARTMENT DO THEY WORK IN?			

EDUCATION HISTORY

	NAME & LOCATION OF SCHOOL	DID YOU GRADUATE?	WHAT MONTH/YEAR DID YOU GRADUATE?	DIPLOMA OR SUBJECTS STUDIED / DEGREE OBTAINED
HIGH SCHOOL				
COLLEGE				
SECOND COLLEGE OR GRADUATE SCHOOL				
TRADE, VOCATIONAL, OR TECHNICAL SCHOOL				

WORK HISTORY START WITH MOST RECENT

DATE: MONTH & YR	NAME & ADDRESS OF EMPLOYER	POSITION	SALARY	REASON FOR LEAVING
FROM:				
TO:				☐ MAY WE CONTACT
FT, PT, OR PRN?	IF APPLICABLE, LIST SPECIFIC AREA OF SPECIALTY/ SPECIFIC UNITS: ex. adult psych, geriatric psych, med-surg, L&D, etc.			

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PROFESSIONAL REFERENCES (not personal)

NAME	E-Mail Address	PHONE NO.	Company	Supervisor?

AUTHORIZATION

“I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements or omissions on this application shall be grounds for dismissal**.**

I authorized investigation of all statements contained herein and the references and employers listed about to give you any and all information concerning my previous employment and pertinent information they may have, personal or otherwise, and release the company from all liability for any damage they may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative. This waiver does not permit the release or use of disability-related or medical information in a prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.”

DATE______________________________ SIGNATURE____