

APPLICATION FOR EMPLOYMENT
Equal Opportunity Employer

POSITION DESIRED:	SALARY REQUIREMENT:	DATE AVAILABLE:	DATE:
NAME-LAST	FIRST	MI	REFERRED BY:
ADDRESS-STREET	APT#	CITY	STATE
			ZIP
			TELEPHONE #:
			CELL #:
			SOCIAL SECURITY #:

ARE YOU 18 YEARS OR OVER? YES NO INDICATE PREFERRED HOURS OF WORK:
 DAY EVENING NIGHT FULL TIME PART TIME-APPROX. HRS. _____ WEEKENDS & HOLIDAYS

ARE YOU LEGALLY ENTITLED TO WORK IN THE U.S.? YES NO (DOCUMENTATION PROOF MAY BE REQUIRED)

EDUCATION

	NAME	ADDRESS	COURSE OF STUDY	DID YOU GRADUATE?	DEGREE OR DIPLOMA
HIGH SCHOOL OR EQUIVALENT					
COLLEGE					
GRADUATE SCHOOL					
NURSING OR OTHER SCHOOL					

GENERAL DATA

PROFESSIONAL LICENSES

NJ REGISTRATION#:	NJ PERMIT #:	NJ LICENSE #:	EFFECTIVE DATE:	EXPIRATION DATE:
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HAS YOUR PROFESSIONAL LICENSE BEEN VOLUNTARILY OR INVOLUNTARILY LIMITED, SUSPENDED, REVOKED OR RESTRICTED IN NEW JERSEY OR ANY OTHER JURISDICTION? NO YES IF YES, EXPLAIN:

LIST TRAINING AND/OR CERTIFICATION: CPR IV ACLS OTHER SKILLS (PLEASE STATE): PC

LIST PROFESSIONAL ORGANIZATION MEMBERSHIPS:

WERE YOU EVER EMPLOYED AT BAYONNE MEDICAL CENTER? NO YES IF YES, GIVE DATES: _____
POSITION: _____

LIST RELATIVES AND THEIR DEPARTMENTS EMPLOYED AT BAYONNE MEDICAL CENTER:

WERE YOU EVER EMPLOYED BY ANOTHER NAME? NO YES IF YES, UNDER WHAT NAME: _____

IN CASE OF EMERGENCY NOTIFY: NAME: _____ TELEPHONE: _____

WORK EXPERIENCE

PLEASE GIVE COMPLETE RECORD OF PAST AND PRESENT EMPLOYMENT, STARTING WITH THE CURRENT OR LAST EMPLOYER.

NAME AND ADDRESS OF EMPLOYER	POSITION	REASON FOR LEAVING
TELEPHONE: FAX:	DATE OF EMPLOYMENT: FROM TO	SALARY:
TYPE OF BUSINESS:	SUPERVISOR'S NAME:	
NAME AND ADDRESS OF EMPLOYER	POSITION	REASON FOR LEAVING
TELEPHONE: FAX:	DATE OF EMPLOYMENT: FROM TO	SALARY:
TYPE OF BUSINESS:	SUPERVISOR'S NAME:	
NAME AND ADDRESS OF EMPLOYER	POSITION	REASON FOR LEAVING
TELEPHONE: FAX:	DATE OF EMPLOYMENT: FROM TO	SALARY:
TYPE OF BUSINESS:	SUPERVISOR'S NAME:	

Personal References

Name	Address	Length of Acquaintance	Relationship

PLEASE READ CAREFULLY BEFORE SIGNING

(1) Have you been provided a copy of any notice filed by any health care entity with the Division of Consumer Affairs under the Health Care Professional Responsibility and Reporting Act?

Yes No

If yes, please explain and provide the notification document.

(2) Have you received any performance evaluation where your job performance, as it relates to patient care or your abilities, as they relate to your suitability for employment with any health care entity, been questioned?

Yes No

If yes, please provide a copy of the performance evaluation (s) and explain.

(3) Have you ever been convicted of a felony?

Yes No If yes, please explain:

(4) Has your professional license ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare, Medicaid)? Yes No

If yes explain: _____

(5) May we contact your: Present employer? Yes No Former employer(s)? Yes No

(6) I certify that the information contained in this application is correct and complete to the best of my knowledge.

Initial: _____

(7) I understand that false, misrepresentation or omissions of facts with regard to this employment application or interview(s) will be cause for rejection of this application or dismissal from Medical Center if I have already been employed regardless of the date of discovery. Initial: _____

(8) I understand, further, my employment is subject to passing the Bayonne Medical Center pre-employment process, which includes a background check and physical examination in accordance with the New Jersey State Department of Health. Initial: _____

I understand that any offer of employment is conditioned upon BMC's receipt of satisfactory reference checks including, but not limited to, information about your job performance as it relates to patient care; the reasons for your separation from your prior employers, and; information about your job performance while employed by any former employer. Also, BMC reserves the right to revoke any offer of employment in the event any reference information or inquiry from the N.J. Division of Consumer Affairs or other Federal/State reporting entities is not acceptable to BMC. (Revised 01/07)

Signature

Date