

**WEST GEORGIA HEALTH SYSTEM  
1514 VERNON ROAD  
LAGRANGE, GEORGIA 30240**

**LOGGED:** \_\_\_\_\_

**APPLICATION FOR EMPLOYMENT**

WEST GEORGIA HEALTH SYSTEM IS AN EQUAL OPPORTUNITY EMPLOYER AND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, RELIGION, SEX, CITIZENSHIP, NATIONAL ORIGIN, AGE, DISABILITY OR ANY OTHER CHARACTERISTIC PROTECTED BY APPLICABLE LAW.

I. PERSONAL INFORMATION				
Social Security Number			Today's Date	
Last Name		First Name		Middle Name
Street Address		City		State      Zip Code
Home Phone Number			Business Phone Number	
In case of emergency notify: Name:		Address		Phone Number
Are you at least 18 years of age?      Yes _____ No _____      Only if under age 18, state age _____				

II. EMPLOYMENT DESIRED									
Position					Date Available			Salary Expected	
Employment Desired:	FT	PT	TEMP	Shift Preferred:	Day (1st)	Evening (2nd)	Night (3rd)	Other (Specify)	

III. EDUCATION							
Type of School	Name and Address	From Mo./Yr.	To Mo./Yr.	Graduated		Degree	Major
				Yes	No		
High School (G.E.D.)							
College Undergraduate							
College Graduate							
Vocational/ Business							
Other							

#### IV. U.S. MILITARY

<b>Are you a Veteran?</b>	<b>Dates of Service</b>	<b>Branch/Rank/ Type of Discharge</b>	<b>Special Training</b>
Yes      No	From      To		

#### V. LICENSES & SPECIAL SKILLS

List the Number, Expiration Date, and State of Issuance of any Professional or Occupational License (not Driver's License) you hold.

Have you ever had your Professional or Occupational license revoked or restricted for any reason? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when and for what reason?

Do you type? Yes \_\_\_\_\_ No \_\_\_\_\_ WPM \_\_\_\_\_ Do you use dictating equipment? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Are you computer literate? Yes \_\_\_\_\_ No \_\_\_\_\_ What software used?

List any other special skills you have.

#### VI. GENERAL INFORMATION

Have you ever been convicted of a criminal offense other than a minor traffic violation? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please give all of the facts regarding your conviction. NOTE: A conviction will not automatically disqualify you from a position at WGHS.

Are you currently excluded, debarred, suspended or otherwise ineligible to participate in any federally funded healthcare program including Medicare or Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Are you aware of any potential exclusion, debarment, suspension or other ineligibility? Yes \_\_\_\_\_ No \_\_\_\_\_

Can you furnish proof of identity and authorization to work in the United States prior to hire? Yes \_\_\_\_\_ No \_\_\_\_\_.

Have you ever worked for West Georgia Health System before? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give date \_\_\_\_\_  
 Have you ever applied to work at West Georgia Health System before? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give date \_\_\_\_\_  
 How did you learn of this position and/or who referred you for this position:

#### VII. EMPLOYMENT HISTORY

**INSTRUCTIONS:** Beginning with your present or most recent employer, please list in order all of your employment history. Also, please explain any periods in which you were not employed. (Use additional sheet of paper if necessary). Please specify if any of these employments are recorded under another name.

<b>Name of Employer:</b>	<b>Date of Employment:</b> From _____ Mo. _____ Yr. To _____ Mo. _____ Yr.
<b>Address of Employer:</b>	<b>Salary:</b> Beginning _____ Ending _____
<b>Phone Number of Employer if known:</b>	<b>Supervisor:</b> Name _____ Title _____
<b>Job Title and Specific Duties:</b>	
<b>Reason for Leaving:</b>	

<b>Name of Employer:</b>	<b>Date of Employment:</b> From _____ Mo. _____ Yr. To _____ Mo. _____ Yr.
<b>Address of Employer:</b>	<b>Salary:</b> Beginning _____ Ending _____
<b>Phone Number of Employer if known:</b>	<b>Supervisor:</b> Name _____ Title _____
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<b>Phone Number of Employer if known:</b>	<b>Supervisor:</b> Name _____ Title _____
<b>Job Title and Specific Duties:</b>	
<b>Reason for Leaving:</b>	

**VIII. PERSONAL REFERENCES**

Name of three persons not related to you that you have known at least one year.

NAME	ADDRESS	BUSINESS & POSITION	TELEPHONE
1.			
2.			
3.			

**PLEASE READ CAREFULLY AND ACKNOWLEDGE BY YOUR SIGNATURE AND TODAY'S DATE**

WEST GEORGIA HEALTH SYSTEM IS COMMITTED TO MAINTAINING A HEALTHY ENVIRONMENT AND IS A TOBACCO/SMOKE -FREE FACILITY. POLICY PROHIBITS USE OF TOBACCO IN ANY AREA OF THE HEALTH SYSTEM.

IT IS THE POLICY OF WEST GEORGIA HEALTH SYSTEM TO MAINTAIN A WORK ENVIRONMENT FREE FROM USE OF ILLEGAL DRUGS AT ALL LOCATIONS. IT IS AGAINST THE HEALTH SYSTEM'S POLICY TO HIRE PERSONS USING ILLEGAL DRUGS. IN ORDER TO BE CONSIDERED FOR EMPLOYMENT, APPLICANTS MUST SUBMIT TO A URINE TEST TO DETERMINE IF THE APPLICANT MAY BE USING ILLEGAL DRUGS. IF YOU HAVE ANY QUESTIONS CONCERNING THIS POLICY, ASK THE DIRECTOR OF HUMAN RESOURCES.

I UNDERSTAND THAT WEST GEORGIA HEALTH SYSTEM WILL PERFORM AN INVESTIGATION TO DETERMINE MY SUITABILITY FOR EMPLOYMENT AND I AUTHORIZE WEST GEORGIA HEALTH SYSTEM TO HAVE WRITTEN ACCESS TO ANY RECORDS CONCERNING MY EDUCATIONAL OR EMPLOYMENT BACKGROUND. I AGREE TO SUBMIT TO A POST OFFER PHYSICAL ASSESSMENT AND/OR EXAMINATION. I WILL FAMILIARIZE MYSELF WITH THE POLICIES AND PROCEDURES AND WILL ABIDE BY THE POLICIES OF THIS INSTITUTION AS ESTABLISHED. I WILL READ THOROUGHLY AND ABIDE BY THE EMPLOYEE HANDBOOK.

I HEREBY CERTIFY THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS TRUE, CORRECT AND COMPLETE. I AUTHORIZE MY PERSONAL REFERENCES AND PREVIOUS EMPLOYERS NAMED ABOVE OR ANY OF THEIR AGENTS TO DISCLOSE ANY INFORMATION IN THEIR POSSESSION REGARDING ME OR MY PRIOR EMPLOYMENT. IN CONSIDERATION OF THEIR COOPERATION IN FURNISHING SAID INFORMATION TO WEST GEORGIA HEALTH SYSTEM, I HEREBY RELEASE MY PRIOR EMPLOYERS FROM ANY AND ALL LIABILITY WHICH MAY ARISE OUT OF THEIR FURNISHING SUCH INFORMATION TO WEST GEORGIA HEALTH SYSTEM, ITS SUBSIDIARIES, AFFILIATES OR SUCCESSORS.

I FURTHER UNDERSTAND AND AGREE THAT IF HIRED, MY EMPLOYMENT IS AT WILL, FOR NO DEFINITE PERIOD OF TIME, THAT IT MAY BE TERMINATED AT ANY TIME, AND THAT MY EMPLOYER MAY UNILATERALLY CHANGE ANY TERM OR CONDITION OF EMPLOYMENT (INCLUDING ANY WAGE RATES OR BENEFITS DESCRIBED WITHIN ANY HANDBOOK OR PERSONNEL POLICY MANUAL) EITHER WITH OR WITHOUT PRIOR NOTICE TO ME, AND THAT SUCH CHANGES WILL BECOME EFFECTIVE AND SHALL GOVERN MY EMPLOYMENT RIGHTS AS SOON AS THEY ARE ADOPTED OR IMPLEMENTED.

I HEREBY REPRESENT TO THE WEST GEORGIA HEALTH SYSTEM, ITS SUBSIDIARIES, AFFILIATES, OR SUCCESSORS THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS ACCURATE, COMPLETE, AND TRUE IN ALL RESPECTS, AND THAT IF EMPLOYER SHOULD HEREAFTER DETERMINE THAT THE INFORMATION SUPPLIED ON THIS APPLICATION IS INCORRECT, INCOMPLETE, OR INACCURATE IN ANY WAY, IT MAY IMMEDIATELY TERMINATE MY EMPLOYMENT.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NOTICE: THIS APPLICATION WILL REMAIN IN OUR ACTIVE APPLICANT FILE FOR A PERIOD OF 60 DAYS FROM THIS DATE. IF YOU WISH TO BE CONSIDERED FOR EMPLOYMENT BEYOND 60 DAYS, YOU MUST COMPLETE A NEW APPLICATION.

**IX. ADDITIONAL COMMENTS OF APPLICANT**

FAX TO: 888-454-7679

CLIENT NAME: West Georgia Health System

CLIENT ACCOUNT NUMBER: 225649

CLIENT CONTACT: Donna Smiley

PHONE NUMBER: 706-812-2863

**NOTICE REGARDING BACKGROUND INVESTIGATION**

**NOTICE AND ACKNOWLEDGMENT**

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT]

**West Georgia Health System** may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may include employment history and reference checks, criminal and civil litigation history information, motor vehicle records ("driving records"), sex offender status, credit reports, education verification, professional licensure, drug testing, Social Security Verification, and information concerning workers' compensation claims (only once a conditional offer of employment has been made). You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Employment Screening Services, 1401 Providence Park Birmingham, AL 35242, toll-free 866.859.0143 or another outside organization. The scope of this notice and authorization is all-encompassing; however, allowing **West Georgia Health System** to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by ESS, another outside organization acting on behalf of **West Georgia Health System**. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

**California applicants or employees only:** By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law.

**Minnesota and Oklahoma applicants or employees only:** Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

**New York applicants or employees only:** You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by **contacting the consumer reporting agency identified above directly.**

\_\_\_\_\_  
Signature of Employee or Prospective Employee

\_\_\_\_\_  
Date

**APPLICANT INFORMATION: TO BE COMPLETED BY APPLICANT**

**The following is for identification purposes only to perform the background check and will not be used for any other purpose: PLEASE USE BLACK INK.**

Print: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Alias Names (Other names I have been known by): \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_ State \_\_\_\_\_

Current Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Previous Address (Past 7 Years): \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**TO BE COMPLETED BY COMPANY - (PLEASE RUN THE FOLLOWING SEARCHES):**

<input checked="" type="checkbox"/>	<b>Georgia Statewide</b>	<input checked="" type="checkbox"/>	<b>USOne Search</b>	
	Social Security Trace		Education Verification	FACIS
	Statewide Criminal		Professional License Verification	Credit Report
	County Criminal		Employment Verification	MVR
	Federal Criminal			

## **A Summary of Your Rights under the Fair Credit Reporting Act**

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you -- such as if you pay your bills on time or have filed bankruptcy -- to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission's web site (<http://www.ftc.gov>). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a CRA to take action against you -- such as denying an application for credit, insurance, or employment -- must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs -- to which it has provided the data -- of any error.) The CRA must give you a written report of the investigation, and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.
- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified.** If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.

- **You can dispute inaccurate items with the source of the information.** If you tell anyone -- such as a creditor who reports to a CRA -- that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with a need recognized by the FCRA -- usually to consider an application with a creditor, insurer, employer, landlord, or other business.
- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.
- **You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

<b>FOR QUESTIONS OR CONCERNS REGARDING:</b>	<b>PLEASE CONTACT:</b>
CRAs, creditors and others not listed below	Federal Trade Commission Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4367 (Toll-Free)
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Programs Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-518-6360
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 800-934-FDIC
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051

## DISCLOSURE AND AUTHORIZATION

I understand and hereby authorize West Georgia Health System, its parents, subsidiaries, affiliates, or designated representatives (“WGHS”) to obtain, for employment purposes, a consumer report and/or investigative consumer report bearing on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. Information may be obtained through personal interviews of my neighbors, friends, or associates, or of others with whom I am acquainted or who may have knowledge concerning any such item or information. These reports may also contain information regarding my credit history, criminal record history, driving record history, or any other sources of information which are permissible by all governing laws pertaining to employment, insurance, or credit information. I understand this information may be obtained from previous employers, companies, credit bureaus, businesses, and individuals.

I understand and hereby authorize WGHS to obtain a consumer and/or investigative consumer report as part of the employment application process. Further, I authorize WGHS to obtain additional consumer and/or investigative consumer reports at any time during my employment with WGHS.

I understand that I may request in writing for WGHS to provide me with a disclosure concerning the nature and cope of any investigative consumer report (should such a report be requested), in which case WGHS will mail or otherwise deliver the requested information, in writing, not later than five (5) days of receipt of my request or when such report was first requested, whichever is later.

I acknowledge that I have also been provided “A Summary of Your Rights Under the Fair Credit Reporting Act.” I understand that if I have any questions regarding this disclosure or the Summary, I should not sign this form until my questions are answered to my satisfaction. By signing this form, I acknowledge that I have no questions, that I have received this form and that I understand its contents.

Signature: \_\_\_\_\_

Print Full Name: \_\_\_\_\_

Date: \_\_\_\_\_

*West Georgia Health System  
Standards of Behavior*

**COMMUNICATION**

Communication is exchanging thoughts or ideas effectively so that all parties involved reach a common understanding.

**CONFIDENTIALITY**

Confidentiality is limiting private information to persons authorized with the need to know and discussing only as necessary the care and needs of the patient.

**PROFESSIONALISM**

Knowing that our patients will judge us by our actions, I will hold myself to the highest standards of behavior.

**SAFETY**

The ability to avoid injury, danger, or loss through assuming personal responsibility for a clean, safe, and healthy environment.

**INTEGRITY**

By adhering to moral and ethical principles and by being honest, we keep our word and we are faithful to who we say we are.

**OUR VALUES**

As an employee of West Georgia Health System, I pledge that my daily actions will reflect these principles.

**TEAMWORK**

Teamwork is a cooperative and coordinated effort of a group of people working together to reach a common goal. This is the core of our system's strength: **TEAM = Together Everyone Accomplishes More**

**SERVICE**

Service is the ability to anticipate, recognize, and provide for the needs of others by going above and beyond. **ACT: Apologize, Correct the problem, and Take action.**

**A-I-D-E-T**

Regardless of what area I work in, I will abide by the principles of A-I-D-E-T. *I will...*

**A** – Acknowledge the patient (by the last name, if possible).

**I** – Introduce myself, my skill set, and my professional certification and training.

**D** – Describe the duration of the test: how long it will take; how long the patient will be here and how long the patient will have to wait on the results.

**E** – Explain the tests and the pain involved, being very honest, and what happens next. Explain that I am looking at the patient's wrist band because of patient safety and very good care.

**T** – Thank the patient for choosing WGHS.

**Please acknowledge you have read and understand West Georgia Health System's Standards of Behavior. Your signature below indicates that you understand that this is the standard by which West Georgia Health System adheres to and agree to apply your best efforts to uphold these Standards should you be offered employment.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PLEASE READ CAREFULLY AND ACKNOWLEDGE WITH YOUR SIGNATURE AND TODAY'S DATE**

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**I UNDERSTAND THAT WEST GEORGIA HEALTH SYSTEM WILL PERFORM AN INVESTIGATION TO DETERMINE MY SUITABILITY FOR EMPLOYMENT AND I AUTHORIZE WEST GEORGIA HEALTH SYSTEM TO HAVE ACCESS TO ANY RECORDS CONCERNING MY EDUCATIONAL, CRIMINAL AND EMPLOYMENT BACKGROUND. I UNDERSTAND THAT IF I SUBMIT INCOMPLETE INFORMATION, OMIT INFORMATION OR FALSIFY ANY EDUCATIONAL, CRIMINAL OR EMPLOYMENT INFORMATION, MY APPLICATION WILL NOT BE CONSIDERED.**

**I HEREBY CERTIFY THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE. I AUTHORIZE MY PERSONAL REFERENCES AND PREVIOUS EMPLOYERS NAMED ABOVE OR ANY OF THEIR AGENTS TO DISCLOSE ANY INFORMATION IN THEIR POSSESSION REGARDING ME OR MY PRIOR EMPLOYMENT.**

**I FURTHER ACKNOWLEDGE THAT SHOULD I BE OFFERED AND ACCEPT EMPLOYMENT WITH WEST GEORGIA HEALTH SYSTEM, IF EMPLOYER SHOULD HEREAFTER DETERMINE THAT THE INFORMATION SUPPLIED ON THIS APPLICATION IS INCORRECT, INCOMPLETE, OR INACCURATE IN ANY WAY, IT MAY IMMEDIATELY TERMINATE MY EMPLOYMENT.**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**