

**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

Are you a Veteran?	Dates of Service	Branch/Rank/ Type of Discharge	Special Training
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.

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

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

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

**AUTHORIZATION, NOTIFICATION, AND RELEASE FORM
FOR PROCUREMENT OF CONSUMER CREDIT / BACKGROUND REPORT**

In connection with my application for employment, and/or employment with **(West Georgia Health System)** ("Company"), I, _____ (applicant's or employee's name), understand and am hereby notified and authorize Company to procure a consumer report from a consumer reporting agency in accordance with the Fair Credit Reporting Act, 15 U.S.C. 1681 et seq. (the "FCRA"), or any "person" as defined under the California Consumer Credit Reporting Agencies Act (if a CA applicant) for evaluation of me for employment (i.e. employment, promotion, reassignment, or retention as an employee). I understand that these consumer reports may contain information from public records, including written, oral, or other communications bearing on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living, which may or may not be used as a factor for employment purposes. I further understand that such inquiries may include, but are not limited to, criminal history, motor vehicle records, employment history and verification, income verification, DOT verifications, military background, civil listings, education background, and professional background, from any individual, corporation, partnership, law enforcement agency, institution, school, organization, credit bureau, state board, licensing agency, and other entities, including present and past employers.

In connection with my application for employment and/or employment with Company, I further understand and am hereby notified that Company may procure an investigative consumer report concerning me from a consumer reporting agency or any "person" as defined by the California Consumer Credit Reporting Agencies Act (if a CA applicant). I understand that an investigative consumer report may contain information from public records, including but not limited to, written, oral or other communications bearing on my credit worthiness, credit standing, character, general reputation, personal characteristics, or mode of living, which may be obtained through personal interviews with neighbors, friends or associates of me and may or may not be used as a factor for employment purposes. I further understand that such inquiries may include, but are not limited to, investigations regarding worker's compensation, harassment, violence, theft, or fraud.

I have received and reviewed a copy of the Summary of Rights under the FCRA and the California Investigative Consumer Reporting Agencies Act (If a California applicant). I understand that I have the right to request, in writing, information regarding the nature and scope of any investigative report prepared on me.

I authorize without reservation any party or agency contacted by this employer to furnish the above-referenced information. I further authorize ongoing procurement of the above-referenced reports at any time, either during the time my application for employment is being considered or throughout the duration of my employment in the event that I am hired or am a current Company employee.

My Social Security number is _____ **My Date of Birth ("DOB") is** ___/___/____. **** Please see below.**
****If ME, MI, MN, OH, PA, RI, or WV applicant DO NOT provide DOB.**
 Instead call 877-292-3331 within **2 hours** of submitting your application.

My Previous Name (if any) is _____.

My Drivers License number is _____ **and was issued by the state of** _____.

If you have had another Drivers License in the last three years please put that number here: _____.

My High School, named _____, **is located in (City)** _____, **(State)** _____.

Current Address:

No. Street	City	State	Zip	County	Years	_____
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Previous Addresses within the last seven (7) years: (Attach additional pages if necessary)

No. Street	City	State	Zip	County	Years	_____
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No.	Street	City	State	Zip	County	Years
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Oklahoma, Minnesota and California applicants only:

You have the right to receive a copy of your Consumer Credit Report free of charge should one be requested for employment purposes.

I wish to be furnished with a copy of my consumer credit report should one be ordered.

Applicant Signature: _____ **Date:** _____

I acknowledge that I have voluntarily provided the above the above information for employment purposes, and I have carefully read and I understand this authorization.

**The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age.

Client Account Number: **927103 – West Georgia Health Systems (Premier Ascend)**

SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records.) Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take adverse action against you- must tell you, and must give you the name, address and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (you “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identify theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every twelve (12) months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven (7) years old, or bankruptcies that are more than ten (10) years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to be consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identify theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you have more rights under the state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
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 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
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 scope 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: _____