



CITY OF ALAMEDA HEALTH CARE DISTRICT

2070 Clinton Avenue, Alameda, CA 94501 •(510)814-4084•Fax(510)814-4381
JOB LISTINGS: www.alamedahospital.org or (510)814-4025

AN EQUAL OPPORTUNITY EMPLOYER

Instructions

PLEASE ANSWER ALL QUESTIONS ACCURATELY AND COMPLETELY.
IF YOU NEED MORE ROOM, YOU MAY USE THE BACKSIDE OF THE APPLICATION. PLEASE PRINT.

Form with fields: LAST NAME, FIRST NAME, MIDDLE NAME, DATE OF APPLICATION, ADDRESS, CITY, STATE, ZIP CODE, HOME TELEPHONE #, EMAIL ADDRESS, SOCIAL SECURITY #, POSITION APPLYING FOR, SECOND CHOICE, DATE AVAILABLE

Complete The Following Questions:

- 1. Have you ever previously been employed at Alameda Hospital? From: To: Under what name?
2. Have you ever applied for employment at Alameda Hospital before? When?
3. If related to any employee of Alameda Hospital, please state name, department and nature of relationship:
4. How were you made aware of the position for which you are applying?
5. How many years of experience do you have for the position for which you are applying?
6. If offered employment, are you able to submit legal verification of the right to work in the United States?
7. If hired can you show proof of age? or if under 18 years can you provide a work permit?
8. Have you ever been involuntarily discharged from a position? If yes, explain
9. Have you ever been convicted of a felony (do not indicate any conviction that has been judicially dismissed, expunged, sealed or eradicated)?

STATEMENT: Conviction for a crime is not necessarily a reason to disqualify for employment.

Employment History

LIST BELOW EMPLOYERS BEGINNING WITH YOUR MOST RECENT EMPLOYMENT:

→ IF YOUR WORK OR EDUCATION HISTORY WAS OBTAINED UNDER A DIFFERENT LAST NAME, PLEASE GIVE NAME(S) / DATES USED:

NAME OF PRESENT OR LAST EMPLOYER:	ADDRESS:	CITY, STATE, ZIP CODE:	TELEPHONE:
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TITLE AND DUTIES:

EMPLOYED DATES: FROM TO	PAY: START FINAL	REASON FOR LEAVING:	NAME OF LAST SUPERVISOR:
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NAME OF EMPLOYER:	ADDRESS:	CITY, STATE, ZIP CODE:	TELEPHONE:
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TITLE AND DUTIES:

EMPLOYED DATES: FROM TO	PAY: START FINAL	REASON FOR LEAVING:	NAME OF LAST SUPERVISOR:
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NAME OF EMPLOYER:	ADDRESS:	CITY, STATE, ZIP CODE:	TELEPHONE:
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TITLE AND DUTIES:

EMPLOYED DATES: FROM TO	PAY: START FINAL	REASON FOR LEAVING:	NAME OF LAST SUPERVISOR:
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NAME OF EMPLOYER:	ADDRESS:	CITY, STATE, ZIP CODE:	TELEPHONE:
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TITLE AND DUTIES:

EMPLOYED DATES: FROM TO	PAY: START FINAL	REASON FOR LEAVING:	NAME OF LAST SUPERVISOR:
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Are you presently employed: Yes No
 If yes, may we contact your present employer? Yes No

I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever. I agree that Alameda Hospital shall not be liable in any respect if my employment is terminated because of falsity of statements, answers or omissions made by me in this questionnaire. I also authorize employers, schools or persons named above to give any information regarding my employment, character and qualifications. I understand that any misleading or incorrect statements or omissions made in any part of this application may render this application void, and if employed, would be cause for termination at any time. I am willing that a true copy of this authorization be accepted with the same authority as the original.

Signature: _____ Date: _____

Professional Information

Education and Licensing

→ IF YOUR WORK OR EDUCATION HISTORY WAS OBTAINED UNDER A DIFFERENT LAST NAME, PLEASE GIVE NAME(S) USED:

NAME AND ADDRESS OF THE HIGH SCHOOL YOU ATTENDED:	CIRCLE LAST FULL YEAR COMPLETED 1 2 3 4	GRADUATED? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME AND ADDRESS OF COLLEGE, UNIVERSITY, PROFESSIONAL OR BUSINESS SCHOOL YOU ATTENDED:	CIRCLE LAST FULL YEAR COMPLETED 1 2 3 4 5 6	DATE COMPLETED:
		DEGREE:
		MAJOR:

ARE YOU REGISTERED OR PROFESSIONALLY LICENSED IN THE STATE OF CALIFORNIA? IF YES :

LICENSE TYPE _____ REGISTRATION OR LICENSE NO. _____ EXPIRES _____ Z

Special skill and abilities applicable to the position you are applying for

MEDICAL TERMINOLOGY:	WORD PROCESSING SKILL:	WHAT MACHINES?:
INSURANCE BILLING:	DATA PROCESSING SKILL:	WHAT MACHINES?:
TYPING (WPM):	SHORTHAND (WPM):	PBX:
FOREIGN LANGUAGES SPOKEN: _____ FLUENT?		
OTHER SKILLS:		

OTHER HOSPITAL EXPERIENCE:

Professional Organizations

Please list job-related organizations, clubs, professional societies or other associations to which you belong.

Alameda Hospital is a 24 hour care facility, most work schedules require flexibility.
Check as many as possible.

Mark SHIFT (s) you are able to work: Days Evenings Nights Weekends

Willing to work: Full time Part time On call

Are you willing to work overtime as required? Yes No

MINIMUM SALARY ACCEPTABLE: _____

PERSONAL REFERENCES (DO NOT INCLUDE RELATIVES OR FORMER EMPLOYERS)

NAME	ADDRESS & TELEPHONE #	BUSINESS OR OCCUPATION

Space available for additional comments by applicant.

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Employment information to be completed by the hospital

TO BE FILLED OUT BY DEPARTMENT DIRECTOR

TO BE FILLED OUT BY HUMAN RESOURCES

HIRED: YES NO

POST OFFER:

STATUS: (REGULAR FULL-TIME, REGULAR PART-TIME, PART-TIME[2/5,3/5,4/5],ETC.) _____

PRE-EMPLOYMENT APPOINTMENT: _____

STARTING DATE: _____

POSITION: _____

HOSPITAL ORIENTATION DATE: _____

DEPARTMENT: _____

LOCATION: _____

GRADE: _____ STEP: _____

SHIFT TO WHICH INITIALLY ASSIGNED
 7-3, 3-11, 11-7, WEEKEND, ROTATING,
 ON CALL, OTHER

TENURE CREDIT: _____

COMPLETED BY: _____