CITY OF ALAMEDA HEALTH CARE DISTRICT

2070 Clinton Avenue, Alameda, CA 94501 • PH: (510)814-4026 •FAX: (510)814-4381
JOB LISTINGS: www.alamedahospital.org • EMAIL: hr@alamedahospital.org

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.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF APPLICATION
ADDRESS	CITY	STATE	ZIP CODE
HOME TELEPHONE #	EMAIL ADDRESS		SOCIAL SECURITY NUMBER
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, MISDEMEANOR or MILITARY CRIME? (do not indicate any conviction that has been judicially dismissed, expunged, sealed or eradicated)...**If yes, please state yes on the line below along with the nature of the conviction.**

   ____

(Note: Do not include misdemeanor marijuana conviction which occurred more than two years prior to the date of this application. A conviction is not necessarily a bar to employment. Each case is considered individually on the basis of the nature of the crime and the position applied for).

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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:
TITLE AND DUTIES:			
EMPLOYED DATES: FROM TO	PAY: START FINAL	REASON FOR LEAVING:	NAME OF LAST SUPERVISOR:

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

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

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

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? ❒ Yes ❒ 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______________________

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.

Employment information to be completed by the hospital

TO BE FILLED OUT BY DEPARTMENT DIRECTOR

HIRED: ☐ YES ☐ NO

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

STARTING DATE: ____________________

HOSPITAL ORIENTATION DATE: ____________________

LOCATION: ____________________

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

COMPLETED BY:____________________

TO BE FILLED OUT BY HUMAN RESOURCES

POST OFFER:

PRE-EMPLOYMENT APPOINTMENT:____________________

POSITION: ____________________

DEPARTMENT: ____________________

GRADE:__________ STEP: __________

TENURE CREDIT:____________________

EQUAL OPPORTUNITY QUESTIONNAIRE

Last Name: ____________________________ First Name: _______________________ MI: ________

Social Security: _________________________ Home Zip Code#: _________________

Position/s Applying for: ____

It is the policy of Alameda Hospital to provide equal opportunity in all decisions regarding terms and conditions of employment including recruitment, hiring, training, promotions, transfers, discipline, layoff, recall, and termination without regard to race, sexual orientation, marital status, color, religion, creed, age, national origin, ancestry, physical or mental disability, medical condition (including cancer-related), veteran status and/or any other protected category as defined by law. We value the contributions that a diverse workforce brings to Alameda Hospital.

To ensure compliance with State and Federal government regulations, we request that you provide the following information. **NOTE: Submission of this information is optional and voluntary and this information will not adversely affect employment decisions, or become a part of your applicant file. Refusal to provide this information will not subject you to an adverse treatment.** Persons receiving this information will keep it confidential and use it only accordance with regulations.

☐ I prefer not to provide this information.

Please fill in appropriate response to each section.

Sex: _____ (M) _____ (F)

Birth Date: _____ - _____ - _____
(Month) (Day) (Year)

Race/ Ethnic Group (Choose One)

______ Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
______ White (Not Hispanic or Latino)	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
______ Black or African American (Not Hispanic or Latino)	A person having origins in any of the black racial groups of Africa.
______ Native Hawaiian or other Pacific Islander (Not Hispanic or Latino)	A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
______ Asian (Not Hispanic or Latino)	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
_______American Indian or Alaska Native (Not Hispanic or Latino)	A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
______Two or More Races (Not Hispanic or Latino)	All persons who identify with more than one of the above five races.

______________________________ ______________________________

Signature **Date**

Last Name: ______________________ First Name: ______________________ M.I _____

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To ensure compliance with State and Federal Government regulations, we suggest that you provide the following in your submission of information. Submission of this information is voluntary and is intended for use solely with the Hospital's Affirmative Action Program. This information will not adversely impact employment decisions, and will not become a part of your application file. Human Resources staff members will keep this information and use it in accordance of the Americans with Disabilities Act of 1973, as amended.

☐ I prefer not to provide this information. Refusal to provide this information will not subject you to any unfair treatment

Are you an Individual with a Disability?
_____ YES _____ NO

Individual with a Disability – Persons who have a physical or mental impairment, which substantially limits one or more major life activities; or persons who have a record of such impairment.

Are you a Vietnam Era Veteran?
______ YES ______ NO

Vietnam Era Veteran – Veterans who served on active duty for a period of more than 180 days between August 5, 1964, and May 7, 1975, and were discharged or released there from with an Honorable Discharge.

Are you a Special Disabled Veteran?
______ YES ______ NO

Special Disabled Veteran – Veterans entitled to disability compensation under the laws administered by the Veterans Administration for a disability rate at 30% or more, or released from active duty during a war in a campaign or expedition for which a campaign badge has been authorized.

Are you an Other Covered Veteran?
_____ YES ______ NO

Other Covered Veterans – Veterans who served on Active duty during a war or in a campaign or expedition for which a campaign badge had been authorized.

If you answered "Yes" to any of the questions above, do you require any accommodation to effectively perform the essential functions of your Job? ____ Yes _____ No

If yes, please indicate what accommodation(s) you require ____

____

Note: You can request accommodation now or at any time in the future.

Applicant Signature: ________________________________ **Date:** ________________

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