



Bibb Medical Center  
208 Pierson Avenue  
Centreville, AL 35042

# Application for Employment

*Bibb Medical Center is an Equal Opportunity Employer*

Application Date \_\_\_\_\_

PERSONAL DATA			
Last Name	First Name	Middle Name	Position Desired
Current Mailing Address			Please Check one of the Following: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary
City, State, and Zip Code			Willing to work shifts? Evenings <input type="checkbox"/> Yes <input type="checkbox"/> No Nights <input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone Number	Social Security Number		Willing to work weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth	The <b>Age Discrimination Act</b> prohibits discrimination on the basis of age with respect to individuals who are at 40, but less than 70 years of age.		Will you take a physical examination? <input type="checkbox"/> Yes <input type="checkbox"/> No

SELECTION SERVICE DATA	
Have you ever been in the U.S. Military Service	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service From:	To:
List Service Schools:	

EDUCATIONAL DATA				
<u>Name and Address of High School</u>	<u>Course or Major</u>	<u>Dates Attended</u>	<u>Graduate?</u>	<u>Date of Graduation</u>
<u>Name and Address of College</u>	<u>Course or Major</u>	<u>Dates Attended</u>	<u>Graduate?</u>	<u>Date of Graduation</u>
<u>Names and Address of Business, Technical or Professional School(s) Attended</u>	<u>Course or Major</u>	<u>Dates Attended</u>	<u>Graduate?</u>	<u>Date of Graduation</u>

Other Special Training

SPECIAL SKILLS AND INTERESTS
List any maintenance, shop equipment or office equipment you operate
Do you type? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how many words per minute?
Professional organizations, interest, hobbies (Please omit any which might indicate race, religion, color, national origin or ancestry)

**I understand that Bibb Medical Center reserves the right to administer a drug test to any applicant or employee at any time and I give my consent.**

\_\_\_\_\_  
Signature



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<b>EMPLOYMENT DATA (Begin with you most recent job)</b>		
<b>DATES OF EMPLOYMENT (Give Month and Year)</b>  From _____  To _____	Employer's Name	Salary Starting _____ Ending _____
	Employer's Address	List Duties
	Supervisor's Name	
	Reason for Leaving	May we contact your employer? ( ) Yes ( ) No
From _____  To _____	Employer's Name	Salary Starting _____ Ending _____
	Employer's Address	List Duties
	Supervisor's Name	
	Reason for Leaving	May we contact your employer? ( ) Yes ( ) No
From _____  To _____	Employer's Name	Salary Starting _____ Ending _____
	Employer's Address	List Duties
	Supervisor's Name	
	Reason for Leaving	May we contact your employer? ( ) Yes ( ) No

Have you ever worked at Bibb Medical Center before? ( ) Yes ( ) No  
If yes, give date: From \_\_\_\_\_ To \_\_\_\_\_

Names of relatives working at Bibb Medical Center \_\_\_\_\_

**GIVE NAME AND ADDRESS OF PERSON TO NOTIFY IN CASE OF EMERGENCY**

Name	Telephone Number	Address
City, State and Zip		

**MISCELLANEOUS INFORMATION**

Have you ever been convicted of a felony? ( ) Yes ( ) No If yes, list offenses: \_\_\_\_\_  
Date of Conviction(s) \_\_\_\_\_

Have you ever been reused a surety bond? ( ) Yes ( ) No

**Note: An answer of yes to either question does not necessarily disqualify you for employment at Bibb Medical Center**

**CERTIFICATION OF APPLICANT**

THE INFORMATION GIVEN IN THIS APPLICATION IS GIVEN OF MY OWN FREE WILL AND ACCORD AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS IS MY EXPRESSED PERMISSION FOR BIBB MEDICAL CENTER TO CONDUCT AN INVESTIGATION INTO MY BACKGROUND, EXPERIENCE, QUALIFICATIONS, ETC. I FULLY UNDERSTAND THAT, AS A CONDITION OF EMPLOYMENT, I WILL BE REQUIRED TO TAKE A PHYSICAL EXAMINATION AND THE INTERPRETATION OF THE RESULTS OF SUCH EXAMINATION SHALL BE MADE BY BIBB MEDICAL CENTER, IN ACCORDANCE WITH THE REHABILITATION ACT OF 1973. I FULLY UNDERSTAND THAT THE PERSONAL AND FAMILY MEDICAL RECORD FORM WILL BE KEPT CONFIDENTIAL, EXCEPT TO THE EXTENT THAT DISCLOSURE MAY BE REQUIRED IN ORDER TO COMPLY WITH THE REHABILITATION ACT OF 1973 OR ENSURE MY SAFETY OR THAT OF OTHER EMPLOYEES. ANY FALSE STATEMENT HEREON, OR ANY WITHHOLDING OF REQUESTED INFORMATION WILL BE SUFFICIENT CAUSE FOR REJECTION OR TERMINATION. I FURTHER UNDERSTAND THAT THIS STATUS CAN ONLY BE ALTERED BY A WRITTEN CONTRACT OF EMPLOYMENT WHICH IS SPECIFIC AS TO ALL MATERIAL TERMS AND IS SIGNED BY BOTH ME AND THE ADMINISTRATOR OF BIBB MEDICAL CENTER.

SIGNATURE OF APPLICANT \_\_\_\_\_

DATE \_\_\_\_\_