

CASCADE MEDICAL CENTER

817 Commercial Street
Leavenworth, WA 98826
Phone: 509-548-5815 Fax 509-548-2521
Website: www.cascademedicalcenter.org
An Equal Opportunity Employer

APPLICATION FOR EMPLOYMENT

INSTRUCTIONS: Please furnish all information requested on this form. If you wish to supply additional education or work history information, attach a separate sheet. Please type or print clearly.

POSITION(S) _____ DATE OF
APPLIED FOR _____ APPLICATION ____/____/____

PERSONAL DATA

Name _____ / ____ / ____
Last First Middle Social Security Number

Present
Address _____ (____)
Street City State Zip Phone Number

Email Address (please print) _____ Cell Phone# _____

Mailing Address _____ (____)
(If other than above) Street City State Zip Phone Number

Are you age 18 or older? Yes No

How did you learn about this position opening? Ad Friend Website Other _____

Have you any relatives employed here? Yes No If yes, please indicate name(s) and in what position.

Have you been previously employed here? Yes No If yes, give dates _____

Have you been convicted or pleaded no contest to any criminal offense?
 Yes No (A "yes" answer to this question will not necessarily bar the applicant from employment.)

If yes, explain fully _____

List any foreign language(s) and check the box that best describes your skill level.

LANGUAGE	READ/WRITE/SPEAK	READ/WHITE	READ/SPEAK	READ ONLY	SPEAK ONLY

ATTENDANCE

Do you now have or do you anticipate having any activities, commitments or responsibilities that may prevent you from meeting our work attendance requirements? Yes No

If yes, please explain _____

PROFESSIONAL REGISTRATION/LICENSURE

Type of Registration or License	State	Number	Date of Expiration

If you do not have a required registration or license, have you applied for one? Yes No

If an examination is required, what date are you scheduled to take the examination? _____

If not licensed in Washington State, have you applied for reciprocity? Yes No

I certify that the information set forth in this Application for Employment is true and complete to the best of my knowledge. I understand that, if employed, if I give false or incomplete information during the application process, it may result in immediate dismissal. I understand that my employment shall be contingent upon proof of identity and verification of eligibility for employment in the United States in accordance with the Immigration Reform and Control Act of 1986 of the Department of Homeland Security. I further understand that my employment is contingent upon the checking of references furnished by me, and contingent upon a background check performed by a third party for any criminal offenses.

I consent to and authorize Cascade Medical Center (CMC) and its personnel to request any information concerning my previous employment record as indicated on this Application for Employment. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such job related information. If employed, I release CMC from any liability for future references it may provide regarding my work history with Cascade Medical Center.

I understand and agree that my employment and compensation may be terminated at any time without prior notice, with or without cause, at the option of Cascade Medical Center or myself, unless my employment is covered by a collective bargaining agreement. I understand that no representative of Cascade Medical Center other than the CEO has authority to enter into any agreement contrary to the foregoing.

If employed, I further agree that if CMC advances any paid leave before it has been accrued, or advances/loans me any money during the course of my employment, or if I lose, damage or fail to return any CMC property, CMC is authorized to deduct from my wages sufficient funds to repay such loans/advances or the cost to replace its property in accordance with current state administrative codes

Signature of Applicant

Date

Cascade Medical Center Mission Statement

Cascade Medical Center is a rural healthcare center of dedicated professionals focused on providing high quality primary care services within our clinical and financial ability to meet the healthcare needs of all persons who seek out care, both patients and their families.

Cascade Medical Center is an equal opportunity employer and does not unlawfully discriminate on the basis of race, gender, sexual orientation, age, color, religion, national origin, marital status, veteran status, disability status or any other basis prohibited by federal, state, or local law. Please let us know if you need an accommodation in order to participate in our application process.

WORK SKILLS

LIST TRAINING AND/OR EXPERIENCE WHICH MAY QUALIFY YOU FOR THE POSITION(S) DESIRED: (MARK "T" IF YOU HAVE TRAINING IN THE SKILL "E" IF YOU HAVE EXPERIENCE IN THE SKILL. MARK "B" IF YOU HAVE BOTH TRAINING AND EXPERIENCE.)

<p>BUSINESS</p> <p>_____ Typing _____ W.P.M.</p> <p>_____ Shorthand _____ W.P.M.</p> <p>_____ Transcription _____ W.P.M.</p> <p>_____ Medical Terminology</p> <p>_____ Bookkeeping</p> <p>_____ Accounting</p> <p>_____ Ten-Key Adding</p> <p>_____ Calculator</p> <p>_____ Key Punch</p> <p>_____ Invoicing/Inventory</p> <p>_____ Reception</p> <p>_____ Phone Switchboard</p> <p>_____ Insurance Billing</p> <p>_____ Medicare/Medicaid</p> <p>_____ Word Processing</p> <p>_____ Software _____</p> <p>_____ Computers</p> <p>_____ Data Entry</p> <p>_____ Scanning</p> <p>_____ Coding</p> <p>Other: _____</p>	<p>GENERAL</p> <p>_____ Floor Care (Manual)</p> <p>_____ Floor Care (Machines)</p> <p>_____ Linen Packing</p> <p>_____ Autoclave</p> <p>_____ Sterilizer (Steam/Gas)</p> <p>_____ Dishwasher (Industrial)</p> <p>_____ Sewing</p> <p>_____ Maintenance (General)</p> <p>_____ Maintenance (Craft)</p> <p>_____ Electrical _____</p> <p>_____ Plumbing _____</p> <p>_____ Building _____</p> <p>_____ Electronics _____</p> <p>_____ Small Power Tools</p> <p>_____ Driving</p> <p>Other: _____</p>	<p>PATIENT CARE</p> <p>_____ Sterile Technique</p> <p>_____ Vital Signs</p> <p>_____ Pre-Op Preps</p> <p>_____ Isolation Technique</p> <p>_____ Catheterization</p> <p>_____ Coronary Care</p> <p>_____ Charting</p> <p>_____ Monitor</p> <p>_____ Type _____</p> <p>_____ Intensive Care</p> <p>_____ Orthopedic</p> <p>_____ Pediatric</p> <p>_____ Geriatric</p> <p>_____ Medical</p> <p>_____ Surgical</p> <p>_____ Obstetrics</p> <p>_____ Oncology</p> <p>_____ EMR</p> <p>Other: _____</p>
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Comments: _____

WORK AVAILABILITY

Full-time Part-time Temporary On-call If temporary or on-call, indicate when available:

Indicate shift(s) you will work:

1st shift - days 2nd shift - evenings 3rd shift - nights

Will you rotate shifts? Yes No Will you work weekends? Yes No

Indicate which days you are available for work.

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday

JOB PERFORMANCE ABILITY

Given your knowledge, skills, education and experience, are you able to perform all the essential functions of the position for which you are applying, with or without reasonable accommodation, as set forth in the job description? Yes No

EDUCATION

High School

Name, Location	Diploma or GED <input type="checkbox"/> Yes <input type="checkbox"/> No
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College after high school (include any job related education or training in military service)

Name, Location	Academic Major, Skill or Trade	Dates Attended	Did you graduate?

WORK EXPERIENCE

List most recent employer first. Include the past ten (10) years, and account for any periods of unemployment of more than 60 days in your employment history. Please include any military service. (Attach additional sheets if necessary.)

1. Name of employer, address	Dates employed (mo/yr) From To Final Salary \$	Name of supervisor Phone # May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your last job title and description		Reason for leaving:
2. Name of employer, address	Dates employed (mo/yr) From To Final Salary \$	Name of supervisor Phone # May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your last job title and description		Reason for leaving:
3. Name of employer, address	Dates employed (mo/yr) From To Final Salary \$	Name of supervisor Phone # May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your last job title and description		Reason for leaving:
4. Name of employer, address	Dates employed (mo/yr) From To Final Salary \$	Name of supervisor Phone # May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your last job title and description		Reason for leaving:

Did you work for any of the above employers under a different name? If so, please circle which one(s) 1 2 3 4

Give previous name _____