



AFFILIATED WITH  
SCOTT AND WHITE HEALTHCARE

1507 WEST MAIN • GATESVILLE, TEXAS 76528 • 254-248-6386 • Fax 254-248-6288  
Web site: [www.cmhos.org](http://www.cmhos.org) or E-mail address: [humanresources@cmhos.org](mailto:humanresources@cmhos.org)

Applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, or the presence of a non-job related medical condition or handicap.

(PLEASE PRINT)

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

Position(s) Applied For: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Address: \_\_\_\_\_  
NUMBER STREET CITY STATE ZIP CODE

E-Mail Address: \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Area Code Phone Number

If employed and you are under 18, can you furnish a work permit?  Yes  No  N/A

Relatives who are employed at Coryell Memorial Healthcare System - give names, relationship, and department:  
\_\_\_\_\_

Have you ever been employed here before?  Yes  No If yes, give date \_\_\_\_\_

Are you employed now?  Yes  No May we contact your present employer?  Yes  No

In case of emergency notify: \_\_\_\_\_  
Name Relationship

Address: \_\_\_\_\_  
Number Street City State Zip Code Telephone Number

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status?  Yes  No

**Proof of citizenship or immigration status is required upon employment (Form I-9)**

On what date would you be available for work? \_\_\_\_\_

Are you available to work  Full Time  Part-Time  Shift Work  Temporary

Are you on a lay-off and subject to recall?  Yes  No

Can you travel if a job requires it?  Yes  No

Have you been convicted of a felony within the last 7 years?  Yes  No

(Conviction will not necessarily disqualify applicant from employment.)

If **Yes**, please explain \_\_\_\_\_

AN EQUAL OPPORTUNITY EMPLOYER

Veteran of the U.S. Military service?  Yes  No If Yes, Branch \_\_\_\_\_

Indicate languages you speak, read, and/or write.

	FLUENT	GOOD	FAIR
SPEAK			
READ			
WRITE			

List professional, trade, business or civic activities and offices held. (You may exclude those which indicate race, color, religion, sex or national origin): \_\_\_\_\_

Give name, address and telephone number of three references who are not related to you, are not previous employers, and that can be reached during regular working hours (8:00 AM to 5:00 PM).

---



---



---

NURSING APPLICANTS ONLY		
Check one if applicable: <input type="checkbox"/> REGISTERED NURSE <input type="checkbox"/> LICENSED VOCATIONAL NURSE <input type="checkbox"/> STUDENT NURSE <input type="checkbox"/> GRADUATE NURSE <input type="checkbox"/> GRADUATE VOCATIONAL NURSE		CURRENT LICENSE NUMBER STATE: _____
BASIC NURSING PROGRAM <input type="checkbox"/> DIPLOMA <input type="checkbox"/> DEGREE: ___B.S. ___A.D.N.	LENGTH OF PROGRAM: _____ DATE OF GRADUATION: _____	CURRENT CERTIFICATIONS <input type="checkbox"/> BLS <input type="checkbox"/> ACLS <input type="checkbox"/> PALS <input type="checkbox"/> ATLS
SCHOOL OF NURSING: _____ ADDRESS: _____ CITY: _____ STATE: _____		
ADVANCED NURSING PREPARATION INSTITUTE OF STUDY: _____		MAJOR: _____ DATES ATTENDED: _____ DEGREE: _____
Indicate Service Preferred According to 1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Choice: <ul style="list-style-type: none"> <li>_____ Medical Services</li> <li>_____ Surgical Services</li> <li>_____ Special Care Services (ER/ICU)</li> <li>_____ Nursing Home</li> <li>_____ Home Health</li> <li>_____ Assisted Living</li> <li>_____ Other: _____</li> </ul>		

# Employment Experience

Start with your present or last job. Include military service assignments and volunteer activities. Exclude organization names which may indicate race, color, religion, sex or national origin.

<b>1</b>	Employer	Telephone	Dates Employed		<b>Work Performed</b>
		(            )	From	To	
	Address				
	Job Title	Hourly Rate / Salary			
		Starting	Final		
	Supervisor				
	Reason for Leaving				
<b>2</b>	Employer	Telephone	Dates Employed		<b>Work Performed</b>
		(            )	From	To	
	Address				
	Job Title	Hourly Rate / Salary			
		Starting	Final		
	Supervisor				
	Reason for Leaving				
<b>3</b>	Employer	Telephone	Dates Employed		<b>Work Performed</b>
		(            )	From	To	
	Address				
	Job Title	Hourly Rate / Salary			
		Starting	Final		
	Supervisor				
	Reason for Leaving				
<b>4</b>	Employer	Telephone	Dates Employed		<b>Work Performed</b>
		(            )	From	To	
	Address				
	Job Title	Hourly Rate / Salary			
		Starting	Final		
	Supervisor				
	Reason for Leaving				

**If you need additional space, please continue on a separate sheet of paper.**

## Special Skills and Qualifications

Summarize special skills and qualifications acquired from employment or other experience.

---



---



---

# Education

	Elementary	High School	College/University	Graduate/Professional
School Name				
Highest Grade Completed: (Circle)	4 5 6 7 8	9 10 11 12	1 2 3 4	1 2 3 4
Diploma/Degree Describe Course Of Study:				
Describe any Specialized Training, Apprenticeship, Skills and Extra-Curricular Activities				

Honors Received:

---



---

State any additional information you feel may be helpful to us in considering your application:

---



---

## Applicant's Statement

"I certify that the facts contained in this application and in any resume or other material provided to Coryell Memorial Healthcare System are true and complete to the best of my knowledge. I understand that, if employed, omissions, incomplete statements, or false statements on this application or other materials supplied to Coryell Memorial Healthcare System shall be grounds for dismissal." \_\_\_\_\_

"I authorize investigation of all statements contained herein and authorize the employers and references listed above to give you any and all information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you." \_\_\_\_\_

"I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time without any prior notice and without cause. I understand that employment for any period of time and any specific salary or benefits cannot be guaranteed to me except by a written employment agreement between me and Coryell Memorial Healthcare System, which is signed by the CEO of Coryell Memorial Healthcare System." \_\_\_\_\_

"In addition to all other rights provided herein, after I have accepted employment with the Healthcare System, I authorize Coryell Memorial Healthcare System to contact all present or past employers and references regarding me and all facts in the application and in other materials provided by me to Coryell Memorial Healthcare System and I release all parties from any damage that may result to me from furnishing the same to you." \_\_\_\_\_

"I understand that Coryell Memorial Healthcare System has a Drug and Alcohol Policy which includes the testing by urinalysis or otherwise of all applicants and of employees for alcohol and drug use. I agree to comply with that policy and consent to taking such tests as are requested of me." \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

**CORYELL MEMORIAL HEALTHCARE SYSTEM  
PRE-EMPLOYMENT DISCLOSURE & RELEASE**

APPLICANT'S FULL NAME: \_\_\_\_\_

MAIDEN/OTHER NAMES USED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_ STATE: \_\_\_\_\_

Pursuant to the requirements of the Fair Credit Reporting Act, I acknowledge that an investigative consumer report may be made in connection with my application for employment with Coryell Memorial Healthcare System, (including contract for services). I understand that these investigative background inquiries may include criminal, driving, prior employment and other reports. These reports may include information as to my character, work habits, performance and experience, along with reasons for termination of past employment from previous employers. Further, I understand that Coryell Memorial Healthcare System may be requesting information from various Federal, State and other agencies which maintain records concerning my past activities relating to my driving, criminal, civil and other experiences, as well as claims involving me in the files of insurance companies.

I authorize, without reservation, any party or agency contacted by Coryell Memorial Healthcare System to furnish the above-mentioned information. A photocopy of this authorization shall have the same effect as the original.

I understand the information obtained will be used as one basis for employment or denial of employment. I hereby discharge, release and indemnify Coryell Memorial Healthcare System, their agents, servants and employees, and all parties that rely on this release and/or the information obtained with this release from any and all liability and claims arising by reason of the use of this release and dissemination of information that is false and untrue if obtained from a third party without verification.

It is expressly understood that Coryell Memorial Healthcare System will not verify the information obtained through the use of this release.

The authorization granted herein expires one year from the date hereof.

I have read and understood the above information, and assert that all information provided by me is true and accurate.

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

.....  
**Do not write below this line**

**OFFICE USE ONLY**

If you are denied employment, either wholly or partly because of information contained in a report, a disclosure will be made to you of the name and address of the investigative agency making such report. Upon your written request within a reasonable period of time, the investigative agency compiling the report will make a complete and accurate disclosure of the nature and scope of the investigation.

*The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is for consumer report purposes. An "Investigative Consumer Report" means a consumer report or portion thereof in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with persons having knowledge.*

Position Held: \_\_\_\_\_ Company Name: \_\_\_\_\_

Dates Employed: From- \_\_\_\_\_ To- \_\_\_\_\_ Company Representative: \_\_\_\_\_

Eligible for Rehire: YES NO Reason for Leaving: Voluntary Involuntary

Additional Comments: \_\_\_\_\_

Information Received By: \_\_\_\_\_ Date: \_\_\_\_\_



## APPLICATION FOR EMPLOYMENT

This application will be active for (3) months after this application has been filed.

Name \_\_\_\_\_  
Last First Middle Social Security #

Position Applied for: \_\_\_\_\_

Where did you hear about us? \_\_\_\_\_

Do you have physical limitations that would hinder or impair your performance of the essential job functions of the position for which you have applied? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain \_\_\_\_\_

Would any special accommodations be required? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain \_\_\_\_\_

I have read the Job Posting and am familiar with the general qualifications for each position for which I have made application.

I understand that Coryell Memorial Healthcare System has published certain procedures and rules as guidelines for the conduct of employees and, if employed, I will be an employee at will and that neither my application nor the employee handbook constitutes all or any part of an employment contract between Coryell Memorial Healthcare System and me.

Date \_\_\_\_\_ Signature \_\_\_\_\_

The information requested below is used by the Personnel Department in keeping records and in filing reports as required in compliance with state and federal equal employment status, as Coryell Memorial Healthcare System is an Equal Opportunity Employer. This form or the information provided will not be attached to and/or accompany your Biographical Information form or affect the decision on your employment in any manner.

Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Race:

- \_\_\_\_\_ Black
- \_\_\_\_\_ White
- \_\_\_\_\_ Hispanic (includes Spanish origin or culture regardless of race)
- \_\_\_\_\_ American Indian (includes Alaskan natives)
- \_\_\_\_\_ Asian (includes Pacific Islanders)

I understand that this information is given voluntarily and is not a required part of the application process.

Date \_\_\_\_\_ Signature \_\_\_\_\_