SOUTH LYON MEDICAL CENTER
APPLICATION FOR EMPLOYMENT

APPLICATIONS NOT FILLED OUT COMPLETELY WILL BE REJECTED

South Lyon Medical Center is an equal opportunity employer and recruits, advertises, employs, promotes, transfers, disciplines and terminates without regard to race, color, religion, national origin, citizenship, age, gender, physical or mental disabilities, pregnancy, veteran status, or sexual orientation. Any applicant will be immediately rejected for employment or, if hired, will be terminated without notice for giving false information, omission of information, or failing to accurately provide information requested. **If hired, employment is "at-will" for no fixed term. The Hospital or the employee can terminate employment at any time.**

DATE: ______________________

PERSONAL DATA

Full name: ____ **S.S. number** ____________________
(Last) (First) (Middle)

List all other names you have worked under or are known by: ________________________________

Address: ____

mailing address if different: ____

Telephone: home ______________________ business ______________________

Have you ever worked for South Lyon Medical Center? [ ] yes [ ] no
If "yes", when? ______________ Under what name? ______________________

Have you ever applied for work at South Lyon Medical Center? [ ] yes [ ] no
If "yes", when? ______________________________

Do you have relatives who work, or have worked for this hospital? [ ] yes [ ] no
If "yes", give name, relationship, when employed: ______________________________

____

If hired, can you furnish proof of age? [ ] yes [ ] no (An offer of employment, if made, will be subject to verification that the applicant's age meets legal requirements i.e. that they are at least 16 years of age for most jobs and 18 years of age for some jobs.)

POSITION DESIRED

For what position are you applying? (Only one position per application) ______________________

Do you desire: **[ ] full time work [ ] part time work** **[ ] either full time or part time work**

Are you available to work: (check all that apply)

[ ] days [ ] evenings

[ ] nights [ ] weekends

Are you able to work overtime if requested?
[ ] yes [ ] no

On what date will you be available to start?______________________________

Are you now or, if hired, will you be working more than one job? [ ] yes [ ] no
If "yes", please explain:______________________________

____

BACKGROUND

Have you ever been convicted of a crime (misdemeanor or felony) under your current or another name in this or any other state? **[ ] YES** **[ ] NO**
If yes, document all information for all convictions. Please attach additional sheets if needed.

Conviction #1 – *

1. Your name at the time of the conviction______________________________
2. What you were charged with______________________________
3. Date of arrest______________ 4. Date of conviction______________
5. What you were convicted of______________________________
6. Disposition of the case______________________________
____
7. Location/Jurisdiction including city, county & state______________________________

Conviction #2 – *

1. Your name at the time of the conviction______________________________
2. What you were charged with______________________________
3. Date of arrest______________ 4. Date of conviction______________
5. What you were convicted of______________________________
6. Disposition of the case______________________________
____
7. Location/Jurisdiction including city, county & state ______________________________

* Please attach copies of official court proceedings and disposition of each conviction you have listed. Applications will be immediately rejected for omission of information or failing to provide documentation requested.

Have you ever been convicted of a DUI (Driving under the Influence)? **[ ] YES** **[ ] NO**
If yes, document all information for all convictions. Please attach additional sheets if needed.

Conviction #1 – *

1. Your name at the time of the conviction______________________________
2. Was it related to alcohol or controlled substance?______________________________
3. Date of arrest______________ 4. Date of conviction______________
5. Disposition of case______________________________
____
6. Location/Jurisdiction including city, county & state______________________________

* Please attach copies of official court proceedings and disposition of each conviction you have listed. Applications will be immediately rejected for omission of information or failing to provide documentation requested.

GENERAL

Can you speak, read and write English? [ ] yes [ ] no

Do you understand that all offers will be contingent upon the verification of lawful employment status as required by the Immigration Reform and Control Act of 1986 and that you must complete this process before starting work? If hired, can you verify eligibility to work in the United States?

[ ] yes [ ] no

Employment with the hospital is contingent upon successfully completing a urine screening for drugs. If an offer of employment is made, before commencement of your duties, you will be required to undergo a medical examination and a drug test, the results of which may affect the offer of employment. Are you willing to undergo such an examination and testing?

[ ] yes [ ] no

EDUCATION AND TRAINING

Name and address of High School attended: ____

____

Did you graduate? [ ] yes [ ] no If "no", do you have a GED? [ ] yes [ ] no

Name and address of other schools attended: (college, vocational, university, etc.)

School	address	dates attended from	to	Course or major	Did you graduate? yes	no

List other courses or special training, including military, which may relate to this job. Give dates of attendance.

____

____

Do you have any technical skills or foreign language skills which might help you in this job? Please explain.

____

____

List any other accomplishments or achievements which relate to this job. ______________________________

____

EMPLOYMENT HISTORY **(SLMC DOES NOT ACCEPT RESUMES)**

Please complete the following information.)

Have you ever been involuntarily terminated or asked to resign? If so, explain:____________________

____

____

LIST LAST FIVE EMPLOYERS IN CHRONOLOGICAL ORDER STARTING WITH THE MOST RECENT. DO NOT MAKE ANY OMISSIONS.

1. Name of Employer____________________ phone no.__________

   Address:______________________________

   Name of immediate supervisor:____________________ pay :$__________

   From:______ To:______ Position: __________ Reason for leaving: __________

2. Name of Employer____________________ phone no.__________

   Address:______________________________

   Name of immediate supervisor:____________________ pay :$__________

   From:______ To:______ Position: __________ Reason for leaving: __________

3. Name of Employer____________________ phone no.__________

   Address:______________________________

   Name of immediate supervisor:____________________ pay :$__________

   From:______ To:______ Position: __________ Reason for leaving: __________

4. Name of Employer____________________ phone no.__________

   Address:______________________________

   Name of immediate supervisor:____________________ pay :$__________

   From:______ To:______ Position: __________ Reason for leaving: __________

5. Name of Employer____________________ phone no.__________

   Address:______________________________

   Name of immediate supervisor:____________________ pay :$__________

   From:______ To:______ Position: __________ Reason for leaving: __________

What prompted your application? Own accord [ ] Advertisement [ ] Employee referral [ ] Other [ ]

If employee referral, please name the employee who referred you: ______________________________

AFFIDAVIT

I certify that the information on this application is true and complete. I understand that any misstatements or omissions of information are grounds for denial of employment, and if hired, for dismissal. I understand that employment is conditioned upon verification of information contained herein, as well as my undergoing a post-offer pre-employment drug test and job-related physical examination with results satisfactory to the Hospital.

I give the Hospital the right to request from the listed employers and schools as well as any other persons, schools, companies, credit bureau, state licensing, law enforcement, and other governmental agencies, any and all information about my background, along with any other pertinent information they may have, personal or otherwise without further notice to me. I release all parties from all liability, and agree not to file any claims, lawsuit, or any other cause of action of any kind against any person or entity arising out of the furnishing, receipt or use of such information.

I authorize the Hospital to obtain a consumer report as defined under the Fair Credit Reporting Act in accordance with 15 U.S. C. 1681, et. seq., which includes information on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, criminal record, or mode of living, and to use such information for employment purposes. I understand that if the Hospital relies upon a consumer report, I will be notified about my rights in a separate document.

I AGREE THAT MY EMPLOYMENT WITH THE HOSPITAL WILL BE AT-WILL. THIS MEANS THAT EITHER THE HOSPITAL OR I MAY TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME FOR ANY REASON AT ALL, WITH OR WITHOUT NOTICE. THIS CLAUSE CANNOT BE AMENDED, CHANGED, ALTERED, OR ABOLISHED EXCEPT IN WRITING SIGNED BY THE HOSPITAL ADMINISTRATOR. I ALSO AGREE THAT MY EMPLOYMENT WILL BE GOVERNED BY THE EMPLOYEE HANDBOOK TO THE EXTENT THESE DOCUMENTS ARE CONSISTENT WITH MY EMPLOYMENT AGREEMENT. THESE DOCUMENTS ARE SUBJECT TO CHANGE FROM TIME TO TIME.

______________________________ ______________________________
Applicant signature Date

______________________________ ______________________________
Received by Date

Return applications to:

Human Resources Department
South Lyon Medical Center
213 S. Whitacre St.
P.O. Box 940
Yerington, Nevada 89447

(775) 463-2301 ext. 217

All applications are "active" for one month and then kept in a "non-current" status for 3 months, after which time the applicant will need to re-apply if they wish to be considered for a future opening.

SOUTH LYON MEDICAL CENTER
YERINGTON, NEVADA

According to the requirements contained in NRS 449.160, 449.188, 200.5099 and 200.50955, and the federal Omnibus Reconciliation Act of 1987, **long term care and home health facilities are prohibited from employing anyone convicted of any of the following:**

1. Murder, voluntary manslaughter or mayhem;
2. Assault with intent to kill or to commit sexual assault or mayhem;
3. Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
4. Abuse or neglect of a child or contributory delinquency;
5. A violation of any federal or state law regulating possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 or NRS, within the past seven years;
6. Committing, allowing, or permitting the neglect, exploitation, isolation or abuse of an older person causing the older person to suffer unjustifiable physical pain or mental suffering;
7. Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property, within the immediately preceding seven years; or
8. Any other felony involving the use of a firearm or other deadly weapon, within the immediately preceding seven years.

By my signature below I certify that I *have not been convicted* of any of the above mentioned violations within the time frame indicated. I hereby authorize South Lyon Medical Center to investigate any criminal record and understand that such a conviction would prohibit my employment under the law. I further understand that if I have been hired and begun work and notice is received of conviction of any of the above, that I will be terminated. I understand that if I feel the information provided by the central repository is incorrect, I must immediately inform the Hospital and I will be given a reasonable amount of time of not less than 30 days to correct the information.

____

Applicant signature Date

SOUTH LYON MEDICAL CENTER
HUMAN RESOURCES DEPARTMENT
P.O. BOX 940
YERINGTON, NEVADA 89447
775-463-2301 ext.217 FAX 775-463-7864

South Lyon Medical Center provides health care for the public and in order to protect the public's trust, we must carefully consider each applicant applying for a position.

VALIDATION OF EMPLOYMENT - APPLICANT'S STATEMENT

I authorize South Lyon Medical Center and its personnel to ask any and all of my former employers and schools in a manner they choose, for information concerning me, whether good or bad. I know that complete information is important to my being hired or retained in any position offered to me.

I, therefore, release all parties and persons connected with any requests for information from all claims, liability and damages for whatever reason arising out of furnishing this information.

I authorize all of my former employers and schools to release to South Lyon Medical Center any requested information regarding my previous employment, schooling and performance.

APPLICANT
SIGNATURE______________________________ DATE____________________

Applicant - do not write below this line

EMPLOYER OR SCHOOL____________________________________

Please verify the following information

NAME OF APPLICANT__________________________ SS#______________

EMPLOYED OR ATTENDED SCHOOL FROM_______ TO ________

JOB TITLE____

APPLICANT'S STATED REASON FOR LEAVING__________________________

Is the above information correct? YES [ ] NO [ ] Please indicate any differences.
Is the employee eligible for rehire or recommendation for hire? YES [ ] NO [ ]
If not, why not?____
Reason for termination______________________________________
Please rate the applicant on the following:

		satisfactory	unsatisfactory
1.	Quality of Work	[ ]	[ ]
2.	General Knowledge	[ ]	[ ]
3.	Dependability	[ ]	[ ]

REFERENCE INFORMATION COMPLETED BY:

____________________________ ________________________
signature Title Date

Thank you for completing this request and returning it to me.________________________
SLMC HR coordinator Date

South Lyon Medical Center
Conditions of Admission

1. **Consent to Medical and Surgical Procedures.** The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services and which may include, but are not limited to, laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or surgeon. The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered to the patient under the general and special instructions of the physician. The undersigned recognizes that certain of the doctors furnishing services to the patient, including the radiologist, pathologist, anesthetist and the like are independent contractors and are not employees or agents of the hospital.

2. **General Duty Nursing.** The hospital provides only general duty nursing care. Under this system, nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special duty nursing care, it is agreed that such must be arranged by the patient, or his legal representative, or his physicians, and the hospital shall in no way be responsible for failure to provide the same, and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. **Release of Information.** The hospital may disclose all or any part of the patient's record to (1) any person or corporation which is or may be liable under a contract to the hospital or to the patient or to a family member for all or part of the hospital's charges, including but not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, and welfare funds, or (2) any governmental agency administering any state or federal civil law or regulation necessitating the examination of the patient's records, or (3) any insurance company or accreditation organization which either insures the hospital or examines it for accreditation.

4. **Personal Valuables.** It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables and the hospital shall not be liable for loss of or damage to any money, jewelry, glasses, dentures, furs, fur coats, fur garments or other articles of unusual value and small compass, unless placed therein, and shall not be liable for loss of or damage to any other personal property, unless deposited with the hospital for safekeeping.

5. **Assignment of Insurance Benefits.** In the event that the undersigned is entitled to hospital benefits of any type whatsoever arising out of any policy or insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to hospital for application on patient's bill, and it is agreed that the hospital may receipt for any such payment, and such payment shall discharge said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges not covered by this assignment.

6. **Medicare Patients Only.** Please be aware that all oral and take home drugs dispensed in the ER, Urgent Care, and Interim Care are not covered by Medicare, and that the patient is responsible for this charge.

7. **Financial Agreement.** The undersigned agrees, whether signing as an agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

8. **Notice of Possible Intern, Medical Student, Nursing Assistant Student, or Students in other Medical Disciplines Patient Care Participation.** The undersigned hereby acknowledges that he/she is aware that South Lyon Medical Center functions as a teaching hospital, and that a Medical Student, Intern, or student in another medical discipline may participate in his/her care.

The undersigned certifies that...

***☐YES ☐NO Have you applied for, or do you anticipate an application to *Nevada Medicaid* for this admission?

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms.

Date:______/______/______Time:__________ Patient's Signature____________________

Patient's Representative:____________________ and Relationship____________________