LIMESTONE SURGERY CENTER

1941 Limestone Rd, Suite 010
PO Box 5030
Wilmington, DE 19808-0030
302-633-9873 PHONE • www.limestonemed.com

Employment Application

Limestone Medical Center, Inc. is an Equal Opportunity Employer. Our personnel policy is aimed at assuring equal treatment to all individuals with regard to employment, rates of pay, and all other terms and conditions of employment regardless of race, religion, color, national origin, sex, age, veteran's status, or non-job related physical or mental handicap or disability.

POSITION APPLIED FOR _____ DATE OF APPLICATION _____/_____/_____

TYPE OF EMPLOYMENT DESIRED: ☐ FULL TIME… ☐ PART TIME ☐ REGULAR ☐ AS NEEDED ☐ EDUCATIONAL CO-OP

NAME (LAST)	FIRST	MIDDLE

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE: HOME (_____) _____-_____ WORK (_____) _____-_____ CELL (_____) _____-_____

EMAIL ADDRESS _____

HOW BEST MAY WE CONTACT YOU……. ☐ HOME ☐ WORK ☐ CELL TIME _____

SOCIAL SECURITY NO (Last 4 digits only)…… XXX-XX-_____

ARE YOU CURRENTLY EMPLOYED…… ☐ YES ☐ NO

IF NOT A U.S. CITIZEN, DO YOU HAVE WORK AUTHORIZATION…… ☐ YES ☐ NO

(PROOF OF CITIZENSHIP OR IMMIGRATION STATUS WILL BE REQUIRED BEFORE EMPLOYMENT)

ARE YOU UNDER 18…… ☐ YES ☐ NO

(IF YES A WORK PERMIT MAY BE REQUIRED)

HAVE YOU BEEN CONVICTED OF A FELONY IN THE LAST SEVEN (7) YEARS…… ☐ YES ☐ NO

DATE AVAILABLE FOR WORK…… _____/_____/_____

PAY RATE DESIRED_____

HAVE YOU EVER FILED AN APPLICATION AT THE CENTER BEFORE…… ☐ YES ☐ NO

WHEN_____

HAVE YOU EVER BEEN EMPLOYED IN THE LIMESTONE MEDICAL CENTER BEFORE…… ☐ YES ☐ NO

WHERE_____

IF YES, GIVE DATES…… FROM _____/_____/_____ TO _____/_____/_____

ARE YOU APPLYING AS A RESULT OF AN ADVERTISEMENT…… ☐ YES ☐ NO

EDUCATIONAL BACKGROUND

A. LIST SCHOOLS ATTENDED B. LIST NUMBER OF YEARS COMPLETED C. INDICATE DEGREE OR DIPLOMA
D. MAJOR FIELD OF STUDY

A. NAME		B. NO. YEARS COMPLETED	C. DEGREE DIPLOMA	D. MAJOR
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR				

MILITARY SERVICE

DATES OF SERVICE	FROM	TO	BRANCH
RANK AND PRINCIPLE DUTIES			
TYPE OF DISCHARGE			

EMPLOYMENT HISTORY

LIST BELOW YOUR FORMER EMPLOYERS, BEGINNING WITH THE MOST RECENT OR CURRENT:

CURRENT EMPLOYER	DATES EMPLOYED		WORK PERFORMED
	FROM	TO	
ADDRESS			
JOB TITLE	HOURLY RATE (SALARY)		
	STARTING		
IMMEDIATE SUPERVISOR NAME & TITLE			
REASON FOR LEAVING	HOURLY RATE		
	FINAL		

I AUTHORIZE LIMESTONE MEDICAL CENTER, INC. TO CONTACT MY CURRENT EMPLOYER FOR REFERENCES.

SIGNATURE:_____ DATE:_____

PREVIOUS EMPLOYER	DATES EMPLOYED		WORK PERFORMED
	FROM	TO	
ADDRESS			
JOB TITLE	HOURLY RATE (SALARY)		
	STARTING		
IMMEDIATE SUPERVISOR NAME & TITLE			
REASON FOR LEAVING	HOURLY RATE		
	FINAL		

EMPLOYMENT HISTORY ***(Continued)***

PREVIOUS EMPLOYER	DATES EMPLOYED		WORK PERFORMED
	FROM	TO	
ADDRESS			
JOB TITLE	HOURLY RATE (SALARY)		
	STARTING		
IMMEDIATE SUPERVISOR NAME & TITLE			
REASON FOR LEAVING	HOURLY RATE		
	FINAL		

PREVIOUS EMPLOYER	DATES EMPLOYED		WORK PERFORMED
	FROM	TO	
ADDRESS			
JOB TITLE	HOURLY RATE (SALARY)		
	STARTING		
IMMEDIATE SUPERVISOR NAME & TITLE			
REASON FOR LEAVING	HOURLY RATE		
	FINAL		

IF YOU NEED ADDITIONAL SPACE, PLEASE CONTINUE ON A SEPARATE SHEET OF PAPER.

LIST PROFESSIONAL, TRADE, BUSINESS OR CIVIC ASSOCIATIONS AND ANY OFFICES HELD:

ORGANIZATION	OFFICE HELD

LIST SPECIAL ACCOMPLISHMENTS OR AWARDS: _____

LIST ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO BE CONSIDERED: _____

I understand that any false answer, statement or representation made by me on this application is sufficient cause for rejection of employment or discharge, if employed. I also understand that nothing contained in this application, in any interview I receive or in any dealings I have with LIMESTONE MEDICAL CENTER, INC. is intended to create a contract between LIMESTONE MEDICAL CENTER, INC. and me either for employment or for benefits. If employed, I understand and agree that my employment is not for a definite period of time and that I and LIMESTONE MEDICAL CENTER, INC. have the right to terminate my employment at any time for any reason. I understand that, if accepted for employment, I must follow the rules and policies of LIMESTONE MEDICAL CENTER, INC. and that I will be on a trial period for six (6) months.

SIGNATURE: _____ DATE: _____

REFERENCES:

LIST NAME, ADDRESS AND TELEPHONE NUMBER OF THREE INDIVIDUALS WHO CAN PROVIDE INFORMATION ABOUT YOUR WORK EXPERIENCE, DEPENDABILITY, MOTIVATION AND OTHER RELEVANT FACTORS:

	TELEPHONE NUMBER	YEARS KNOWN
NAME ADDRESS	( ) -	
NAME ADDRESS	( ) -	
NAME ADDRESS	( ) -	

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for LIMESTONE MEDICAL CENTER, INC. ("LMC") to assess and verify educational background, professional qualifications and suitability for employment, I, authorize LIMESTONE MEDICAL CENTER, INC. to make inquiries about me from my previous employer(s), educational institutions, state licensing boards, professional liability insurance carrier(s), professional organizations and/or persons, agencies, organizations or institutions listed by me as a reference and to any other appropriate sources, to whom LIMESTONE MEDICAL CENTER, INC. may be referred by those contacted, authorize LIMESTONE MEDICAL CENTER, INC. to disclose sufficient information about me to such persons, employers, institutions, boards, insurance carriers, organizations, or agencies in order for LIMESTONE MEDICAL CENTER, INC. to make its inquiries concerning my qualifications, authorize release of such information and copies of related records to LIMESTONE MEDICAL CENTER, INC. release from liability all those who provide information about me without malice during the course of such inquiries.

SIGNATURE OF APPLICANT DATE (Month, Day, Year)