



**3533 South Alameda**  
**Corpus Christi, Texas 78411**  
**Phone: 361/694-6408**  
**Fax: 361/808-2115**  
**1-800-852-1366**  
www.driscollchildrens.org

# EMPLOYMENT APPLICATION

This facility is an Equal Opportunity/Affirmative Action Employer and considers employment applicants solely on the basis of qualifications for the job without regard to sex, race, religion, color, creed, national origin, disability, or veteran status. This facility does not discriminate on the basis of age for those applicants between 40 years of age and above. Any applicant with questions related to this policy is invited to contact the Administration of this facility.

(PLEASE PRINT)

**PERSONAL**

|  |  |                |                     |
|--|--|----------------|---------------------|
| LAST NAME  | FIRST  | MIDDLE         | SOCIAL SECURITY NO. |
| PRESENT ADDRESS  | CITY   | STATE          | ZIP CODE            |
| TELEPHONE NO.  | ALTERNATE NO.  |                |                     |
| ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THE U.S.?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | ARE YOU 18 YEARS OR OLDER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | E-MAIL ADDRESS |                     |

**JOB AND AVAILABILITY**

|   |   |  |
|---|---|--|
| JOB(S) APPLYING FOR:  |   |  |
| ARE THERE ANY HOURS, SHIFTS OR DAYS YOU CANNOT OR WILL NOT WORK?                |   |  |
| EXPECTED WAGE:  | STATUS PREFERRED:<br><input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> POOL | SHIFTS PREFERRED:  |
| WERE YOU EMPLOYED BY DRISCOLL CHILDREN'S HOSPITAL BEFORE?<br>DATES              | <input type="checkbox"/> YES <input type="checkbox"/> NO<br>JOB TITLES  | IF YES, PLEASE PROVIDE:<br>LAST NAME AT TIME OF EMPLOYMENT |
| RELATIVES EMPLOYED HERE:  | NAME(S)   | DEPARTMENT(S)  |
| SKILLS/WHERE RELATED TO POSITION:   |   |  |
| SHORTHAND _____ CALCULATOR _____ PBX _____ DICTAPHONE _____ CASH REGISTER _____ |   |  |
| COMPUTER SOFTWARE _____ OTHER _____   |   |  |

**EDUCATION**

|                                    |  |  |
|------------------------------------|--|--|
| HIGH SCHOOL                        |  | CIRCLE HIGHEST GRADE COMPLETED   |
| NAME OF LAST SCHOOL ATTENDED _____ |  | 1 2 3 4 5 6 7 8 9 10 11 12   |
| ADDRESS _____                      |  | GRADUATED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> GED _____                               |
| CITY/STATE _____                   |  |  |
| COLLEGE OR UNIVERSITY              |  | CIRCLE HIGHEST LEVEL COMPLETED   |
| NAME OF SCHOOL _____               |  | 1 2 3 4 5 6 7  |
| ADDRESS _____                      |  | DEGREE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MAJOR _____                                |
| CITY/STATE _____                   |  | <input type="checkbox"/> ASSOCIATE <input type="checkbox"/> BACHELOR <input type="checkbox"/> MASTERS <input type="checkbox"/> OTHER |
| COLLEGE/BUSINESS/TECHNICAL SCHOOL  |  | CIRCLE HIGHEST LEVEL COMPLETED   |
| NAME SCHOOL _____                  |  | 1 2 3 4 5 6 7  |
| ADDRESS _____                      |  | COURSE OF STUDY _____  |
| CITY/STATE _____                   |  | COMPLETED PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO  |

**PROFESSIONAL/TECHNICAL CLASSIFICATION**

CHECK APPROPRIATE SPACES:

NURSING: \_\_\_\_\_NURSE PRACTITIONER ( \_\_\_\_\_NNP \_\_\_\_\_PNP \_\_\_\_\_FNP)  
\_\_\_\_\_RN \_\_\_\_\_GN  
\_\_\_\_\_LVN \_\_\_\_\_GVN  
LICENSE# \_\_\_\_\_ STATE \_\_\_\_\_ EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

CERTIFICATIONS: \_\_\_\_\_CCC \_\_\_\_\_THORACIC COURSE  
\_\_\_\_\_CEN \_\_\_\_\_CPN \_\_\_\_\_CNOR \_\_\_\_\_CCRN \_\_\_\_\_RNC \_\_\_\_\_TNCC \_\_\_\_\_CHEMO \_\_\_\_\_SANE  
\_\_\_\_\_EMT \_\_\_\_\_PARAMEDIC \_\_\_\_\_OTHER EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICAL LAB: \_\_\_\_\_MT \_\_\_\_\_MLT \_\_\_\_\_PBT  
\_\_\_\_\_ASCP/CERTIFIED \_\_\_\_\_ASCP/ELIGIBLE EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SOCIAL WORK: \_\_\_\_\_LMSW \_\_\_\_\_LBSW \_\_\_\_\_LCSW EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

RADIOLOGY: \_\_\_\_\_RTR \_\_\_\_\_RTN \_\_\_\_\_CNMT \_\_\_\_\_RDMS \_\_\_\_\_CMRT \_\_\_\_\_ARRT EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PHARMACY: \_\_\_\_\_PHARM D \_\_\_\_\_LICENSED PHARMACIST \_\_\_\_\_CERTIFIED PHARMACY TECH EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

DIETITIAN: \_\_\_\_\_RD \_\_\_\_\_LD EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICAL RECORDS: \_\_\_\_\_RHIA \_\_\_\_\_RHIT EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

RESPIRATORY THERAPY: \_\_\_\_\_RRT \_\_\_\_\_CRT EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

CERTIFIED SURGICAL TECH EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

CERTIFIED NURSE AIDE EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

CERTIFIED OR REGISTERED MEDICAL ASSISTANT EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

REHAB. SERVICES  
\_\_\_\_\_ OCCUPATIONAL THERAPIST EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ PHYSICAL THERAPIST EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ SPEECH LANGUAGE PATHOLOGIST EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ AUDIOLOGIST EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ 8 WEEK NDT BABY COURSE (OT/PT/SLP) EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ AUGMENTATIVE COMMUNICATION SPECIALIST (SLP) EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ NIDCAP OR NDT BABY COURSE (OT/PT/SLP) EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

OTHER \_\_\_\_\_  
LICENSE# \_\_\_\_\_ STATE \_\_\_\_\_ EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

HAVE YOU EVER HAD YOUR WORK-RELATED REGISTRATION OR LICENSE SUSPENDED OR REVOKED?

YES  NO IF YES, GIVE DETAILS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF ACCEPTED FOR EMPLOYMENT, I AGREE TO MAINTAIN A CURRENT REGISTRATION, CERTIFICATION AND/OR LICENSE IN THIS STATE AND TO INFORM THIS HOSPITAL IN WRITING OF ANY REVOCATION, SUSPENSION OR VOLUNTARY TERMINATION OF REGISTRATION/LICENSE STATUS.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

DO YOU HAVE A LANGUAGE SKILL OTHER THAN ENGLISH THAT MAY BE OF USE IN YOUR EMPLOYMENT?

YES  NO IF "YES", PLEASE INDICATE:

MAKE ANY COMMENTS YOU BELIEVE SHOULD BE CONSIDERED.



**RECRUITMENT INFORMATION**

WHAT BROUGHT YOU TO THIS HOSPITAL?

- DCH WEBSITE \_\_\_\_\_
- EMPLOYEE REFERRAL \_\_\_\_\_
- INTERNSHIP/CLINICALS \_\_\_\_\_
- JOB/CAREER FAIR \_\_\_\_\_
- JOBLINE \_\_\_\_\_
- MAGAZINE \_\_\_\_\_
- INTERNET \_\_\_\_\_
- NEWSPAPER \_\_\_\_\_
- OTHER REFERRAL \_\_\_\_\_
- REHIRE \_\_\_\_\_
- WALK IN \_\_\_\_\_

HAVE YOU BEEN DISCHARGED OR ASKED TO RESIGN FROM A JOB?  YES  NO

IF "YES", EXPLAIN EACH OCCURRENCE:

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Other than minor traffic offenses, have you ever been, 1) convicted of a crime (misdemeanor or felony), 2) received a probated sentence (including deferred adjudication/pretrial diversion) for an alleged crime, 3) been assigned a probation officer, or 4) pleaded nolo-contendere to an alleged crime? ( A "Yes" response will not necessarily disqualify an applicant from employment.)

YES  NO

If "Yes", please explain. Attach additional pages if necessary

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**IMPORTANT READ CAREFULLY**

**EMPLOYMENT ACKNOWLEDGEMENT**

1. I understand that my application will be considered active for 90 days (3 months) from date of completion and that a completed application does not constitute an employment agreement. If not hired during this period of time, I may complete another application.
2. I understand that this application and any attachments are the property of Driscoll Children's Hospital.
3. If employed, I agree to be bound by the rules and policies of the hospital as made known to me at the time of employment or at any subsequent time; I further understand that I will be on an introductory period for ninety (90) days.
4. I understand, if offered employment, that as a condition of employment and as a condition of continued employment I am required to submit to and pass physical examinations and/or laboratory tests, or other tests that may be prescribed by the hospital.
5. I understand that I may be required to work varying hours including days, evening, nights, weekends, and holidays as patient care staffing needs of the hospital necessitate.
6. I certify that the statements made by me in this application and any attachment or documents, such as resumes, etc. submitted by me are true, complete and correct to the best of my knowledge and belief and are made in good faith.
7. I understand that any false statement, misrepresentation or omission of fact shall be sufficient cause for rejection of the application, or for the dismissal if such false statement is discovered subsequent to my employment.
8. I hereby authorize the authorities of the hospital to investigate all statements made on this application and release said hospital from any/all liability resulting from such investigation. I understand that Public Law 91-508 requires that the hospital advise me that routine inquiry may be made which will provide information concerning character, reputation, personal characteristics and mode of living. If such inquiry is made, I understand that I may obtain information as to the nature and scope of the report upon written request to the hospital.
9. I understand that if employed, my employment will be at will and may be terminated by the hospital or myself at anytime with or without cause. No hospital representative other than its president or a vice-president (and then only in writing) has any authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing.
10. I authorize DCH and its agents to confirm all information provided on this application, exhibits and resumes and to investigate my suitability for employment, including my work skills, work habits, ability, personal character and reputation. I agree to furnish additional information if requested. I release DCH and all persons and companies from any claims, liabilities or damages from obtaining or furnishing information about me. I understand that I will be provided a supplemental notification and authorization if DCH elects to conduct a consumer report about me under the fair credit reporting act.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**CONSUMER REPORT DISCLOSURE**

Pursuant to the requirements of the Fair Credit Reporting Act, notice is given that a consumer report and/or investigative consumer report may be obtained in connection with your application for and/or continued employment with Driscoll Children's Hospital (DCH). These reports may include information such as employment records, educational verification, licensure verification, driving history, previous addresses, criminal history, and other information relating to your character, general reputation, personal characteristics, and mode of living. A consumer report and/or an investigative consumer report may be obtained at any time during the application process or during your employment with DCH. If an investigative consumer report is prepared, you have the right to request in writing a complete and accurate disclosure of the nature and scope of the report, which may involve personal interviews with sources such as your former employers, friends, or associates.

Before any adverse action is taken, based in whole or in part on the information contained in a consumer report, you will be provided a copy of the report, the name, address, and telephone number of the reporting agency, and a summary of your rights under the Fair Credit Reporting Act.

**CONSUMER REPORT AUTHORIZATION**

I acknowledge receipt of this Consumer Report Disclosure and authorize DCH and its agents to obtain consumer reports and/or investigative consumer reports on me that may obtain information as to my character, general reputation, personal characteristics, and mode of living, for employment purposes at any time during my employment or as part of DCH's pre-employment background investigation. I understand that this consumer report and/or investigative consumer report will be obtained under the federal Fair Credit Reporting Act and will be used to determine my suitability for employment/continued employment.

I understand that DCH requires me to consent to the consumer report and/or investigative consumer report and provide certain identifying information to facilitate the record check process as a condition of employment. I also understand that failure to consent to consumer reports and/or investigative consumer reports will result in ineligibility for employment or termination of employment.

I authorize any person, organization, governmental authority, or other party to release and disclose information and cooperate in the obtaining and producing of consumer reports and/or investigative consumer reports on me. I understand that if an investigative consumer report is prepared, I have the right to request in writing complete and accurate disclosure of the nature and scope of the information requested and a summary of my rights as a consumer under the Fair Credit Reporting Act.

Today's Date: \_\_\_\_\_

Applicant/Employee's Signature: \_\_\_\_\_

**PLEASE PRINT THE FOLLOWING INFORMATION:**

Today's Date: \_\_\_\_\_

Applicant/Employee's Signature: \_\_\_\_\_

**General Information**

**PRINT your name as it appears on your Social Security Card**

Applicant/Employee's Name: \_\_\_\_\_

Applicant/Employee's Former names used: \_\_\_\_\_

Current Address (No PO Boxes): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Driver's License No.: \_\_\_\_\_ State: \_\_\_\_\_

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**Education Verification**

College/University: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_

Degree: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

**List all of the cities (including state and county) lived in for the last SEVEN YEARS (Please PRINT)**

| City | State | County (do not enter USA) |
|------|-------|---------------------------|
| 1.   |       |                           |
| 2.   |       |                           |
| 3.   |       |                           |
| 4.   |       |                           |

**\*\* I authorize, without reservation, any party or agency contacted by PreCheck, Inc. to furnish the information mentioned above. A photocopy of this authorization shall have the same effect as the original.**



Date:

To:

Fax:

Dear Sir/Madam:

You have been identified as a reference for the individual named below. We would appreciate your supplying the following information at your earliest convenience. Thank you for your prompt reply.

Recruiter  
Human Resources  
(361) 694-6408  
**FAX: (361) 808-2115**

I hereby authorize any prior employers, educational institutions and/or enforcement agencies to provide to the authorities of the Driscoll Children's Hospital such information, transcripts, records or official copies, etc. as may be deemed necessary.

**\*\*APPLICANT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
*(Applicant, please sign and date only)*

APPLICANT: \_\_\_\_\_ SS# \_\_\_\_\_

LAST NAME WORKED UNDER: \_\_\_\_\_ TERM DATE: \_\_\_\_\_

EMPLOYMENT DATES: FROM \_\_\_\_\_ TO: \_\_\_\_\_

FULL TIME \_\_\_\_\_ PART TIME \_\_\_\_\_ POOL \_\_\_\_\_ TITLE: \_\_\_\_\_

ELIGIBLE FOR REHIRE: YES \_\_\_\_\_ NO \_\_\_\_\_ IF NO, PLEASE COMMENT: \_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_

ADDITIONAL COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
VERIFIED BY: \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_

For Office Use Only

Name (print): \_\_\_\_\_  
SS#: \_\_\_\_\_

|                     |
|---------------------|
| For Office Use Only |
| _____               |
| _____               |

## **Driscoll Children's Hospital**

### **Authorization and Release to Test**

I hereby consent to let any necessary samples of hair, blood, breath, fingernails, or urine be taken and tested by a laboratory designated by Driscoll Children's Hospital (the "Hospital") to determine the current illegal use of drugs, and/or the presence of alcohol in my system. (Applicants will not be tested for the presence of alcohol.)

I understand that any offer of employment that I receive is contingent upon a negative drug test (as defined by the Hospital's Alcohol and Drug Abuse Guidelines).

I hereby authorize the Hospital to take the above samples and to perform any test to make the above determination. I agree to cooperate in the taking and testing of such samples. I also authorize the release of the results of such tests to Hospital management officials.

I understand that refusal to cooperate in giving any samples (including signing this Authorization and Release to Test) as required will result in my ineligibility for employment with the Hospital or my termination from employment with the Hospital. I also understand that the results of these tests will be used to determine my eligibility or continued suitability for employment with the Hospital and my compliance with the Alcohol and Substance Abuse policy. I understand that I may refuse to be tested. However, I also understand that my employment with the Hospital may be terminated if I refuse such testing.

I hereby release the Hospital and laboratory performing the testing and their officers, directors, employees, attorneys, representatives, and/or agents from any and all liability arising out of the taking or testing of any samples and/or communicating the test results pursuant to this authorization and release.

I understand that as an employee of the Hospital, I am subject to further substance abuse testing, including but not limited to, reasonable suspicion and random testing. I also understand that my employment with the Hospital may be terminated if I refuse such testing.

I understand that this testing authorization and release does not constitute an employment agreement or contract with the Hospital.

I have signed this authorization and release voluntarily and of my own free will.

Signature: \_\_\_\_\_

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