OCONEE
REGIONAL
MEDICAL
CENTER

P. O. Box 690
821 N. Cobb Street
Milledgeville, GA 31061
(478) 454-3500

APPLICATION INSTRUCTIONS

Oconee Regional Health Systems Inc. (ORHS) thanks you for your interest in employment with us. To assist you in completing the application process we have posted this on-line application that you can submit. For your convenience, we have provided this application to you online. To complete this application, please follow the instructions provided below. If we can be of further assistance to you, please contact us at (478) 454-3540 in the Human Resources Department. [Fax: (478) 454-3546]

Instructions:

1. Once opening this file, you can print it, fill it out by hand, and either deliver or mail to:

   Oconee Regional Medical Center
   Attn: Human Resources
   PO Box 690
   Milledgeville, GA 31061

2. To complete online, please follow these instructions:
   a. Pre-Hire Voluntary Survey (page 2)
      i. Note: This is not a part of the application process or personnel file and will not effect any employment decision. This form is confidential and participation is voluntary.
      ii. If you choose not to complete this form, please go to page 3 of this document.
   b. Application for Employment (page 3)
      i. This form is in Adobe Acrobat format. You will need an email program configured (such as Microsoft Outlook, Eudora, etc.) to submit. If you reach the end of this application and are unable to submit for any reason, simply print this completed application and either deliver, fax, or mail to the address above. You can also save the application and submit using another email application as an attachment.
      ii. Now, let's complete this application. To type in your information, begin by placing your mouse pointer in the block under "Last Name" on the Application. Once typing in your last name, you can navigate the Application by simply pressing the [TAB] key on your keyboard. This will take you to the next field in sequence.
      iii. For "Home Phone" and "Phone Number for MSG" just type in the 7 digits to your phone number (e.g. 4444444444). When you press [TAB], the number is reformatted to look like (444) 444-4444. If you enter the phone numbers with any other characters than numbers, it will reject the input. Follow these same instructions for any and all phone number fields in the application (there are 10). Follow the same process for entering your social security number. (444444444 will be formatted to view as 444-44-4444)
      iv. To check a checkbox, just press the [SPACEBAR] on your keyboard. You may also manually place a check in the box by pressing the left mouse button after placing the mouse pointer inside the box you want to check. To uncheck a box, use either your space bar (prior to [TAB] to the next field) or follow the same procedure with your mouse as you would to check the box.
      v. To insert your digital signature at the end of the application, just type in your name "-" social security number. (e.g. Firstname Lastname / ###-##-####)
      vi. To complete the process press the [SUBMIT] button. The form will automatically select your email program and place this application as an attachment. All you need to do is send the email. Once exiting the email program, a confirmation will appear in the window of your browser.

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PRE-HIRE VOLUNTARY SURVEY

Oconee Regional Health Systems Inc. (ORHS) is an Equal Employment Opportunity employer. ORHS is committed to providing equal opportunity in employment, including but not limited to selection, hiring, assignment, reassignment, promotion, transfer, compensation, discipline and termination.

This voluntary survey assists us in complying with government requirements. Your completion of the Pre-Hire Voluntary Survey is optional. If you choose to volunteer the requested information, please note that this form is kept in a Confidential File and is not a part of your application for employment or personnel file.

YOUR COOPERATION IS VOLUNTARY. INCLUSION OR EXCLUSION OF ANY DATA WILL NOT AFFECT ANY EMPLOYMENT DECISION.

The data collected from applicants is for statistical analysis with respect to equal employment opportunity.

Name: ______________________________ **Date:** ______________

Address: ____

City: ____________________________ **State:** __________ **Zip:** __________

Position Applied For: ______________________________________

Check One: Male_______ Female________

Check one of the following:

_____ Black or African American

_____ Caucasian or White

_____ Native Hawaiian or other Pacific Islander

_____ American Indian/ Alaskan Native

____ Hispanic or Latino (White race)

____ Hispanic or Latino (all other races)

____ Asian

____ Other ______________________

(For Office Use Only)
EEO-4 Number __________

ORMC IS A DRUG-FREE WORKPLACE ***Revised 12/12/03***

OCONEE REGIONAL MEDICAL CENTER

821 NORTH COBB STREET
MILLEDGEVILLE, GA 31061

APPLICATION FOR EMPLOYMENT

PLEASE READ CAREFULLY- WRITE CLEARLY ANSWER ALL QUESTIONS

FEDERAL AND STATE LAWS PROHIBIT DISCRIMINATION IN EMPLOYMENT BECAUSE OF RACE, COLOR, CREED, AGE, SEX, MARITAL STATUS, NATIONAL ORIGIN, PHYSICAL OR MENTAL IMPAIRMENT OR MEDICAL CONDITION.

PRINT NAME AS IT APPEARS ON YOUR SOCIAL SECURITY CARD

NAME & LOCATION

(LAST NAME) | (FIRST NAME) | (MIDDLE NAME) | APPLICATION DATE

CURRENT ADDRESS (NUMBER & STREET) | HOME PHONE | PHONE NUMBER FOR MSG

CITY, STATE & ZIP | SOCIAL SECURITY NO.

EMPLOYMENT DESIRED

FIRST CHOICE — EXPERIENCE? YES ☐ NO☐

SECOND CHOICE — EXPERIENCE? YES ☐ NO☐

HAVE YOU WORKED FOR US BEFORE? YES ☐ NO☐ (IF YES, STATE DATE LEFT)

WILL YOU ACCEPT PART TIME WORK') YES ☐ NO☐

WILL YOU ACCEPT TEMPORARY WORK? YES ☐ NO☐

HAVE YOU WORKED FOR US BEFORE UNDER ANOTHER NAME? YES ☐ NO☐ (IF YES, STATE NAME)

SHIFT OR HOURS YOU CAN WORK 1ST ☐ 2ND ☐ 3RD ☐

OTHER

CITIZENSHIP

ARE YOU EITHER A UNITED STATES CITIZEN OR AN ALIEN WHO HAS THE LEGAL RIGHT TO WORK IN THE JOB FOR WHICH YOU ARE APPLYING? YES ☐ NO☐

PURSUANT TO THE IMMIGRATION REFORM AND CONTROL ACT OF 1986, ALL APPLICANTS UPON BEING MADE AN OFFER OF EMPLOYMENT, MUST PRODUCE **DOCUMENTS WHICH ARE** SPECIFIED BY THE FEDERAL GOVERNMENT, ESTABLISHING THEIR IDENTITY AND AUTHORIZATION FOR EMPLOYMENT IN THE UNITED STATES. THESE DOCUMENTS MUST BE PRODUCED NO LATER THAN SEVENTY-TWO (72) HOURS AFTER COMMENCE-MENT OF EMPLOYMENT. YOU WILL ALSO BE REQUIRED TO SIGN FORM 1-9 (ISSUED BY THE FEDERAL GOVERNMENT) VERIFYING, UNDER OATH, YOUR EMPLOYMENT AUTHORIZATION.

U.S. MILITARY SERVICE

HAVE YOU SERVED IN THE U.S. MILITARY? YES ☐ NO☐

PLEASE LIST JOB-RELATED SKILLS OR EXPERIENCE

STATEMENT OF HEALTH

CAN YOU SAFELY PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION FOR WHICH YOU ARE APPLYING? YES ☐ NO☐

EXPLAIN:

ARE YOU WILLING TO TAKE A PHYSICAL EXAMINATION AND/OR A DRUG TEST AT OUR EXPENSE UPON A CONDITIONAL OFFER OF EMPLOYMENT? YES ☐ NO☐

PERSONAL

HAVE YOU, SINCE THE AGE OF 18, EVER BEEN CONVICTED OF A FELONY? YES ☐ NO☐ — IF YES, EXPLAIN - GIVE DATES

HAVE YOU EVER BEEN INVOLUNTARILY DISCHARGED FROM A JOB? YES ☐ NO☐ — IF YES, EXPLAIN -GIVE DATES

HAVE YOU ANY HOBBIES OR INTERESTS, OR BELONG TO ANY CLUB, ORGANIZATION, SOCIETY OR PROFESSIONAL GROUP WHICH HAS A DIRECT BEARING ON YOUR QUALIFICATION FOR THE JOB WHICH YOU ARE SEEKING? YOU MAY OMIT THOSE WHICH INDICATE YOUR RACE, RELIGIOUS CREED, COLOR, NATIONAL ORIGIN, ANCESTRY, SEX, AGE, PHYSICAL OR MENTAL IMPAIRMENT, OR MEDICAL CONDITION.

IF YES, EXPLAIN

YES ☐ NO☐

EDUCATION

NAMES / COMPLETE ADDRESSES OF SCHOOLS	ACADEMIC MAJOR	NUMBER OF YRS ATTENDED	DIPLOMA?
LAST ELEMENTARY SCHOOL			
LAST HIGH SCHOOL			
JR. COLLEGE, COLLEGE, OR UNIVERSITY			
TECHNICAL OR VOCATIONAL SCHOOL			

OTHER DETAILS OF EXPERIENCE OR TRAINING, INCLUDING INFORMATION ON ADULT EDUCATION PROGRAMS WHICH HAVE A DIRECT BEARING ON THE JOB WHICH YOU ARE SEEK-ING?	SCHOOL	COURSE	DIPLOMA OR CERTIFICATE	DATE COMPLETED

REFERENCES

GIVE NAME(S) OF PERSONS WE MAY CONTACT TO VERIFY YOUR QUALIFICATIONS FOR THE POSITION.

NAME	OCCUPATION	ORGANIZATION
	PHONE	ADDRESS
NAME	OCCUPATION	ORGANIZATION
	PHONE	ADDRESS
NAME	OCCUPATION	ORGANIZATION
	PHONE	ADDRESS

EXPERIENCE

GIVE A COMPLETE RECORD OF ALL EMPLOYMENT AND REASONS FOR PERIODS UNEMPLOYED DURING PAST FIFTEEN YEARS. START WITH MOST RECENT EMPLOYMENT

LAST EMPLOYMENT FIRST		EMPLOYER'S NAME, ADDRESS, TELEPHONE NUMBER		LAST SALARY AND POSITION(S) HELD	REASON FOR LEAVING	VERIF
FROM - MO/YR	TO - MO/YR					
		EMPLOYER		SALARY		
		NO. & STREET		POSITION		
		CITY, STATE & ZIP	PHONE	SUPERVISOR		
		EMPLOYER		SALARY		
		NO. & STREET		POSITION		
		CITY, STATE & ZIP	PHONE	SUPERVISOR		
		EMPLOYER		SALARY		
		NO. & STREET		POSITION		
		CITY, STATE & ZIP	PHONE	SUPERVISOR		
		EMPLOYER		SALARY		
		NO. & STREET		POSITION		
		CITY, STATE & ZIP	PHONE	SUPERVISOR		
		EMPLOYER		SALARY		
		NO. & STREET		POSITION		
		CITY, STATE & ZIP	PHONE	SUPERVISOR		

MAY WE CONTACT YOUR PRESENT EMPLOYER FOR A REFERENCE? YES ☐ NO ☐

LIST OFFICE MACHINES YOU CAN USE NOT APPLICABLE ☐

TYPING SPEED WPM

SHORTHAND SPEED WPM

PLEASE LIST WHAT OTHER EQUIPMENT YOU CAN OPERATE NOT APPLICABLE ☐

CAN YOU TRANSCRIBE DR's ORDERS? YES ☐ NO ☐ NOT APPLICABLE ☐

PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS

TYPE	STATE ISSUED	ORIGINAL ISSUE DATE	NO,	VERIF
TYPE	STATE ISSUED	ORIGINAL ISSUE DATE	NO.	
TYPE	STATE ISSUED	ORIGINAL ISSUE DATE	NO.	

AREA OF SPECIALIZATION OR MAJOR INTEREST

AFFIDAVIT I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever, I agree that my employer shall not be liable in any respect if my employment is terminated because of the falsity of statements, answers or omissions made by me in this questionnaire. I authorize employers, companies, schools or persons named above to give any information regarding my employment, together with any information they may have regarding me whether or not it is in their records. I hereby release said employees, companies, schools or persons from all liability for any damage, both legal and otherwise, for issuing this information. I also understand a conditional offer of employment may be based on results of a later medical examination. In addition, if accepted for employment, I hereby agree to abide by the rules and policies of my employer.

Further, I understand that any employment is not for a stated period of time and may be terminated with or without cause, at any time, at the option of either myself or my employer. ORMC is certified as a Drug-Free Workplace. I agree to abide by such established policies as relates thereto.

Signed ______________________________ Date ______________

ORMC IS A DRUG-FREE WORKPLACE

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

TYPING YOUR NAME AND SSN CERTIFIES THIS APPLICATION SHOULD BE SUBMITTED WITH YOUR APPROVAL.
ALTHOUGH THIS WILL BE ACCEPTED AS YOUR DIGITAL SIGNATURE, YOUR ACTUAL SIGNATURE IS REQUIRED PRIOR TO POSITION BEING OFFERED.

APPLICANT - PLEASE DO NOT USE THIS SPACE

INTERVIEWED BY		DATE	TIME	RATED BY	DATE	TIME
DISPOSITION	POSITION TITLE	POSITION CODE	DEPARTMENT	RATE	SHIFT	STARTING DATE	SUPERVISOR