

# Sabine Medical Center

\*Allegiance Behavioral Health Centers  
 \*Allegiance Health Centers  
 \*Critical Access Hospitals

\*Inspirations Counseling Centers  
 \*Allegiance Specialty Hospitals  
 \*Rural Hospitals

## APPLICATION FOR EMPLOYMENT

ALLEGIANCE HEALTH MANAGEMENT INC (ALLEGIANCE) IS AN EQUAL OPPORTUNITY EMPLOYER. All practices of recruiting, hiring, promotion, transfer, wage and salary administration, benefits and terminations are administered without regard to race, color, creed, sex, religion, national origin, disability, age, veteran status or any and all other unlawful biases regarding federal, state or local laws. Further, we are committed to providing a work environment that prohibits, in any form, unlawful harassment. To be considered for employment, all applicants must fill out this form completely. ("See resume" is not an appropriate response). This application will be considered, but its receipt does not imply that the applicant will be employed by the company. This form becomes a part of your permanent employment record if you are hired.

### PERSONAL INFORMATION (Please Print Full Legal Name)

Last Name	First Name	Middle Name	Social Security Number
Current Street Address		P.O. Box No. /Apt. No. /Unit No.	Area Code – Current Phone Number
City	State	Zip Code	Email

List all names or aliases ever used: \_\_\_\_\_

List all addresses for the last 7 years:

Previous Address - Street/P.O. Box No.	City/State	Zip Code
Previous Address - Street/P.O. Box No.	City/State	Zip Code
Previous Address - Street/P.O. Box No.	City/State	Zip Code

### TYPE OF WORK DESIRED

Position(s) applying for \_\_\_\_\_ Requested Salary \$ \_\_\_\_\_ Per \_\_\_\_\_ Hour

The following conditions might be required at some point in a job assignment. Do you agree to satisfy the following work schedule?

- |                                     |   |
|-------------------------------------|---|
| a. Shift work?    ___ Yes ___ No    | d. Work schedule other than Monday to Friday?    ___ Yes ___ No                 |
| b. Overtime work?    ___ Yes ___ No | e. Do you agree to work the hours required for your position?    ___ Yes ___ No |
| c. Rotation work?    ___ Yes ___ No | f. Shift desired?    ___ Day ___ Evening ___ Night                              |

Status of employment for which you are applying:    \_\_\_ Full-time    \_\_\_ Part-time    \_\_\_ Per Diem (PRN)

### GENERAL INFORMATION

Are you at least 18 years of age or older?    \_\_\_ Yes \_\_\_ No

As a U.S. citizen or based on immigrant status, do you have legal right to work in the United States?    \_\_\_ Yes \_\_\_ No

Has Allegiance or any of its subsidiaries ever employed you or any of your relatives? If yes, please indicate which subsidiary and dates of employment:

\_\_\_\_\_

Are you a United States Veteran?    \_\_\_ Yes \_\_\_ No    If yes, please list date of separation: \_\_\_\_\_

To assist us in our recruitment efforts, please indicate how you were referred to Allegiance Health Management.

___ Walk-in _____	___ Newspaper Ad (please specify): _____
___ Job Fair (please specify): _____	___ Website or Internet (what site?): _____
___ Employee Referral (please specify): _____	___ Other: (please specify): _____

Do you have a relative that works for any Allegiance Health Management facility? If yes, what department?  
 \_\_\_\_\_

**SECURITY DATA**

Pursuant to the OIG Compliance Program, Employees convicted of criminal offenses or offenses including fraud and abuse related to health care are prohibited from participating in any portion of the direct or indirect health care delivery process. In the event of any pending charges, current employees may be removed from direct responsibility including patient care or involvement with any Federal health care program.

Have you ever been convicted or plead guilty or no contest to any criminal offense? \_\_\_\_\_ Yes \_\_\_\_\_ No  
*(Criminal convictions are not an automatic ban from employment and will only be considered in relation to specific job requirements.)*

Have you ever been convicted of a criminal offense related to health care or listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federal health care programs? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you answered "yes" to either or the above questions, please briefly describe the circumstances of your conviction indicating the date, nature and place of the offense and disposition of the case.

\_\_\_\_\_  
 \_\_\_\_\_

EDUCATION AND TRAINING		No. of Years Completed	Graduated		Type of Degree, Diploma or Certificate and Major Course of Study	Academic Standing
Institution Name and Location			Yes	No		
High School						
College/ University						
Graduate School						
Trade School/ Other						

**ACADEMIC ACHIEVEMENTS AND ACTIVITIES:**

Please list academic honors, scholarships, or fellowships; memberships in academic honorary societies; or participation in or offices held in extracurricular activities you consider significant. **(You may exclude all information of age, sex, race, religion, color, national origin and handicap.)**

\_\_\_\_\_  
 \_\_\_\_\_

**EMPLOYMENT HISTORY**

Please list your employment history for the past 15 years or your last five employers. Start with your current employer. Include U.S. Military Service.

Name of Employer: \_\_\_\_\_ Area Code & Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_ Salary: Starting \_\_\_\_\_ Ending \_\_\_\_\_

Duties Performed: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

May we contact this employer? \_\_\_\_\_ Yes \_\_\_\_\_ No If no, please explain why \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Area Code & Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_ Salary: Starting \_\_\_\_\_ Ending \_\_\_\_\_

Duties Performed: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

May we contact this employer?  Yes  No If no, please explain why \_\_\_\_\_

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Name of Employer: \_\_\_\_\_ Area Code & Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_ Salary: Starting \_\_\_\_\_ Ending \_\_\_\_\_

Duties Performed: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

May we contact this employer?  Yes  No If no, please explain why \_\_\_\_\_

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Name of Employer: \_\_\_\_\_ Area Code & Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_ Salary: Starting \_\_\_\_\_ Ending \_\_\_\_\_

Duties Performed: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

May we contact this employer?  Yes  No If no, please explain why \_\_\_\_\_

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Name of Employer: \_\_\_\_\_ Area Code & Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_ Salary: Starting \_\_\_\_\_ Ending \_\_\_\_\_

Duties Performed: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

May we contact this employer?  Yes  No If no, please explain why \_\_\_\_\_

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Please explain all periods of unemployment:

\_\_\_\_\_

\_\_\_\_\_

LICENSED/CERTIFIED APPLICANTS ONLY					
	State & License No.	Expires (Date)		State & License No.	Expires (Date)
Registered Nurse			Licensed Social Worker		
LVN / LPN			Speech/Language Pathologist		
Certified Nursing Assistant			Licensed Professional Counselor		
Respiratory Therapist			Recreational Therapist		
Physical Therapist			CPR (BCLS)		
Occupational Therapist			Other (specify)		
Have any disciplinary actions been taken against your license/licenses? If so, explain					

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Please indicate any other information you think would be helpful to us in considering you for employment, such as additional work experience, activities, accomplishments, voluntary work experience, and any other languages spoken.

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Please list any other professional memberships, organizations or certifications you hold.

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**REFERENCES**  
List three (3) Business Professional Reference of those who have worked with you. If this is your first job, please list i.e. Teachers, Pastors, Professors that know you. Do not list anyone related to you.

Name	Address & Phone No.	Occupation	Years Known
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**READ CAREFULLY BEFORE SIGNING THE APPLICATION FOR EMPLOYMENT:**  
If employed by Allegiance and in consideration thereof, I understand and agree to:

- I certify that the answers given by me to the forgoing questions and statements on the employment application and or during the employment interview process are true and correct without any consequential omissions of any kind whatsoever. I understand that any misleading or incorrect statements may render this application void and, if employed, would be cause for my termination. I further agree that Allegiance shall not be liable in any respect if my employment is terminated because of falsity of statements, answers or omissions made by me in this application.
- I authorize the companies' schools, persons or entities given during the employment process or on this employment application as references or past employers or affiliations to give any information regarding my employment, character, qualifications, certifications and licenses and hereby release said companies, schools, persons or entities from all liability for any damage for issuing this information.
- I understand that I may be required to have a medical examination and/or drug and alcohol test after an offer of employment has been made and prior to the commencement of my employment duties. A favorable result on the medical examination and/or drug and alcohol test would be a condition of my employment or commencement of any employment duties.
- I understand that my employment is not for a specified or definite term and that I may resign, or I may be discharged, at any time with or without prior notice. I further understand that this policy cannot be changed or amended except by written agreement signed by me and by a corporate officer.
- My employment shall be in accordance with the terms of this application, all safety and incident reporting rules, all health care industry compliance program requirements and all other Allegiance rules, regulations, policies and procedures currently or hereafter in effect.
- I certify that as a part of the application process, I have been provided with a written job description or have had the opportunity to review and/or discuss the requirements for the available position. I understand each requirement and certify that I am capable of meeting each and every requirement. I also understand if the position for which I am applying requires licenses and/or certifications, it is my responsibility and a requirement for continued employment to maintain valid licenses and/or certifications.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date