

Employment History *must be completed in full*, regardless of attaching/including a resume.

Are you currently employed? Yes No

Please list all employers beginning with current or most recent employer leaving no employer out. (If additional room is required, please attach separate sheet with the complete employment history.)

Employer: _____ Phone # _____ Fax # _____

Address: _____ Postal Code _____

Supervisor: _____ Title: _____

Position Occupied: _____ Employment Status: FT PT Casual

Dates Employed: From _____ To _____

Briefly describe duties and responsibilities: _____

Reason for Leaving: _____

May this Employer be contacted for a reference? Yes No

Employer: _____ Phone # _____ Fax # _____

Address: _____ Postal Code _____

Supervisor: _____ Title: _____

Position Occupied: _____ Employment Status: FT PT Casual

Dates Employed: From _____ To _____

Briefly describe duties and responsibilities: _____

Reason for Leaving: _____

May this Employer be contacted for a reference? Yes No

Employer: _____ Phone # _____ Fax # _____

Address: _____ Postal Code _____

Supervisor: _____ Title: _____

Position Occupied: _____ Employment Status: FT PT Casual

Dates Employed: From _____ To _____

Briefly describe duties and responsibilities: _____

Reason for Leaving: _____

May this Employer be contacted for a reference? Yes No

EMPLOYMENT HISTORY

I HEREBY CERTIFY THAT I HAVE COMPLETED THIS APPLICATION IN MY OWN HANDWRITING AND THAT THE INFORMATION GIVEN ON THIS APPLICATION FORM IS TRUE AND CORRECT. I UNDERSTAND THAT ANY FALSE STATEMENT, OMISSION OR MISREPRESENTATION MAY BE SUFFICIENT REASON FOR REJECTION OF THIS APPLICATION OR, IF EMPLOYED, IMMEDIATE DISMISSAL FROM MOUNT ST. MARY HOSPITAL.

Personal information contained on this form is collected under the Freedom Of Information and Protection of Privacy Act (FOIPPA) and will be used for the purpose of your application for employment.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

Applicant: Please sign and date Authorization to Release Information

Mount St. Mary Hospital

AUTHORIZATION TO RELEASE INFORMATION: I consent and authorize Mount St. Mary Hospital to obtain information from my present/previous employers and/or educational facilities and that no act of libel or damages shall be instigated by me against same by the release of such information.

Print Name: _____ **Signature:** _____ **Date:** _____