



GENERAL HOSPITAL

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 Comox, British Columbia, Canada V9M 1P2
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 www.sjghcomox.ca

APPLICATION FOR EMPLOYMENT

PLEASE NOTE

Application CANNOT be completed ON LINE nor sent ELECTRONICALLY using our email form.
 Please PRINT FORM, complete in your own handwriting, and return via fax, mail or in person.
 Please complete all sections in full, even if you are attaching a resume.

PLEASE ALL APPROPRIATE BOXES

DATE:

Please note: Personal information contained on this form is collected under the Freedom of Information and Protection of Privacy Act and will be used only for the purpose of your application for employment.

PERSONAL INFORMATION	NAME AND ADDRESS OF APPLICANT (PLEASE PRINT)				
	LAST	FIRST	MIDDLE	PREFERRED FIRST NAME	PREVIOUS LAST NAME
	STREET ADDRESS			HOME PHONE	CELL PHONE
	MAILING ADDRESS <i>(If different from above)</i>			BUSINESS PHONE/FAX	EMAIL
	CITY OR TOWN		PROVINCE	POSTAL CODE	
	ARE YOU LEGALLY ENTITLED TO WORK IN CANADA? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	<input type="checkbox"/> CANADIAN CITIZEN <input type="checkbox"/> LANDED IMMIGRANT <input type="checkbox"/> WORK PERMIT <input type="checkbox"/> OTHER (PLEASE SPECIFY): (PLEASE ATTACH COPY OF LANDED IMMIGRANT STATUS OR WORK PERMIT)				
	HAVE YOU PREVIOUSLY WORKED AT ST. JOSEPH'S? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, STATE AREA OF WORK & DATES WORKED: _____				
	HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? <u>LAST</u> <u>FIRST</u> <u>INITIAL</u>				
	DO YOU HAVE ANY MEDICAL/PHYSICAL CONDITIONS WHICH WOULD PREVENT YOU FROM PERFORMING SPECIFIC KINDS OF DUTIES REQUIRED AS PART OF THE POSITION YOU HAVE APPLIED FOR? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE & EXPLAIN WORK LIMITATIONS, IF YOU REQUIRE ACCOMMODATION, ETC _____ _____ _____				
ARE YOU WILLING TO UNDERGO A MEDICAL EXAMINATION FOR THE PURPOSE OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					

POSITION APPLIED FOR	POSITION(S) DESIRED: 1. _____ 2. _____ <i>(Please specify clinical area(s) of interest (if applicable))</i>
	NATURE OF WORK DESIRED: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> CASUAL DATE AVAILABLE TO START WORK: _____
	SHIFTS AVAILABLE FOR: <input type="checkbox"/> DAYS <input type="checkbox"/> EVENINGS <input type="checkbox"/> NIGHTS <input type="checkbox"/> ALL SHIFTS ABLE TO WORK 11 HOUR SHIFTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
	SHORT NOTICE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, HOW MUCH NOTICE WILL YOU REQUIRE? _____

EDUCATION	NAME & LOCATION OF INSTITUTION ATTENDED		DATES ATTENDED FROM TO		CERTIFICATE OBTAINED	PROGRAM
	SECONDARY SCHOOL				LAST GRADE SUCCESSFULLY COMPLETED 7 8 9 10 11 12 13	
	COLLEGE					PRACTICUM AT:
	UNIVERSITY					PRACTICUM AT:
	SCHOOL OF NURSING					PRECEPTORSHIP AT:
	TRADES TECHNICAL COMMERCIAL					
	OTHER TRAINING OR EDUCATION					
ARE YOU ATTENDING SCHOOL NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO INSTITUTION: _____ <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> EVENING CLASSES? COURSE OR AREA OF SCHOOLING: _____						

REGISTRATION INFO	LIST ANY ACTIVE MEMBERSHIPS / REGISTRATIONS IN A PROFESSIONAL CAREER RELATED ORGANIZATION OR SOCIETY:	
	<i>* PLEASE ATTACH A COPY OF YOUR REGISTRATION</i>	
	CURRENT B.C. REGISTRATION <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF REGISTRATION AND #: _____
	CURRENT CANADIAN REGISTRATION <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF REGISTRATION AND #: _____
	INTERIM OR TEMPORARY: <input type="checkbox"/> YES <input type="checkbox"/> NO	EXAMINATION DATE: _____
<input type="checkbox"/> CPR-BASIC RESUER CERTIFCATION: _____ (expiry date) <input type="checkbox"/> ACLS _____ (completion date) <input type="checkbox"/> BASIC ARRHYTHMIA COURSE _____ (completion date) <input type="checkbox"/> 1 ST AID CERTIFICATE _____ (level & expiry date) <input type="checkbox"/> VALID DRIVER'S LICENSE: CLASS: _____		

SKILLS / CERTIFICATONS	PATIENT/CLIENT CARE: NURSING: <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> RPN <input type="checkbox"/> PARAMEDICAL _____ <input type="checkbox"/> OTHER _____ <small>(Position Title)</small>	
	<input type="checkbox"/> MEDICAL <input type="checkbox"/> SURGICAL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> CRITICAL CARE <input type="checkbox"/> COMMUNITY <input type="checkbox"/> NURSERY <input type="checkbox"/> OBSTETRICS <input type="checkbox"/> OPERATING ROOM <input type="checkbox"/> RECOVERY ROOM <input type="checkbox"/> ONCOLOGY <input type="checkbox"/> CHEMOTHERAPY <input type="checkbox"/> MENTAL HEALTH <input type="checkbox"/> PEDIATRICS <input type="checkbox"/> LABOUR./DELIVERY <input type="checkbox"/> REHABILITATION <input type="checkbox"/> AMBULATORY CARE <input type="checkbox"/> TELEMTRY <input type="checkbox"/> PALLIATIVE CARE <input type="checkbox"/> GERONTOLOGY <input type="checkbox"/> PSYCHIATRY <input type="checkbox"/> LAB ASSISTANT	
	<input type="checkbox"/> OTHER :	
	CLERICAL: <i>(include copies of certifications with application)</i>	
	<input type="checkbox"/> MEDICAL TERMINOLOGY <input type="checkbox"/> TRANSCRIPTION <input type="checkbox"/> ACCOUNTING <input type="checkbox"/> PAYROLL <input type="checkbox"/> UNIT CLERK <input type="checkbox"/> <input type="checkbox"/> KEYBOARDING _____ WPM <input type="checkbox"/> HEALTH RECORDS TECH <input type="checkbox"/> ADMITTING/SWITCHBOARD <input type="checkbox"/> COMPUTER <i>(list types of software)</i> : <input type="checkbox"/> WORD PROCESSING _____ <input type="checkbox"/> SPREADSHEET _____ <input type="checkbox"/> OTHER: _____	
	SUPPORT SERVICES: <i>(include copies of certifications with application)</i>	
<input type="checkbox"/> WHMIS <input type="checkbox"/> FOOD SAFE 1 <input type="checkbox"/> FOOD SAFE - ADVANCED <input type="checkbox"/> CLEANING-INSTITUTIONAL <input type="checkbox"/> FLOOR POLISHER/AUTOSCRUBBERS <input type="checkbox"/> CENTRAL PROCESSING STERILIZATION CERT <input type="checkbox"/> INDUSTRIAL 1 ST AID LEVEL: _____ <input type="checkbox"/> POWER / STEAM CLASS: _____ <input type="checkbox"/> TRADE QUALIFICATION: _____		
ADDITIONAL EXPERIENCE, SKILLS, OR QUALIFICATION THAT ARE RELEVANT TO THIS APPLICATION:		

WORK HISTORY (PRESENT EMPLOYER FIRST)

LIST ALL EMPLOYERS YOU HAVE WORKED FOR IN THE LAST 6 YEARS. (Complete all sections – even if attaching a resume).

In order to establish the appropriate increment (RNs/RPNs/Paramedicals) proof of hours or part-time status must be provided (or current paystub with hourly rate)

NAME OF EMPLOYER:		ADDRESS OF BUSINESS (Include Postal Code):	
SUPERVISOR'S NAME & TITLE:		BUS. PHONE: () CELL PHONE: ()	FAX: ()
YOUR POSITION TITLE:		SUPERVISOR'S EMAIL ADDRESS:	
JOB DUTIES: (describe in detail)			
DATES EMPLOYED: (Month/Day/Year) <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> CASUAL			
FROM: _____ TO: _____ HOURS/WEEK _____ TOTAL HOURS WORKED: _____ <i>(Information obtained from Payroll)</i>			
REASON FOR LEAVING:			
MAY THIS EMPLOYER BE CONTACTED FOR A REFERENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			

NAME OF EMPLOYER:		ADDRESS OF BUSINESS (Include Postal Code):	
SUPERVISOR'S NAME & TITLE:		BUS. PHONE: () CELL PHONE: ()	FAX: ()
YOUR POSITION TITLE:		SUPERVISOR'S EMAIL ADDRESS:	
JOB DUTIES: (describe in detail)			
DATES EMPLOYED: (Month/Day/Year) <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> CASUAL			
FROM: _____ TO: _____ HOURS/WEEK _____ TOTAL HOURS WORKED: _____ <i>(Information obtained from Payroll)</i>			
REASON FOR LEAVING:			
MAY THIS EMPLOYER BE CONTACTED FOR A REFERENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			

NAME OF EMPLOYER:		ADDRESS OF BUSINESS (Include Postal Code):	
SUPERVISOR'S NAME & TITLE:		BUS. PHONE: () CELL PHONE: ()	FAX: ()
YOUR POSITION TITLE:		SUPERVISOR'S EMAIL ADDRESS:	
JOB DUTIES: (describe in detail)			
DATES EMPLOYED: (Month/Day/Year) <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> CASUAL			
FROM: _____ TO: _____ HOURS/WEEK _____ TOTAL HOURS WORKED: _____ <i>(Information obtained from Payroll)</i>			
REASON FOR LEAVING:			
MAY THIS EMPLOYER BE CONTACTED FOR A REFERENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			

PRACTICUM REFERENCES	IF YOU HAVE RECENTLY COMPLETED A PRACTICUM ASSOCIATED WITH YOUR PROFESSION, PLEASE PROVIDE A MINIMUM OF THREE SUPERVISORS WHO MAY BE CONTACTED.			
	SUPERVISOR/S NAME	SUPERVISOR'S TITLE (INSRUCTORS/PRECEPTOR)	TELEPHONE	FAX / EMAIL

ADDITIONAL REFERENCES	IF YOU HAVE BEEN SELF EMPLOYED , DONE CONTRACT WORK OR VOLUNTEERED PLEASE PROVIDE CONTACT NAMES & NUMBERS OF CLIENTS OR SUPERVISORS.			
	NAME	SUPERVISOR'S TITLE/CLIENT (BUSINESS)	TELEPHONE	FAX / EMAIL

PLEASE READ CAREFULLY

- ❖ I have completed this application in my own handwriting and understand that any misrepresentation made by me in connection with this application will be just and sufficient cause for rejection of this application or for separation from St. Joseph's General Hospital.
- ❖ I agree to complete a pre-employment health screening (including TB skin test and/or chest x0ray) in order to document that I meet an acceptable standard of health which is a condition of employment.
- ❖ I understand that if hired, I will be required to serve the probationary period.
- ❖ If employed, I agree to abide by all the policies of St. Joseph's General Hospital and that any breach of said policies may result in dismissal. In addition, if I am offered employment I agree to sign a confidentiality acknowledgement as a condition of my employment.
- ❖ I understand that any job offer will be conditional upon the consent to and the result of a criminal record check where applicable.
- ❖ I hereby consent and authorize St. Joseph's General Hospital to obtain reference information from my present and/or previous employer(s) and/or education facilities and that no act of libel or damages shall be instigated by me against same by the release of such information.

DATE: _____ SIGNATURE OF APPLICANT: _____

TO BE COMPLETED BY MANAGER

INTERVIEW DATE:		INTERVIEWER: <i>(Please print name)</i>	
POSITION:	DEPARTMENT(S):	STATUS:	
START DATE:	TODAY'S DATE:	SIGNATURE (SUPERVISOR/DEPT HEAD)	
REFERENCES / COMMENTS (eg., preceptorship, practicum, etc)			

TO BE COMPLETED BY APPLICANT

COMPLETE ONLY IF HIRED	SOCIAL INSURANCE #: _____	DATE OF BIRTH: _____ (Mo/Day/Yr)
	HAVE YOU CONTRIBUTED TO A SUPERANNUATION PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	IF YES, WHICH PLAN?	