Application for Employment

WVU Medicine
BARNESVILLE HOSPITAL

PLEASE PRINT

We are an equal opportunity employer: this organization is committed to the policy of equal opportunity in recruitment, hiring, career advancement, and all other personnel practices. Your job-related experience and other qualifications will be considered without illegal discrimination on grounds of race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability status or as a protected veteran defined by law. All information provided in this application will be treated confidentially and will be used to help assure the best of your abilities if you are employed by us. If you feel that any of the following questions are discriminatory in nature, do not answer such questions.

Position(s) applied _____ Date of application _____

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

Telephone # (_____)_____ Mobile/Other Phone # (_____) _____ Social Security # _____

If you are under 18, and it is required, can you furnish a work permit? ..... ☐ Yes ☐ No

If no, please explain _____

Have you ever been employed here before? ..... ☐ Yes ☐ No

Are you legally eligible for employment in this country? ..... ☐ Yes ☐ No

Date available for work ..... ___/ __/__

Type of employment desired ☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Regular ☐ PRN (On-Call)

Shifts you will accept ☐ Days ☐ Afternoons ☐ Midnights

Are you able to perform the job's essential duties with or without reasonable accommodations? ..... ☐ Yes ☐ No

How did you learn of this job opportunity? ☐ WVU Medicine Website ☐ Online Job Board ☐ Employee Referral

❑ Other: _____

Driver's license number if driving is an essential job function _____ State _____

Educational Background

NAME AND LOCATION	YEARS COMPLETED	DID YOU GRADUATE?	COURSE OF STUDY/DEGREE
HIGH SCHOOL			
COLLEGE			
OTHER			

Employment History

Provide the following information for your past four (4) employers, assignments or volunteer activities, starting with the most recent.

Job #1			
From	To	Employer	Telephone
Job Title		Address	
Immediate Supervisor and Title		Summarize the Nature of Work Performed And Job Responsibilities	
Reason for Leaving		Hourly Rate/Salary Start $ _____ Per _____ Final $ _____ Per _____	
Job #2			
From	To	Employer	Telephone
Job Title		Address	
Immediate Supervisor and Title		Summarize the Nature of Work Performed And Job Responsibilities	
Reason for Leaving		Hourly Rate/Salary Start $ _____ Per_____ Final $ _____ Per _____	
Job #3			
From	To	Employer	Telephone
Job Title		Address	
Immediate Supervisor and Title		Summarize the Nature of Work Performed And Job Responsibilities	
Reason for Leaving		Hourly Rate/Salary Start $ _____ Per _____ Final $ _____ Per _____	
Job #4			
From	To	Employer	Telephone
Job Title		Address	
Immediate Supervisor and Title		Summarize the Nature of Work Performed And Job Responsibilities	
Reason for Leaving		Hourly Rate/Salary Start $ _____ Per _____ Final $ _____ Per _____	

Skills and Qualifications

Summarize any training, skills, licenses, and/or certificates that may qualify you as being able to perform job-related functions in the position for which you are applying.

_____

_____

_____

Additional Job-Related Qualifications & Experience

The space below is provided for you to state additional job-related qualifications and experience that you feel makes you particularly well-suited for the position(s) for which you have applied.

_____

_____

_____

References

List three persons, not relatives, clergy, or previous supervisors, with complete address and phone numbers who have known you at least two years.

Name	Address	Telephone	Years Known

READ CAREFULLY BEFORE SUBMITTING THE APPLICATION:

To the best of my knowledge and belief, all statements on this application are complete and correct. I fully understand that any false or omitted statements will be sufficient cause for cancellation of the application and/or separation from Barnesville Hospital`s services, if employed. Furthermore, I give Barnesville Hospital full investigative power as to my character, including criminal records, credit, and financial status, or any other information deemed necessary for my application at Barnesville Hospital. This application becomes inactive after 90 days unless renewed.

By signing here, you are agreeing to the above statements:

Signature of Applicant _____ Date _____

BARNESVILLE HOSPITAL
639 WEST MAIN STREET
BARNESVILLE OH 43713

Voluntary Self-Identification of Race and Ethnicity

WVU Medicine is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, we invite you to voluntarily self-identify your race and ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.
Completion of information below is voluntary.

Name: _____

Are you Hispanic, Latino or of Spanish origin?

☐ Yes ☐ No ☐ I prefer not to answer

What is your race? (check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Two or More Races (not Hispanic or Latino)
☐ I prefer not to answer

What is your gender?

☐ Female ☐ Male ☐ I prefer not to answer

Voluntary Self-Identification of "Protected" Veteran Status

Why Are You Being Asked to Complete This Form?
WVU Medicine is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA). VEVRAA requires Government contractors to take affirmative action to employ and advance in employment protected veterans. To help us measure the effectiveness of our outreach and recruitment efforts of veterans, we are asking you to tell us if you are a veteran covered by VEVRAA. Completing this form is completely voluntary, but we hope you fill it out. Any answer you give will be kept private and will not be used against you in any way.

For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How Do You Know if You Are a Veteran Protected by VEVRAA?
Contrary to the name, VEVRAA does not just cover Vietnam Era veterans. It covers several categories of veterans from World War II, the Korean conflict, the Vietnam era, and the Persian Gulf War, which is defined as occurring from August 2, 1990 to the present.

If you believe you belong to any of the categories of protected veterans please indicate by checking the appropriate box below. *The categories are defined on the next page.*

☐ I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED BELOW
☐ I AM NOT A PROTECTED VETERAN
☐ I DO NOT WISH TO ANSWER

_____ _____
Your Name Today's Date

What Categories of Veterans Are "Protected" by VEVRAA?

"Protected" veterans include the following categories: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These categories are defined below.

A "disabled veteran" is one of the following:

- a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
- a person who was discharged or released from active duty because of a service-connected disability.

A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Voluntary Self-Identification of Disability

OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability

☐ I Don't Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____