COLLEGE HOSPITALS

OFFICE USE ONLY

College Hospital Crisis Stabilization Unit
301 Victoria Street,
Costa Mesa, CA 92627
949-574-3385

APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY EMPLOYER

WHAT IS THE BEST TIME TO CONTACT BY TELEPHONE?

PLEASE TYPE / PRINT / EMAIL TO APPROPRIATE HOSPITAL LISTED ABOVE

GENERAL - PERSONAL INFORMATION

Last Name	First	Middle	Home Telephone

Home Address (Street & Number)	City	State	Zip Code

Previous Residences in the United States	Cell Phone	Email Address

Other Names Under Which You Have Worked

Are you age 18 or over?

Yes ☐ No ☐

Relatives employed by this Hospital

POSITION DESIRED

(First Choice)	(Second Choice)	Minimum Earnings Required

Date Available for Work

☐ Full Time ☐ Per Diem
☐ Part Time ☐ On Call

How Did You Become Aware Of The Position? ☐ Drop-in ☐ Ad ☐ Website ☐ School

NAME

Shift Preferred - 1st Choice	2nd Choice	3rd Choice	Have you ever worked at a College Health Enterprises entity before? Where? When? Under what name?

Are you able to perform the essential functions of the position for which you are applying, either with or without reasonable accommodations?

☐ Yes ☐ No

If necessary, please describe what type(s) of reasonable accommodations are needed:

EDUCATION

NAME AND LOCATION OF SCHOOLS		Number of Years	GRAD. Yes	GRAD. No	Degree	Major Field of Study
High School Last Attended			☐	☐	☐	
College or University	Name City State		☐	☐	☐	
	Name City State		☐	☐	☐	
Graduate School	Name City State		☐	☐	☐	
Business or Vocational	Name City State		☐	☐	☐	
Other			☐	☐	☐	

LICENSING

Identify each license or certification held, include serial numbers and expiration dates.

BCLS for Healthcare Providers ☐ Yes ☐ No Expires ____________

MISCELLANEOUS SKILLS OR ACTIVITIES

List special language skills, scholarships or other significant activities (Please omit those indicating race, color, sex, national origin, ancestry, age, the existence of a disability, or any other protected characteristics).

MEMBERSHIP IN JOB RELATED PROFESSIONAL ORGANIZATIONS

REFERENCES (Other than relatives)

GIVE THREE REFERENCES WHO HAVE KNOWN YOU DURING THE PAST FIVE OR MORE YEARS.

Name	Position	Address (Include City/State)	Phone Work / Home	Number of years known
1.				
2.				
3.				

PAST EMPLOYMENT

Account for the past ten (10) years. Include periods of unemployment, self-employment, schooling or military service. List present (or most recent) position first. Please include any other name under which such records may appear. Attach supplement sheet if more space needed.

May we contact your present employer: ☐ Yes ☐ No

Company Name | Telephone Number | mo | yr | From: | To:

Street | City | State | Zip Code | Type of Business

Title | Supervisor

Duties and Responsibilities?

What did you like most about the work?

What did you like least?

Reason for leaving

Company Name | Telephone Number | mo | yr | From: | To:

Street | City | State | Zip Code | Type of Business

Title | Supervisor

Duties and Responsibilities?

What did you like most about the work?

What did you like least?

Reason for leaving

Company Name | Telephone Number | mo | yr | From: | To:

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Duties and Responsibilities?

What did you like most about the work?

What did you like least?

Reason for leaving

Company Name | Telephone Number | mo | yr | From: | To:

Street | City | State | Zip Code | Type of Business

Title | Supervisor

Duties and Responsibilities?

What did you like most about the work?

What did you like least?

Reason for leaving

SECURITY/RIGHT TO WORK

Are you legally authorized to work in the U.S.? (Proof of identity and legal authority to work in the U.S. is a condition of employment.)

☐ Yes ☐ No

OTHER INFORMATION

Please indicate additional information relevant to your application which may be helpful to us.

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and agree to have any of the statements checked by the Hospital unless I have indicated to the contrary. I authorize the references listed above, as well as all other individuals whom the Hospital contacts, to provide the Hospital any and all information concerning my previous employment and any other pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to the Hospital as well as from any use or disclosure of such information by the Hospital or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or omission of information on this application may result in my failure to receive an offer or, if I am hired, my dismissal from employment.

I agree that, unless modified by a written agreement signed by the president of the Hospital, my employment, compensation, and benefits can be modified or terminated with or without cause, and with or without notice, at any time, either at my option or at the option of the Hospital. I understand that no employee or representative of the Hospital, other than its president, has the authority to enter into any agreement for employment for any specified period of time, or to make any express or implied agreement contrary to the foregoing. Further, the president of the Hospital may not alter the at-will nature of the employment relationship or enter into any employment agreement for a specified time unless the president and I both sign a written agreement that clearly and expressly specified the intent to do so. I agree that this shall constitute a final and fully binding integrated agreement with respect to the at-will nature of my employment relationship and that there are no oral or collateral agreements regarding this issue.

I understand that all offers of employment are conditioned on: (1) the Hospital's receipt of satisfactory responses to reference requests and the provision of satisfactory proof of an applicant's identity and legal authorization to work in the United States; (2) applicant's satisfactory completion of a post-offer medical examination and drug/alcohol screening; and (3) if applicable to the job for which I am applying, satisfactory completion of a background and/or credit investigation.

In exchange for the Hospital's consideration of my application, I agree that any dispute with the Hospital arising from or related to my application or any resulting employment will be resolved exclusively through binding arbitration administered by the American Arbitration Association. Furthermore, if I become employed, then in consideration of my employment, I agree to comply with the Hospital's Mutual Arbitration Policy and execute the Employee Agreement to Arbitrate. I agree to abide by and execute acknowledgment of the Hospital's employee handbook and employment policies.

SIGNATURE ______________________ DATE ______________

COLLEGE HOSPITAL
Voluntary Self-Identification Form

College Hospital is subject to certain governmental recordkeeping and reporting requirements of the administration of civil rights laws and regulations. In order to comply with these laws, College Hospital invites employees to voluntarily self-identify their 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 a specific individual. This form will be kept separate from your personnel file.

I am:

☐ Hispanic or Latino: a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ Not Hispanic or Latino

If you checked "Not Hispanic or Latino", please check one of the following racial/ethnic categories:

☐ American Indian or Alaska Native: a person having origins in any of the original peoples of North, South and Central America, and who maintain cultural identification through tribal affiliation or community attachment.

☐ Asian: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ Black or African American: a person having origins in any of the Black racial groups of Africa.

☐ Native Hawaiian or Other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ White: a person having origins in any of the original peoples of Europe, the Middle East or North Africa.

☐ Two or More: a person who identifies with more than one of the above five races.

I am: ☐ Female ☐ Male

Name: ______________________________ Date: ____________________

Position: ______________________________

PLEASE SAVE FORM TO YOUR COMPUTER AND EMAIL TO APPROPRIATE HOSPITAL LISTED ON THE TOP OF THE FIRST PAGE - THANK YOU!