



**Human Resources Address for Employment Purposes is the Hospital Business Plaza:  
4519 Military Road ~ Niagara Falls, NY ~ 14305-1335 ~ (716) 298-2394**

**SPONSORED BY ASCENSION HEALTH**

*SERVING IN THE SPIRIT OF SAINT VINCENT DE PAUL, SAINT LOUISE DE MARILLAC AND  
SAINT ELIZABETH ANN SETON*

**Our Mission:**

Quality care in a personal manner  
With total regard for individual human dignity

Employment applications will remain active for two (2) years. Applicants must renew application after that time period to be considered for other job openings.

We are an equal opportunity at-will employer. Therefore, prospective employees will receive consideration for all positions without regard to race, color, religion, sex, sexual orientation, national origin, age, marital status, veteran status, genetic predisposition or carrier status, or the presence of a disability. If you require assistance in completing this application, please inform us. Applications should not contain unrequested information.



All information in this application is confidential and is to be used for the intended purpose only.

**APPLICATION FOR EMPLOYMENT**

PRINT LAST NAME			PRINT FIRST NAME – MIDDLE INITIAL			TYPE OF WORK DESIRED		
PRINT HOME ADDRESS			CITY AND STATE					
APT. NO.	ZIP CODE	TELEPHONE NO.	SOCIAL SECURITY NO.	Full Time	Part Time	Day Work	Eve. Work	Night Work
To enable a check of your school and work records, have you attended school or worked under any other name? If yes, give name(s)								

**PERSONAL**

Are you 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, state your date of birth.      _____	Is there any position for which you do not wish to be considered? If so, please list:
Are you legally able to be employed in this country? (Proof of United States citizenship or employment authorization will be required upon employment.) <input type="checkbox"/> Yes <input type="checkbox"/> No	

**EDUCATION**

School	Name and Address of School/College	Dates		Graduated Yes - No	Diploma/Degree Received	Subject of Specialization
		From	To			
Grade School						
High School						
College						
Nursing/Med. Tech./Other						

Class Rank – High School \_\_\_\_\_ College \_\_\_\_\_ College/Grade Point Average (state maximum of scale): \_\_\_\_\_

**PROFESSIONAL LICENSE or REGISTRATION  
(RN, LPN or Medical Technologist, etc.)**

LICENSE or REGISTRATION – TYPE _____	NUMBER _____
ISSUED BY _____	DATE: From: _____ To: _____

Have you ever had any professional registration, license, or certification suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain in detail (use a separate sheet if necessary): _____ _____ _____
---

Have you ever been listed in any national practitioner database or analogous state database? If yes, please explain in detail (use a separate sheet if necessary):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever informally resolved any recommended or potential adverse action involving your professional registration, license, or certification? If yes, please explain in detail (use a separate sheet if necessary):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any professional registration, licensure, or certification actions now pending against you? If yes, please explain in detail (use a separate sheet if necessary):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been named as a defendant in any civil legal action involving your professional competence? If yes, please explain in detail (use a separate sheet if necessary):	<input type="checkbox"/> Yes <input type="checkbox"/> No

**ARMED FORCES**

Have you ever served in the Armed Forces of the United States? _____ Give details of service and training:		
Branch of Armed Forces	Type of Duty	Date of Discharge

Have you ever filled out an application for employment with Mount St. Mary's Hospital or Our Lady of Peace, Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No When? _____   Where? _____   For What Position? _____ Referred by: _____ Have you ever been employed by Mount St. Mary's Hospital <u>or</u> Our Lady of Peace, Inc. or its affiliates? _____ <small>(Give details under "Employment")</small> Have you ever been employed by St. Mary's Manor, DeVeaux Manor or Mount St. Mary's Long Term Care Facility? _____ <small>(Give details under "Employment")</small> Do you have relatives working at Mount St. Mary's Hospital <u>or</u> Our Lady of Peace, Inc. or its affiliates? If so, please list names and relationships below: _____ If employed, why do you desire to change your position? _____ Does your employer know of your intention to change employment? _____ May we contact your present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Salary or wage expected \$ _____ per month, week, hour      Date available for employment: _____
---

Have you ever been convicted of or pled guilty or no contest to a felony, misdemeanor, or any offense other than a minor traffic violation? If yes, please explain in detail (use a separate sheet if necessary): <b>Please note: a "yes" answer will not automatically disqualify you from employment.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Where Convicted</b>	<b>Date</b>	<b>Nature of Charge</b>	<b>Disposition</b>

Are any felony or misdemeanor charges now pending against you? If yes, please explain in detail (use a separate sheet if necessary):  Yes  No

Has any action been taken against you that excludes or has excluded you from participating as a provider for any length of time in any federally funded government health care program, including but not limited to Medicare and/or Medicaid? If yes, please explain in detail (use separate sheet if necessary):  Yes  No

Where	Date	Nature of Exclusion	Disposition

Are you the subject of any investigation or proceedings that could result in your exclusion from participating as a provider for any length of time in any state or federally funded government health care program, including but not limited to Medicare and/or Medicaid? If yes, please explain in detail (use a separate sheet if necessary):  Yes  No

Have you ever been discharged from any of your previous employers? If yes, please explain in detail (use a separate sheet if necessary)  Yes  No

\_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT**

List all past employment as completely as possible, beginning with your present or latest employer and going backwards in time, including summer or seasonal employment. If space is insufficient, continue the list on the next page or on a separate sheet if necessary. Any periods of unemployment or self-employment should be listed in the appropriate time sequence so that all dates are accounted for. All data must be completely filled in. Any falsification, misrepresentation or omission may result in rejection of employment or termination if discovered after employment begins. **DO NOT** put "See Resume."

COMPANY NAME	ADDRESS	DATE	RATE OF PAY	Title of Job or Position you held, and Name and Title of immediate Supervisor (describe duties briefly)	REASON FOR LEAVING
	No. Street	Month Year			
	City	FROM			
	State/Zip Code	TO			
	Telephone Number				
	No. Street	Month Year			
	City	FROM			
	State/Zip Code	TO			
	Telephone Number				
	No. Street	Month Year			
	City	FROM			
	State/Zip Code	TO			
	Telephone Number				
	No. Street	Month Year			
	City	FROM			
	State/Zip Code	TO			
	Telephone Number				

**EMPLOYMENT (continued)**

COMPANY NAME	ADDRESS	DATE Month Year	RATE OF PAY	Title of Job or Position you held, and Name and Title of immediate Supervisor (describe duties briefly)	REASON FOR LEAVING
	No. Street	FROM			
	City				
	State/Zip Code				
	Telephone Number				
		TO			
	No. Street	FROM			
	City				
	State/Zip Code				
	Telephone Number				
		TO			
	No. Street	FROM			
	City				
	State/Zip Code				
	Telephone Number				
		TO			
	No. Street	FROM			
	City				
	State/Zip Code				
	Telephone Number				
		TO			
	No. Street	FROM			
	City				
	State/Zip Code				
	Telephone Number				
		TO			
	No. Street	FROM			
	City				
	State/Zip Code				
	Telephone Number				
		TO			
	No. Street	FROM			
	City				
	State/Zip Code				
	Telephone Number				
		TO			

I hereby certify that all statements made by me on this application are true and complete to the best of my knowledge and I have withheld nothing that would affect this application unfavorably.

I authorize investigation of all matters contained in this application, including authority to request any educational transcript, and agree that if, in the judgment of the Hospital, any misrepresentation has been made by me herein or in a subsequently executed Medical Questionnaire, or the results of such investigation are not satisfactory, any offer of employment made by the Hospital may be withdrawn, or my employment may be terminated immediately, without any obligation or liability to me other than for payment at the rate agreed upon for services actually rendered. I understand that I may be rejected for employment and may be discharged for falsifying, misrepresenting or omitting any information requested in this employment application or during the interview process or subsequent interviews. I may be terminated regardless of when the falsification, misrepresentation or omission is discovered.

I understand that, if hired, I will be an employee at-will and there will be no guarantee of employment in any capacity for any period. Termination of employment can occur anytime, with or without cause. I understand that employment is contingent upon being able to pass a medical examination and laboratory testing, including drug testing, and I agree to submit to one by a physician of the Hospital's choice. Such medical examination can be given only after initial offer of employment. I understand that, during the course of employment, I must immediately disclose to the Vice President-Human Resources any proposed or actual exclusion as a provider from any health care program funded in whole or part by the federal government, including Medicare or Medicaid. Current exclusion from participation in any federally funded health care program, including but not limited to Medicare and Medicaid, will prohibit my employment. Past exclusion from participation in any such federally funded program, conviction of a crime, being named as a defendant in a civil legal action, or adverse action involving my professional registration, license, or certification will not necessarily disqualify me from consideration for employment, however, failure to fully disclose will result in immediate denial or termination of employment. I understand that working overtime is an essential function of the job.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

-----

**AUTHORIZATION FOR REFERENCE RELEASE**

**I hereby authorize Mount St. Mary's Hospital and Health Center to contact any schools, former places of employment, law enforcement agencies and/or persons who may aid the Hospital in determining my suitability for employment at any time. Additionally, I release those individuals and/or organizations contacted from all liability whatsoever for issuing the requested information, background checks and/or contact references.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name