

RIVER VALLEY MEDICAL CENTER AND FAMILY CLINIC

**Allegiance Behavioral Health Centers*
** New Directions Outpatient Counseling Centers*
** Stuttgart MedOpps*
** Allegiance Specialty Hospitals*

** Inspirations Counseling Centers*
** Allegiance Health Centers*
** Critical Access Hospitals*
** Rural Hospitals*

APPLICATION FOR EMPLOYMENT

RIVER VALLEY MEDICAL CENTER (RVMC) IS AN EQUAL OPPORTUNITY EMPLOYER. All practices of recruiting, hiring, promotion, transfer, wage and salary administration, benefits and terminations are administered without regard to race, color, creed, sex, religion, national origin, disability, age, veteran status or any and all other unlawful biases regarding federal, state or local laws. Further, Allegiance is committed to providing a work environment that prohibits, in any form, unlawful harassment. To be considered for employment, all applicants must fill out this form completely. This application will be considered, but its receipt does not imply that the applicant will be employed by the company. This form becomes a part of your permanent employment record if you are hired. This application is valid for 90 days. After that time period, applicants are responsible for reapplying.

PERSONAL INFORMATION (Please Print Full Legal Name)

Last Name First Name Middle Name Social Security Number

Current Street Address PO Box No. / Apt No. / Unit No. Area Code – Current Phone Number

City State Zip Code Area Code – Current Phone Number

List all names or aliases ever used: _____

List all addresses for the last 7 years:

Previous Address – Street/PO Box No. City/State Zip Code

Previous Address – Street/PO Box No. City/State Zip Code

Previous Address – Street/PO Box No. City/State Zip Code

TYPE OF WORK DESIRED

Position(s) applying for _____ Salary \$ _____ Per _____

The following conditions might be required at some point in a job assignment. Do you agree to satisfy the following work schedule?

- a. Shift work? ☐ Yes ☐ No d. Work schedule other than Monday to Friday? ☐ Yes ☐ No
b. Overtime work? ☐ Yes ☐ No e. Do you agree to work the hours required for your positions? ☐ Yes ☐ No
c. Rotation work? ☐ Yes ☐ No f. Shift desired? ☐ Day ☐ Evening ☐ Night

Status of employment for which you are applying? ☐ Full-time ☐ Part-time ☐ Per Diem (PRN)

GENERAL INFORMATION

Are you at least 18 years of age or older? ☐ Yes ☐ No

As a U.S. citizen or based on immigrant status, do you have legal right to work in the United States? ☐ Yes ☐ No

Has Allegiance or any of its subsidiaries ever employed you or any of your relatives? ☐ Yes ☐ No If yes, please indicate which subsidiary and dates of employment:

Are you a United States Veteran? ☐ Yes ☐ No If yes, please list date of separation: _____

To assist us in our recruitment efforts, please indicate how you were referred to Allegiance:

____ Walk-in _____ Newspaper Ad (please specify): _____
____ Job Fair (please specify): _____ Website or Internet (please specify): _____
____ Employee Referral (please specify): _____ Other: (please specify): _____

SECURITY DATA

Pursuant to the OIG Compliance Program, Employees convicted of criminal offenses or offenses including fraud and abuse related to health care are prohibited from participating in any portion of the direct or indirect health care delivery process. In the event of any pending charges, current employees may be removed from direct responsibility including patient care or involvement with any Federal health care program.

Have you ever been convicted or pleaded guilty or no contest to any criminal offense? ____ Yes ____ No
(Criminal convictions are not an automatic ban from employment and will only be considered in relation to specific job requirements.)

Have you ever been convicted of a criminal offense related to health care or listed by a federal agency as debarred, excluded or otherwise ineligible for participation in Federal health care program? ____ Yes ____ No

If you answered "yes" to either of the above questions, please briefly describe the circumstances of your conviction indicating the date, nature and place of the offense and disposition of the case.

EDUCATION AND TRAINING

Institution Name and Location		No. of Years Completed	Graduated Yes No		Type of Degree, Diploma or Certificate and Major Course of Study	Academic Standing
High School						
College / University						
Graduate School						
Trade School / Other Training						

ACADEMIC ACHIEVEMENTS AND ACTIVITIES:

Please list academic honors, scholarships, or fellowships; memberships in academic honorary societies; or participation in or offices held in extracurricular activities you consider significant. (You may exclude all information of age, sex, race, religion, color, national origin and handicap.)

EMPLOYMENT HISTORY

Please list your employment history for the past 15 years or your last five employers. Start with your current employer. Include U.S. Military Service.

Name of Employer: _____ Area Code & Telephone No: _____

Address: _____ City/State: _____ Zip: _____

Job Title: _____ Name of Supervisor: _____

Employed: From _____ To _____ Salary: _____ Start _____ End _____

Duties Performed: _____

Reason for Leaving: _____

May we contact this employer? ____ Yes ____ No

Name of Employer: _____	Area Code & Telephone No: _____
Address: _____	City/State: _____ Zip: _____
Job Title: _____	Name of Supervisor: _____
Employed: From _____ To _____	Salary: _____ Start _____ End _____
Duties Performed: _____	
Reason for Leaving: _____	
May we contact this employer? ____ Yes ____ No	

Name of Employer: _____	Area Code & Telephone No: _____
Address: _____	City/State: _____ Zip: _____
Job Title: _____	Name of Supervisor: _____
Employed: From _____ To _____	Salary: _____ Start _____ End _____
Duties Performed: _____	
Reason for Leaving: _____	
May we contact this employer? ____ Yes ____ No	

Name of Employer: _____	Area Code & Telephone No: _____
Address: _____	City/State: _____ Zip: _____
Job Title: _____	Name of Supervisor: _____
Employed: From _____ To _____	Salary: _____ Start _____ End _____
Duties Performed: _____	
Reason for Leaving: _____	
May we contact this employer? ____ Yes ____ No	

Name of Employer: _____	Area Code & Telephone No: _____
Address: _____	City/State: _____ Zip: _____
Job Title: _____	Name of Supervisor: _____
Employed: From _____ To _____	Salary: _____ Start _____ End _____
Duties Performed: _____	
Reason for Leaving: _____	
May we contact this employer? ____ Yes ____ No	

Please explain all periods of unemployment:

LICENSED/CERTIFIED APPLICANTS ONLY

	State & License No.	Expire Date		State & License No.	Expire Date
Registered Nurse			Licensed Social Worker		
LVN /LPN			Speech/Language Pathologist		
Certified Nursing Assistant			Licensed Professional Counselor		
Respiratory Therapist			Recreational Therapist		
Physical Therapist			CPR (BCLS)		
Occupational Therapist			Other (specify)		

Please list any other professional memberships, organizations or certifications you hold.

Please indicate any other information you think would be helpful to us in considering you for employment, such as additional work experience, activities, accomplishments, voluntary work experience, and any other languages spoken.

REFERENCES

List at least three references other than relatives or friends.

	Name	Address & Phone No.	Occupation	Years Known
1.				
2.				
3.				

READ CAREFULLY BEFORE SIGNING THE APPLICATION FOR EMPLOYMENT:

If employed by Allegiance and in consideration thereof, I understand and agree to:

1. I certify that the answers given by me to the forgoing questions and statements on the employment application and or during the employment interview process are true and correct without any consequential omissions of any kind whatsoever. I understand that any misleading or incorrect statements may render this application void and, if employed, would be cause for my termination. I further agree that Allegiance shall not be liable in any respect if my employment is terminated because of falsity of statements, answers or omissions made by me in this application.
2. I authorize the companies schools, persons or entities given during the employment process or on this employment application as references or past employers or affiliations to give any information regarding my employment, character, qualifications, certifications and licenses and hereby release said companies, schools, persons or entities from all liability for any damage for issuing this information,
3. I understand that I may be required to have medical examination and/or drug and alcohol test after an offer of employment has been made and prior to the commencement of my employment duties. A favorable result on the medical examination and/or drug and alcohol test would be a condition of my employment or commencement of my employment duties.
4. I understand that my employment is not for a specified or definite term and that I may resign, or I may be discharged, at any time with or without prior notice. I further understand that this policy cannot be charged or amended except by written agreement signed by me and by a corporate officer.
5. My employment shall be in accordance with the terms of this application, all safety and incident reporting rules, all health care industry compliance program requirements and all other Allegiance rules, regulations, policies and procedures currently or hereafter in effect.
6. I certify that as a part of the application process, I have been provided with a written job description or have had the opportunity to review and/or discuss the requirements for the available position. I understand each requirement and certify that I am capable of meeting each and every requirement. I also understand if the position for which I am applying requires licenses and/or certification, it is my responsibility and a requirement for continued employment to maintain valid licenses and/or certifications.

Signature of Applicant

Date

Mailing Address:

River Valley Medical Center
Attn: Human Resources
PO Box 578
Dardanelle, AR 72834

Phone: 479-229-4677 ext. 148
Fax: 479-229-6161

21051 – Dardanelle Community Hospital

RELEASE FOR BACKGROUND INVESTIGATION FOR SOUTHERN RESEARCH COMPANY, INC.

By my signature below, I hereby authorize **SOUTHERN RESEARCH COMPANY, INC.**, to procure a consumer report and/or an investigative consumer report, including but not limited to: my consumer criminal history, driving record, education, employment, professional licenses verification, credit history, personal interviews with neighbors, friends, or associates of my character, general reputation, personal characteristics, mode of living and other public records, which may confirm or deny my eligibility for employment, with the Facility named above. I authorize without reservation, any party, including, but not limited to, employers, law enforcement agencies, state agencies, institutions and private information bureaus or repositories, contacted by **SOUTHERN RESEARCH COMPANY, INC.** to furnish any or all of the above-listed information in order to successfully complete a background investigation. I waive such legal rights and release all persons from any liabilities and damages in connection with furnishing such information to the Facility named above.

1. APPLICANT OR SUBJECT OF INVESTIGATION – PLEASE PRINT OR TYPE					
Last Name		First Name		Middle Name	Social Security Number - -
List AKA, Maiden, and/or previous married name(s) to be searched (<i>there is an additional charge for each name</i>)					
aka/maiden name		aka/maiden name		aka/maiden name	aka/maiden name
Address					
City			State	Zip Code	
Date of Birth / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Drivers License Number		State

Applicant's signature: _____ Date: ____/____/____

2. SCOPE OF INVESTIGATION – PLEASE CHECK RECORDS TO BE SEARCHED

____ Social Security Number Trace

____ E-Verify

Criminal Court Records—Company Name Index Search

____ **5-Local Search** (Caddo & Bossier Parish, Western District of LA, Shreveport & Bossier City Courts)

____ County/Parish Search (List County/Parish): _____

____ Statewide Search: (List State Name): _____

____ International Search: (List Country Name): _____

Civil Court Records—Computer Name Index Search

____ Caddo Parish, Bossier Parish, and Western District of LA

____ County/Parish Search (List County/Parish): _____

U. S. District Court Records – Location: _____

Search Type: ____ Bankruptcy; ____ Criminal; ____ Civil

____ Official Driving Record: Louisiana (three-year covering period)

____ Official Driving Record: Out-of-State Record (List State) _____

____ Evictions

____ **OIG Exclusion**

____ Employment Verification

____ **RapidCrim**

____ Education/Professional Credential Verification

____ **GAPSA**

____ **National Sex Offender Registry**

____ **Medicare/Medicaid Exclusion Search**

Client Information: Phone Number: **479-229-6148**

Fax Number: **479-229-6162**

DISCLOSURE/AUTHORIZATION (Employment Purposes)

By my signature below, I hereby authorize **SOUTHERN RESEARCH COMPANY, INC.**, to procure a consumer report and/or an investigative consumer report, including but not limited to: my consumer criminal history, driving record, education, employment, professional licenses verification, credit history, personal interviews with neighbors, friends, or associates of my character, general reputation, personal characteristics, mode of living and other public records, which may confirm or deny my eligibility for employment, with **the Facility named above**. I authorize without reservation, any party, including, but not limited to, employers, law enforcement agencies, state agencies, institutions and private information bureaus or repositories, contacted by **SOUTHERN RESEARCH COMPANY, INC.** to furnish any or all of the above-listed information in order to successfully complete a background investigation. I waive such legal rights and release all persons from any liabilities and damages in connection with furnishing such information to **the Facility named above**.

APPLICANT'S INFORMATION (Please Print – Use Ink Only)
(For identification purposes, please provide the following information)

Applicant's Full Name (Please Print): _____

Current Address: _____

City: _____ State: _____ Zip: _____

DOB: ____/____/____ SSN: ____ - ____ - ____

Drivers License: State: _____ Number: _____

Applicant's name printed: _____
(Last Name) (First Name) (Middle Name)

Applicant's Signature: _____ Date: ____/____/____

A copy of the Summary of Rights MUST BE given to the applicant

"User" Representative's signature: _____ Date: ____/____/____

SOUTHERN RESEARCH COMPANY INC.