HORNEPAYNE COMMUNITY HOSPITAL

P.O. BOX 190, 278 FRONT STREET, HORNEPAYNE, ONTARIO P0M 1Z0 807-868-2442 FAX: 807-868-2697

APPLICANT INFORMATION

Last Name		First		M.I.		Date	
Street Address				Apartment/Unit #			
City		Prov.		Postal Code			
Phone		E-mail Address					
How long have you lived at the above address?							
Date Available		Do you hold a Valid Driver's License		YES ☐	NO ☐		
Position Applied for				FT ☐	PT ☐	CASUAL ☐	
Are you a Canadian citizen?	YES ☐	NO ☐	If no, are you authorized to work in Canada?	YES ☐	NO ☐		
Have you ever worked for this company?	YES ☐	NO ☐	If so, when?				
Have you ever been convicted of a criminal offense/felony for which a pardon has not been granted?	YES ☐	NO ☐	If yes, explain				
Are you bondable?	YES ☐	NO ☐					
List any friends or relatives working for us:							
Languages written or spoken and how fluent:							

Do you have any physical limitations or health condition which may limit your ability to perform the job applied for? Please explain:

EDUCATION

Type of School	Name and Address	FROM	TO	GRADUATED	MAJOR
Secondary School				___Yes ____No	
College				___Yes ____No	
Post Graduate				___Yes ____No	
University				___Yes ____No	
Other				___Yes ____No	

REFERENCES

Please list three professional references. ***May we contact your professional references?*** *YES* ☐ *NO* ☐

Full Name		Relationship	
Company		Phone	( )
Address			
Full Name		Relationship	
Company		Phone	( )
Address			
Full Name		Relationship	
Company		Phone	( )
Address			

PREVIOUS EMPLOYMENT

Company		Phone	( )		
Address		Supervisor			
Job Title		Starting Salary	$	Ending Salary	$
Responsibilities					
From	To	Reason for Leaving			
May we contact your previous supervisor for a reference?	YES ☐	NO ☐			
Company		Phone	( )		
Address		Supervisor			
Job Title		Starting Salary	$	Ending Salary	$
Responsibilities					
From	To	Reason for Leaving			
May we contact your previous supervisor for a reference?	YES ☐	NO ☐			
Company		Phone	( )		
Address		Supervisor			
Job Title		Starting Salary	$	Ending Salary	$
Responsibilities					
From	To	Reason for Leaving			
May we contact your previous supervisor for a reference?	YES ☐	NO ☐			

DISCLAIMER AND SIGNATURE

My signature below certifies that :

I hereby certify that the facts set forth in the above employment application are true and complete to the best of my knowledge.
I understand that if employed, falsified statements on this application shall be considered sufficient cause for dismissal.

I declare all statements on this application to be to the best of my knowledge, and an accurate statement of facts. Falsification of employment information is a just cause for immediate dismissal, if discovered at any time during my employment.

In addition, if employed, I agree; to abide by the conditions of employment as set forth in the hospital personnel and administrative policies and to accept any pension plan, group insurance plan or other benefit while this is in effect.

I understand the information which I wrote on the application for employment is subject to check and verification by the Hornepayne Community Hospital and that my present and former employers may be asked for reference information relative to my employment records with them.

I hereby grant permission to the Hornepayne Community Hospital to contact these employers and further, I hereby authorize my present and former employers to give any information as to my character, performance, and employment records with them. I hereby release from all liability and damage those individuals or companies who provide such information. I understand that any material omission or misrepresentation put on this application may result in refusal of, or immediate separation from any employment with the Hornepayne Community Hospital.

In order to assess your application for employment, the Hornepayne Community Hospital needs to collect personal information about you which may be regulated by the Personal Information Protection and Electronic Documents Act ("PIPEDA"). By completing this form, you hereby consent to the use of the information obtained on this form and in the interview process to assess your experience and verify your qualifications and previous employment by the Hornepayne Community Hospital. If hired, this information will be maintained in your personnel file. If not hired, the application form and any other notes will be retained for a minimum period of six months.

Signature   Date