



Arkansas Health Group

Autumn Road Plaza, Suite 400
904 Autumn Road
Little Rock, AR 72211
(501) 202-4037 (501) 202-4012 (Fax)

APPLICATION FOR EMPLOYMENT

Application Date _____

Instructions: Please **PRINT** all information except your signature. **All sections** must be completed for your application to be considered.

PERSONAL DATA

Name: _____ Social Security #: _____
 Last First Middle
 Address: _____ Home Phone: () _____
 No. Street Apt. #
 _____ Work/Message Phone: () _____
 City State Zip

Are you at least 18 years of age? Yes No If not, what is your age? _____
 Have you ever been convicted of a crime? No Yes – Explain nature and date of the offense _____

If not a U.S. Citizen, can you provide proof from the Immigration and Naturalization Services that permits you to work? Yes No

BACKGROUND INFORMATION (Read carefully)

Have you ever been subjected to or ever been denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily) in either of the following areas?

- License, certification, or registration to provide care in any jurisdiction? Yes No
- Status as a student or participant in good standing in any clinical school, internship, residency, fellowship, preceptorship, or other clinical education program? Yes No

EXPERIENCE IN: (Check ALL that apply)

RN LPN RMA MA Lab Pharmacy Radiology General Office Medical Terminology Insurance Billing
 Accounting Word Processing Management/Supervision Typing ___wpm Adding Machine by Touch Data Entry
 Other (Specify) _____

Proficient in what computer software programs? _____

CERTIFICATION/LICENSES

(If your profession requires a license you must also complete an addendum to this application.)

Type	Number	State Issued	Expires
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

AVAILABILITY

When would you be available for work?
 After two week notice
 Specific Date _____
 Immediately Other _____

POSITION(S) DESIRED: (Include title and facility)

How did you learn about this vacancy?

Newspaper Ad Website Job Line
 HR Office Other _____ Career Fair
 Employee
 Name of Referring Employee _____

Minimum Salary Requirement \$ _____
 Do not leave blank. Do not state negotiable.

Were you previously employed by Baptist Health or one of its facilities? Yes No
 If yes, which facility? _____ When? _____ To _____
 Under what name? _____ Are you eligible for rehire? Yes No Unsure

Please list relatives employed by or on the Board of Directors of Baptist Health:

	Name	Relationship	Department	Board Member
1.	_____	_____	_____	<input type="checkbox"/>
2.	_____	_____	_____	<input type="checkbox"/>

Have you ever served in the armed forces? No Yes – Dates of Services _____
 Branch of Service? _____ Discharge status _____

EDUCATION AND TRAINING

Circle highest grade completed: 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 5 6
 High School City, State Graduate? Yes No

Vocational	City, State	Graduate?	Yes	No
College	City, State	Graduate?	Yes	No Degree
Graduate School	City, State	Graduate?	Yes	No Degree

EMPLOYMENT HISTORY: Please start with most recent employment and complete for past 8 years. Explain all unemployed time periods. You may attach additional paper, if needed. If employed under a different name, please state that name.

From	To	Name & Address of Employer		Job Title & Duties
		Name		Title
Mo./Yr.	Mo./Yr.	Address		Duties
		City	State	Name if-different
Starting Salary	Final Salary	Supervisor	Phone	Reason for Leaving
		Name		Title
Mo./Yr.	Mo./Yr.	Address		Duties
		City	State	Name if-different
Starting Salary	Final Salary	Supervisor	Phone	Reason for Leaving
		Name		Title
Mo./Yr.	Mo./Yr.	Address		Duties
		City	State	Name if-different
Starting Salary	Final Salary	Supervisor	Phone	Reason for Leaving
		Name		Title
Mo./Yr.	Mo./Yr.	Address		Duties
		City	State	Name if-different
Starting Salary	Final Salary	Supervisor	Phone	Reason for Leaving

I realize that my application shall remain active for 60 days from date of completion for the specific position(s) I applied for. If I am not hired during this period, a new application must be completed. My application will not be considered unless all areas of this application are completed. I certify that the information given is true and correct. I understand any misrepresentations or omissions of fact, whenever discovered, shall be cause for rejection of this and subsequent applications and for discipline including immediate termination. Practice Plus/AR Health Group may investigate my past employment, including references and background information and will conduct a pre-employment drug screen. Final approval for employment will be subject to this investigation. I understand that if I am offered and accept employment, that it is not for a specific term, and that my employment may be terminated at will, by either my employer or myself.

Signature _____ Date _____
 (DO NOT PRINT)

Please complete the attached reference authorization form.
 May we contact your current employer? Yes No