A blue text on a white background

Description automatically generatedAPPLICATION FOR EMPLOYMENT

COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE AN INTERVIEW

Bethany, 930 West Main Street, Ripon, CA 95366 (209) 599-4221

|  |  |  |
| --- | --- | --- |
| **DATE:** |  | |
|  | | |
| **NAME (Last, First, Middle Initial):** |  | | | | | | | | | | | |
| **ADDRESS (Street, City, St, Zip):** |  | | | | | | | | | | | |
| **BEST NUMBER TO REACH:** | ( ) - | | **E-MAIL:** | | | |  | | | | | |
|  | | | | | | | | | | | | |
| **EMERGENCY CONTACT (Name):** |  | | | | | **RELATIONSHIP:** | | | |  | | |
| **ADDRESS (Street, City, St, Zip):** |  | | | | | | | | | | | |
| **BEST NUMBER TO REACH:** | ( ) - | | | | |
|  | | | | | | | | | | | | |
| **Have you worked for Bethany in the past?**  **Yes**  **No** | | | | | **If Yes, Enter Dates To/From:** | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | | | | |  | | | | | | |  |
| **If you are under 18 can you submit a work permit after employment?** | | | | |  **Yes** | | | | | | |  **No** |
| **Where did you hear about this employment opportunity with Bethany?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **NURSING OR OTHER PROFESSIONAL LICENSE (Enter Type):** | |  | | | | | | | | | | |
| **POSITION DESIRED:** | |  | | | | **EXPECTED WAGE:** | | | | |  | |
| **SHIFT PREFERRED:** | |  | | | |  **Full Time**  **Part Time**  **Either** | | | | | | |
|  | | | | | | | | | | | | |
| **PREVIOUS WORK EXPERIENCE (List Last Employer First)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **DATES:** | | From \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | | To \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | | | | |
| **POSITION / TITLE:** | |  | | | | | | | | | | |
| **EMPLOYER:** | |  | | | | | | | | | | |
| **ADDRESS (Street, City, St, Zip):** | |  | | | | | | | | | | |
| **PHONE NUMBER:** | | ( ) - | | **SUPERVISOR:** | | | | |  | | | |
| **REASON FOR LEAVING:** | |  | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **DATES:** | | From \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | | | | To \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | | |
| **POSITION / TITLE:** | |  | | | | | | | | | | |
| **EMPLOYER:** | |  | | | | | | | | | | |
| **ADDRESS (Street, City, St, Zip):** | |  | | | | | | | | | | |
| **PHONE NUMBER:** | | ( ) - | | | | | | | | | | |
| **REASON FOR LEAVING:** | |  | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **DATES:** | | From \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | | | | To \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | | |
| **POSITION / TITLE:** | |  | | | | | | | | | | |
| **EMPLOYER:** | |  | | | | | | | | | | |
| **ADDRESS (Street, City, St, Zip):** | |  | | | | | | | | | | |
| **PHONE NUMBER:** | | ( ) - | | | | | | | | | | |
| **REASON FOR LEAVING:** | |  | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **DATES:** | From \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | To \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ |
| **POSITION / TITLE:** |  | |
| **EMPLOYER:** |  | |
| **ADDRESS (Street, City, St, Zip):** |  | |
| **PHONE NUMBER:** | ( ) - | |
| **REASON FOR LEAVING:** |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **CHARACTER REFERENCES (Persons who know you well – do not include relatives or spouses)** | | | |
|  | | | |
| **NAME:** |  | | |
| **OCCUPATION:** |  | | |
| **CITY:** |  | **PHONE NUMBER:** | ( ) - |
| **YEARS KNOWN:** |  | | |
|  | | | |
| **NAME:** |  | | |
| **OCCUPATION:** |  | | |
| **CITY:** |  | **PHONE NUMBER:** | ( ) - |
| **YEARS KNOWN:** |  | | |
|  | | | |
| **NAME:** |  | | |
| **OCCUPATION:** |  | | |
| **CITY:** |  | **PHONE NUMBER:** | ( ) - |
| **YEARS KNOWN:** |  | | |

I understand that an offer of employment may be contingent upon the passing of a physical examination by a physician. I also understand that any misstatement or omission of material facts in my application may be cause for dismissal. You have permission to contact my previous employers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT’S SIGNATURE DATE