DCH Regional Medical Center

DCH Health System

School of Phlebotomy Application

Mail to:
809 University Boulevard, East
Tuscaloosa, Alabama 35401
(205)759-7958 or kathryn.smith@dchsystem.com

Date_____

NAME: _____ TELEPHONE: _____or
LAST FIRST MIDDLE

E-mail Address (if applicable):

ADDRESS:	LOCAL ADDRESS: (If different from permanent)
Number and Street	Number and Street
City, State and Zip Code	City, State and Zip Code
Social Security Number	If accepted into the program, will you take a physical examination? Yes ( ) No ( )
Date of Birth: The Age Discrimination in Employment Act prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age.	**SELECTIVE SERVICE DATA** Are you currently a member of a reserve unit? Yes ( ) No ( )
Other Names Used:	Professional organizations, interests, hobbies (omit any which might indicate race, religion, color, national origin, disability, age, sex, or ancestry)

EDUCATIONAL DATA

Name/Address of High School	Course / Major	Dates Attended	Graduate?	Diploma / GED
Name/Address of College	Course / Major	Dates Attended	Graduate?	Degree
Name/Address of Additional College (if needed)	Course / Major	Dates Attended	Graduate?	Degree
Name/Address of Business, Technical or Professional Schools Attended	Course / Major	Dates Attended	Graduate?	Degree / Diploma

SPECIAL TRAINING OR CERTIFICATES :

PERSONAL REFERENCES Name, complete address and phone of three people (other than relatives or previous employers)

1. Name		Phone Number	
Street	City	State	Zip
E-mail address (if applicable)			
2. Name		Phone Number	
Street	City	State	Zip
E-mail address (if applicable)			
3. Name		Phone Number	
Street	City	State	Zip
E-mail address (if applicable)			

EMPLOYMENT DATA - Begin with your most recent job

DATES OF EMPLOYMENT (Give month and year)	Employer's Name Employer's Address	Salary Start Salary End May we contact your current employer? Yes No
FROM TO	Supervisor's Name Phone Number Reason for Leaving	Job Title/Duties
FROM TO	Employer's Name Employer's Address Supervisor's Name Phone Number Reason for Leaving	Salary Start Salary End May we contact this employer? Yes N Job Title/Duties
FROM TO	Employer's Name Employer's Address Supervisor's Name Phone Number Reason for Leaving	Salary Start Salary End May we contact this employer? Yes N Job Title/Duties
FROM TO	Employer's Name Employer's Address Supervisor's Name Phone Number Reason for Leaving	Salary Start Salary End May we contact this employer? Yes N Job Title/Duties

Have you worked for any of the DCH facilities before?	If yes, which facility	Dates: From To
Name of relatives employed by any DCH facility. Please list relationship		

MISCELLANEOUS INFORMATION

1.Have you ever been convicted of any crime other than a minor traffic violation? **(Check one)** Yes No

If yes, list offenses:

Date of conviction:

2.Have you ever been refused a surety bond? Yes No

Note: An answer of yes to either of the above questions does not necessarily disqualify you for employment with DCH Health System

3. Are you a citizen or otherwise authorized to work in the U.S.? Yes No

CERTIFICATION OF APPLICANT

The information given in this application is given

of my own free will and accord and is true and correct to the best of my knowledge and belief. This is my express permission for DCH Health System to conduct an investigation into my background, experience, qualifications, etc. I fully understand that, as a condition of my employment, I will be required to take a physical examination and the interpretation of the results of such examination shall be made by DCH Health System, in accordance with the Rehabilitation Act of 1973. I fully understand that the personal and family medical record form will be kept confidential, except to the extent that disclosure may be required in order to comply with the Rehabilitation Act of 1973 or ensure my safety or that of other employees, and false statement hereon, or any withholding of requested information will be sufficient cause for rejection or termination. I further understand and agree that, if employed, my employment will be for an indefinite duration and that my employment may be terminated, with or without cause, at any time at the will of either myself or the hospital. I further understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by both me and an administrator of DCH Health System.

_____ Date: _____

Signature of Applicant