



ST. BARNABAS

Pre – Employment Questionnaire

PLEASE PRINT

DATE: ____/____/____

Position(s) for which application is being completed: _____

Name _____ Phone _____ Social Security # _____

Address _____ City _____ State _____ Zip Code _____ Email _____

Address _____

Length of residence in Pennsylvania _____

Are you older than 18? Yes No If under age 18, date of birth _____

If under age 18, can you furnish a work permit? Yes No

Education

Highest grade completed: _____

Name	Location	From	To	Graduate
High School	_____	_____	_____	_____

College _____

Other _____

Special Training _____

Are you a smoker? Yes No

Related skills to the position(s) for which you are applying? _____

Are you presently employed? Yes No

When would you be available to begin work if offered a position of employment? _____

Have you ever been employed by St. Barnabas Health System? Yes No

If yes, Corporation / Department _____ From _____ To Have

you worked in a long-term care facility or other health care facility before? Yes No

If yes, please supply details _____

Why are you interested in working for St. Barnabas Health System? _____

How did you learn about employment possibilities with St. Barnabas? _____

Are you interested in Part-time Full-time Seasonal Temporary

If temporary, please explain _____

Are there any hours when you would not be available for work at St. Barnabas? Yes No

If yes, please specify and give reasons _____

Are you willing to work weekends? Yes No Overtime? Yes No

How many days were you absent from work? 2019 _____ 2018 _____

Have you been discharged from any employment other than layoff due to lack of work? Yes No

If yes, give details _____

Have you been convicted of any crime? Yes No

If yes, please explain _____

Have you ever been barred or sanctioned by Medicaid or Medicare? Yes No

If yes, give details _____

Do you use any illegal drugs of any kind? Yes No

If yes, explain _____

Please set forth any training or special skills you possess: _____

Military Service

Did you serve in the U.S. Armed Forces? Yes No Branch _____

Entered _____ Discharged _____ Final Rank _____ Selective Service Classification _____

Type of discharge: _____

Present military status: Active Inactive Reserve

Personal References (Other than relatives or former employers)

Name	Occupation	Address	Telephone	Years Known
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Employment Experience

Please start with your present or last job. You may include any volunteer activities. You should exclude organizations, which indicate race, color, religion, gender, national origin, sexual orientation, disability or other protected status.

Employer _____	Position / Job Title _____
Address _____	Dates Employed _____
Telephone Number _____	Hourly Rate / Salary _____
Supervisor _____	Reason for Leaving _____
Work Performed _____	

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Supervisor _____	Reason for Leaving _____
Work Performed _____	

May we contact the employers listed above? Yes No

If not, indicated references and which one(s) you do not wish us to contact _____

ST. BARNABAS HEALTH SYSTEM IS AN EQUAL OPPORTUNITY EMPLOYER AND DOES NOT DISCRIMINATE BECAUSE OF RACE, RELIGION, COLOR, AGE, GENDER, NATIONAL ORIGIN, MARITAL STATUS, DISABILITY OR HANDICAP, VETERAN STATUS, SEXUAL ORIENTATION, OR ANY OTHER STATUS PROTECTED BY LAW. NO QUESTION ON THIS APPLICATION IS INTENDED TO SECURE INFORMATION TO BE USED FOR SUCH DISCRIMINATION.

THIS IS NEITHER AN EMPLOYMENT CONTRACT NOR A GUARANTEE OF EMPLOYMENT. YOU MAY SUBMIT A NEW APPLICATION OR UPDATE THIS APPLICATION AT ANY TIME.

1. If you require any special reasonable accommodation completing this application, interviewing, completing any pre-employment testing, or otherwise participation in the employee selection process, please advise us.
2. You will be required to pass a drug and or alcohol screening test as a condition of employment.
3. By signing below, you understand that all statements made herein are subject to verification by St. Barnabas Health System Inc. and you hereby release St. Barnabas Health System, its related entities and employees from all liability associated with these statements and how they are utilized in the employment process.
4. I understand that an investigative consumer report is a report in which information concerning my character, general reputation, personal characteristics, or mode of living, is obtained through personal interviews with neighbors, friends, or associates with whom I am acquainted. By signing below, I am authorizing the St. Barnabas Health System, Inc. to obtain a consumer or investigative consumer report on me as part of the St. Barnabas Health System, Inc. background screening process.
5. I specifically hereby authorize in writing St. Barnabas Health System, Inc. and or its assigns to conduct a Credit Check as defined by the federal Fair Credit Reporting Act (FCRA), conduct a criminal background check, and when not a resident of Pennsylvania for at least two years, conduct an FBI fingerprint check. Your authorization below meets the standards to allowing St. Barnabas Health System, Inc. and or its assigns to contact a consumer reporting agency who may provide information about you.
6. I hereby authorize my prior employer to release any and all information relating to my employment with them to St. Barnabas Health System. I further release and hold harmless St Barnabas Health System from any and all liability that may potentially result from the release and/or use of such information. I understand that any information released by my prior employer will be held in strictest confidence, that it will be viewed only by those involved in the hiring decision, and that neither I nor anyone else not so involved will have the right to see the information.

Signature _____

Print Name _____ Date ____/____/____

List additional employment history on backside of this page if needed.