

DCH Regional Medical Center



School of Phlebotomy Application

809 University Boulevard, East
 Tuscaloosa, Alabama 35401
 (205)759-7958 or KSpidel@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 _____	Salary Start _____
	Employer's Address _____	Salary End _____ May we contact your current employer? Yes _____ No _____
FROM _____	Supervisor's Name _____	Phone Number _____
TO _____	Reason for Leaving _____	
FROM _____	Employer's Name _____	Salary Start _____
	Employer's Address _____	Salary End _____ May we contact this employer? Yes _____ N _____
TO _____	Supervisor's Name _____	Phone Number _____
	Reason for Leaving _____	
FROM _____	Employer's Name _____	Salary Start _____
	Employer's Address _____	Salary End _____ May we contact this employer? Yes ___ N ___
TO _____	Supervisor's Name _____	Phone Number _____
	Reason for Leaving _____	
FROM _____	Employer's Name _____	Salary Start _____
	Employer's Address _____	Salary End _____ May we contact this employer? Yes ___ N ___
TO _____	Supervisor's Name _____	Phone Number _____
	Reason for Leaving _____	
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

