

Dear Applicant:

Thank you for considering Coast Plaza Hospital as a potential place of employment. Please read carefully before beginning to fill out your application.

THE APPLICATION PROCESS

Your application will represent you throughout the pre-employment process. Therefore, present yourself well by submitting a complete, accurate and neat application.

It is the policy of Coast Plaza Hospital to match an applicant's experience and education as closely as possible with the current needs of our open positions. Because of the large volume of applications that we receive on a daily basis, we regret that we are unable to respond in writing to each candidate.

IF YOU ARE SELECTED FOR THE INTERVIEW PROCESS, WE WILL CONTACT YOU. IF YOU DO NOT HEAR FROM US YOU MAY ASSUME THAT THERE WAS NOT A SUITABLE MATCH.

QUALIFYING FOR EMPLOYMENT

In order to qualify for employment with Coast Plaza Hospital we require that you:

1. Fill out the application form completely. List the last 10 years and explain all lapses in your employment record.
2. Satisfactorily complete pre-employment tests and interviews.
3. Possess and be able to verify any required licensures, registrations and certifications.
4. Complete the Employment Eligibility Verification (Form I-9) and be able to produce appropriate ORIGINAL documents verifying your identity and authorizing you to work in the United States. (Immigration Reform and Control Act, 1986)
5. Satisfactorily complete all pre-employment lab test including drug screen and limited health screen. All job offers are considered conditional and open until satisfactorily completed.
6. All jobs are contingent upon satisfactory employment reference checks.

Thank you very much for your cooperation. On behalf of our entire health care team, please accept our best wishes for your success.

Human Resources



E. L. A. DOCTORS HOSPITAL
4060 E. Whittier Blvd.
Los Angeles, CA 90023
(213) 268-4514



HUNTINGTON PARK COMMUNITY
HOSPITAL
2623 E. Slausen Ave.
Huntington Park, CA 90255



COAST PLAZA HOSPITAL
13100 Studebaker Rd.
Norwalk, CA 90650
(562) 868-2751



MEMORIAL HOSPITAL OF GARDENA
1145 W. Redondo Beach Blvd.
Gardena, CA 90247
(310) 532-4200

PLEASE READ CAREFULLY COMPLETE ALL QUESTIONS PRINT CLEARLY IN INK

PERSONAL

TODAY'S DATE	LAST NAME		FIRST	SOCIAL SECURITY NUMBER
STREET APT.		CITY	STATE	ZIP CODE
HOME ADDRESS:				
HOME PHONE () ()	MESSAGE PHONE () ()	ARE YOU 18 OR OVER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF HIRED, YOU WILL BE REQUIRED TO SUBMIT PROOF OF AGE.		
NAME OF PERSON THROUGH WHOM YOU MAY BE CONTACTED FOR MESSAGE PURPOSES:				
ADDRESS:				PHONE:
IF HIRED, CAN YOU FURNISH PROOF THAT YOU ARE LEGALLY PERMITTED TO WORK IN THE UNITED STATES? <input type="checkbox"/> YES <input type="checkbox"/> NO				
WHAT OTHER NAME HAVE YOU BEEN EMPLOYED UNDER IF DIFFERENT FROM PRESENT NAME?				
HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR? IF YES, PLEASE EXPLAIN		<input type="checkbox"/> YES <input type="checkbox"/> NO (Record of conviction does not necessarily disqualify you from employment consideration)		
NAMES OF RELATIVES EMPLOYED BY THIS FACILITY:		DEPARTMENT		
HOW DID YOU LEARN ABOUT THIS JOB OPENING?		HAVE YOU PREVIOUSLY BEEN EMPLOYED BY EAST LOS ANGELES DOCTORS HOSPITAL or MEMORIAL HOSPITAL OF GARDENA? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE? _____ WHEN? _____		

EDUCATIONAL RECORD

HIGH SCHOOL	LOCATION	CIRCLE LAST GRADE COMPLETED 9 10 11 12	DIPLOMA?
COLLEGE	LOCATION	1 2 3 4	DEGREE AND MAJOR
COLLEGE	LOCATION	1 2 3 4	DEGREE AND MAJOR
OTHER EDUCATION, SPECIAL COURSES, OR ACADEMIC HONORS			
COLLEGES IN WHICH YOU ARE CURRENTLY ENROLLED :			

PROFESSIONAL LICENSES/CERTIFICATION

TYPE	NUMBER	STATE ISSUED	DATE ISSUED	EXPIRES ON	OFFICE USE ONLY CONFIRMED
TYPE	NUMBER	STATE ISSUED	DATE ISSUED	EXPIRES ON	CONFIRMED

LIST ANY PROFESSIONAL ORGANIZATIONS OF WHICH YOU ARE A MEMBER (You may omit any which indicates sex, religion, national origin, ancestry, handicap or disability, race, age, sexual orientation, marital status, or Veterans status):

U.S. MILITARY EXPERIENCE

BRANCH	INITIAL RANK	FINAL RANK
SERVICE SCHOOLS ATTENDED:		
SPECIALTY (Nature of Duties):		

SKILLS

TYPING SPEED (Last Date Tested)	SHORTHAND SPEED (Last Date Tested)	10 KEY ADD. MACH. BY TOUCH <input type="checkbox"/> YES <input type="checkbox"/> NO	PBX (Type Board)	MEDICAL TERMINOLOGY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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LIST OTHER KNOWLEDGE OR SKILLS YOU POSSESS OR EQUIPMENT YOU CAN OPERATE:							
JOB INTEREST							
FIRST CHOICE		SECOND CHOICE			DATE AVAILABLE		SALARY DESIRED
HOURS & SHIFTS AVAILABLE	FULL TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	PART TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	ON CALL <input type="checkbox"/> YES <input type="checkbox"/> NO	DAYS <input type="checkbox"/> YES <input type="checkbox"/> NO	EVENINGS <input type="checkbox"/> YES <input type="checkbox"/> NO	NIGHTS <input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKENDS <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYMENT HISTORY MOST RECENT EMPLOYER FIRST - EXPLAIN ANY LAPSES IN EMPLOYMENT BETWEEN JOBS							
PRESENT COMPANY				MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PHONE NUMBER	
ADDRESS				<input type="checkbox"/> FULL TIME		<input type="checkbox"/> PART TIME	
						AVERAGE HOURS WEEKLY	
JOB TITLE:		IMMEDIATE SUPERVISOR:		EMPLOYED			
NATURE OF DUTIES:				FROM:		TO:	
				MO. YR.		MO. YR.	
				HOURLY SALARY			
REASON FOR LEAVING (Also indicate resigned, discharged, etc.)				START:		END:	

EXPLAIN TIME LAPSE: _____

PRESENT COMPANY				MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PHONE NUMBER	
ADDRESS				<input type="checkbox"/> FULL TIME		<input type="checkbox"/> PART TIME	
						AVERAGE HOURS WEEKLY	
JOB TITLE:		IMMEDIATE SUPERVISOR:		EMPLOYED			
NATURE OF DUTIES:				FROM:		TO:	
				MO. YR.		MO. YR.	
				HOURLY SALARY			
REASON FOR LEAVING (Also indicate resigned, discharged, etc.)				START:		END:	

EXPLAIN TIME LAPSE: _____

PRESENT COMPANY				MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PHONE NUMBER	
ADDRESS				<input type="checkbox"/> FULL TIME		<input type="checkbox"/> PART TIME	
						AVERAGE HOURS WEEKLY	
JOB TITLE:		IMMEDIATE SUPERVISOR:		EMPLOYED			
NATURE OF DUTIES:				FROM:		TO:	
				MO. YR.		MO. YR.	
				HOURLY SALARY			
REASON FOR LEAVING (Also indicate resigned, discharged, etc.)				START:		END:	

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and I agree to have any of the statements checked by the Hospital unless I have indicated to the contrary. I authorize the references listed above to provide the Hospital any and all information concerning my previous employment and any pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damage that may result from furnishing such information to the Hospital as well as from the use or disclosure of such information by the Hospital or any of its agent employees, or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or, if I am hired, in my dismissal from employment.

In consideration of my employment, I agree to conform to the rules and standards of the Hospital and agree that my employment and compensation can be

terminated, with or without cause, and with or without notice, at any time, either at my option or at the option of the Hospital. I understand that no employee representative of the Hospital other than the president of the parent company has any authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing. Further, the president of the parent company may not alter the at-will nature of the employment relationship unless he does so specifically and in writing. I also understand that all offers of employment are conditioned on the provision of satisfactory proof of an applicant's identity and legal right to work in the U.S.

I understand that any offer of employment with the Hospital will be conditioned on completing a satisfactory background check, pre-employment medical examination and a pre-employment drug and alcohol test. A purpose of the medical examination is to determine whether I am able to perform the essential functions of the job I am offered with or without reasonable accommodation, to identify any reasonable accommodation if such is warranted, and to ensure that my performance of the essential functions does not present a direct threat to my health and safety or the health and safety of others. I agree to undergo such a pre-employment medical examination and drug and alcohol test. If hired by the Hospital, I further agree to undergo any periodic medical examinations, which are permitted or required by law.

The Hospital complies with Federal and State laws which prohibit discrimination on the basis of race, color, age, sex, religion, national origin, ancestry, disability, handicap, Veteran status, medical condition (as defined by California law), sexual orientation, marital status and Political Affiliation.

Applicant's Signature

Date

EEO GOVERNMENT REPORT DATA COLLECTION

APPLICANTS FOR EMPLOYMENT

THE INFORMATION REQUESTED ON THIS FORM IS REQUIRED FOR FEDERAL GOVERNMENT REPORTING REGULATIONS. THE INFORMATION IS KEPT SEPARATE FROM EMPLOYMENT APPLICATIONS AND WILL NOT AFFECT YOUR CANDIDACY FOR EMPLOYMENT

Social Security Number:

	APPLICANTS NAME: (LAST, FIRST, MI)
	EEO RACE CODE (PLEASE CHECK BOX WHICH DESIGNATES YOUR RACE) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE
	SEX: (PLEASE CHECK APPROPRIATE BOX) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	DISABILITY STATUS: (PLEASE CHECK APPROPRIATE BOX) <input type="checkbox"/> YES <input type="checkbox"/> NO <small>DEFINITION: ANY PERSON WHO HAS A PHYSICAL OR MENTAL IMPAIRMENT THAT SUBSTANTIALLY LIMITS ONE OR MORE MAJOR LIFE ACTIVITIES, HAS A RECORD OF SUCH IMPAIRMENTS OR IS REGARDED AS HAVING SUCH IMPAIRMENTS. ACCOMMODATION REQUIRED</small>
	VETERAN STATUS: (PLEASE CHECK APPROPRIATE BOX) <input type="checkbox"/> VIETNAM ERA VETERANS: Is a person who served on active duty for a period of more than 180 days, any part of which occurred between 8/5/94-5/7/74 and has any discharge other than dishonorable <input type="checkbox"/> DISABLED VIETNAM VETERAN: 30% or more V.A. certified disability incurred or aggravated on duty between 8/5/61 to 5/7/74 <input type="checkbox"/> DISABLED VETERAN: (NOT VIETNAM) 30% or more V.A. certified disability incurred or aggravated in the line of duty before 8/5/64 or after 5/7/74
	ARE YOU OVER FORTY (40), BUT UNDER THE AGE OF SEVENTY (70) <input type="checkbox"/> YES <input type="checkbox"/> NO
	PLEASE STATE THE POSITION YOU ARE APPLYING:
	WHAT SOURCE PROMPTED YOU TO APPLY? (EMPLOYEE REFERRAL, NEWSPAPER ADVERTISEMENT, STATE JOB SERVICE OR OTHER) IF ADVERTISEMENT, PLEASE GIVE NAME OF PUBLICATION. IF EMPLOYEE REFERRAL, PLEASE GIVE PERSONS NAME:

IT IS THE POLICY OF EAST LOS ANGELES DOCTORS HOSPITAL, COAST PLAZA HOSPITAL AND MEMORIAL HOSPITAL OF GARDENA TO TREAT QUALIFIED DISABLED INDIVIDUALS, DISABLED VETERANS AND VETERANS OF THE VIETNAM ERA WITHOUT DISCRIMINATION AND TO FULFILL ITS COMMITMENT TO EQUAL EMPLOYMENT OPPORTUNITY AND THE PROVISIONS OF SECTION 503 OF THE REHABILITATION ACT OF 1973 AND SECTION 402 OF THE VETERAN'S READJUSTMENT ASSISTANCE ACT OF 1974. BOTH ACTS REQUIRE FEDERAL CONTRACTORS TO MAINTAIN AFFIRMATIVE ACTION PROGRAMS FOR APPLICANTS AND EMPLOYEES COVERED BY THESE ACTS. THEY ALSO REQUIRE THAT ALL APPLICANTS BE AFFORDED THE OPPORTUNITY TO VOLUNTARILLY IDENTIFY THEMSELVES AS BEING DISABLED INDIVIDUALS, DISABLED VETERANS AND/OR VETERANS OF THE VIETNAM ERA IN ORDER THAT APPLICANTS AND/OR EMPLOYEES MAY DERIVE BENEFITS UNDER THEIR PROVISIONS.

- I HAVE READ THE ABOVE STATEMENT AND VOLUNTARILY PROVIDED THE REQUESTED INFORMATION TO BE USED FOR THE PURPOSE STATED.
- I HAVE READ THE ABOVE STATEMENT AND DECLINE THE INVITATION TO PROVIDE THE REQUESTED INFORMATION.

_____ DATE

_____ SIGNATURE