

# THOREK MEMORIAL HOSPITAL

850 W Irving Park Road  
Chicago, Illinois 60613

## APPLICATION FOR EMPLOYMENT

*Thorek Hospital is an equal opportunity employer and does not discriminate against race, color, religion, physical or mental impairment, national origin, sex, ancestry, age or veteran status.*

Please Print

<b>Positions Desired</b>  <input type="checkbox"/> Full time <input type="checkbox"/> Part Time  1. _____ 2. _____ 3. _____	<b>How were you referred?</b> <input type="checkbox"/> Tribune <input type="checkbox"/> Careerbuilder <input type="checkbox"/> Thorek Website <input type="checkbox"/> Location of Hospital <input type="checkbox"/> Advance Magazine <input type="checkbox"/> Other Please Specify: _____ <input type="checkbox"/> Thorek Employee Name: _____
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### Personal Data

Name		Social Security Number	
Street Address		Apt/ Unit #	Telephone #
City	State	Zip	
Have You Ever Worked For Us Before? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, When?			
If Thorek Hospital should extend an offer of employment to you, could you furnish proof of U.S. Citizenship or the legal right to work the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are there any reasons that you physically cannot perform any of the essential functions of the job for which you have applied, with or without reasonable accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, what can be done to accommodate your limitation?			
Please disclose where you have any contagious diseases that might prevent or impede you from holding a position requiring direct patient contact. If you have any such condition, please disclose the nature of the condition.			
Have you ever been convicted of a felony or a misdemeanor? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Are you willing to work any shift? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, what shift(s) can you work? <input type="checkbox"/> Days <input type="checkbox"/> PMs <input type="checkbox"/> Nights
As a condition of continued employment, do you realize that it may be necessary for you to work on weekends, holidays or shift rotation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Employment History

<b>Previous Employers List Most Recent First</b>	Company Name	Street	City	Phone Number
	Job Title	Start Date	Date Left	
	Reason for Leaving	Supervisor's Name		Supervisor's Title
<b>Previous Employers List Most Recent First</b>	Company Name	Street	City	Phone Number
	Job Title	Start Date	Date Left	
	Reason for Leaving	Supervisor's Name		Supervisor's Title
<b>Previous Employers List Most Recent First</b>	Company Name	Street	City	Phone Number
	Job Title	Start Date	Date Left	
	Reason for Leaving	Supervisor's Name		Supervisor's Title
<b>Previous Employers List Most Recent First</b>	Company Name	Street	City	Phone Number
	Job Title	Start Date	Date Left	
	Reason for Leaving	Supervisor's Name		Supervisor's Title

### Professional & Technical Information

Are You Currently Registered

Are You Eligible For Registry  Will Take Board Exams \_\_\_\_\_

If licensed or registered, please provide

State of Registry	Registration Number	Other States in Which Registered

### Additional Information

<p><b><u>Specialized Hospital Experience</u></b></p> <p><input type="checkbox"/> Nursing Supervisor    <input type="checkbox"/> Security Guard</p> <p><input type="checkbox"/> Registered Nurse    <input type="checkbox"/> Inhalation Therapist</p> <p><input type="checkbox"/> Practical Nurse    <input type="checkbox"/> Radiology</p> <p><input type="checkbox"/> Nursing Assistant    <input type="checkbox"/> X-Ray Tech</p> <p><input type="checkbox"/> Orderly    <input type="checkbox"/> Physical Therapy</p> <p><input type="checkbox"/> Food Service    <input type="checkbox"/> Medical Transcriptionist</p> <p><input type="checkbox"/> Chef/Cook    <input type="checkbox"/> Medical Record Clerk</p> <p><input type="checkbox"/> Housekeeping    <input type="checkbox"/> Medical Secretary</p> <p><input type="checkbox"/> Laundry    <input type="checkbox"/> Clinical Pharmacy</p> <p><input type="checkbox"/> Lab Tech    <input type="checkbox"/> Purchasing</p> <p><input type="checkbox"/> Engineer    <input type="checkbox"/> Admitting</p>	<p><b><u>Specialized Office Experience</u></b></p> <p><input type="checkbox"/> Typing    <input type="checkbox"/> Calculator</p> <p><input type="checkbox"/> Dictation    <input type="checkbox"/> Billing Machine</p> <p><input type="checkbox"/> Bookkeeping    <input type="checkbox"/> Clerical Work</p> <p><input type="checkbox"/> Record Filing    <input type="checkbox"/> Data Entry</p> <p><input type="checkbox"/> Addressograph    <input type="checkbox"/> Credit/Collections</p> <p><input type="checkbox"/> CRT    <input type="checkbox"/> Cashier</p> <p><input type="checkbox"/> Adding Machine    <input type="checkbox"/> Copy Machine</p> <p><input type="checkbox"/> Mailing Clerk    <input type="checkbox"/> Switchboard</p> <p><input type="checkbox"/> Word Processing    <input type="checkbox"/> Other</p> <p><b><u>Additional Work Experience</u></b></p> <p><input type="checkbox"/> Electrician    <input type="checkbox"/> Air Conditioning</p> <p><input type="checkbox"/> Carpenter    <input type="checkbox"/> General Maintenance</p> <p><input type="checkbox"/> Painter/ Plasterer    <input type="checkbox"/> Warehouse</p> <p><input type="checkbox"/> Plumber    <input type="checkbox"/> Maintenance</p> <p><input type="checkbox"/> Grounds Keeper    <input type="checkbox"/> Other</p>
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	Name and Address of School	Course of Study	Circle Last Year Completed				Did you Graduate?	List Diploma or Degree Received
			1	2	3	4		
High School			1	2	3	4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College			1	2	3	4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate School			1	2	3	4	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Other:**

**Business College or Other Special Courses – Include Special Military Training**

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**Other Skills:**

List any other skills that you consider relevant to your ability to perform the job you are applying for, such as: individual courses, adult education, awards, certificates, professional affiliations, scholarships, patents or publications.

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Please use this space to comment about your special abilities, special work you have done or work you would like to do.

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## Employment Application Provisions

**\*\*Read Carefully!** If you need a translation or an explanation of the contents below, please ask a Human Resources Representative before signing your name. \*\*

**I understand that any false statements made as a part of this application or any accompanying employment interview will be considered sufficient cause for dismissal. I also grant permission for the authorities of the hospital to conduct a detailed investigation of my references and release Thorek Hospital for any and all liability resulting from such investigation.**

**I consent to any and all medical examinations required by the hospital and understand that if I am employed, I will be on a probationary basis for 3 months from date of my employment. Upon my termination, I authorize the release of reference information on my work performance.**

**Thorek Hospital does not discriminate in hiring or employment on the basis of race, color, religion, physical or mental impairment, national origin, sex, ancestry, age or veteran status.**

**I understand that this employment application and any other current or future company document, or oral statement made by any hospital supervisory or management personnel, are changeable without notice and do not create or provide evidence of a contract of employment. I also understand that any individual who is hired may voluntarily leave employment and may be terminated by the hospital at any time for any reason. Only the President of the Hospital may modify in writing the limitations of this disclaimer and disclosure.**

\_\_\_\_\_ **Date**

\_\_\_\_\_ **Signature**



<b>Dept. No.</b>	<b>Position Title</b>		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Pro-Rate <input type="checkbox"/> Wknds Only <input type="checkbox"/> Casual		<input type="checkbox"/> Regular <input type="checkbox"/> Temporary	<b>Shift</b>	<b>Physical Date</b>
<b>To Replace</b>	<b>Job Grade</b>	<b>FLSA</b>	<input type="checkbox"/> Hrs./PP		<b>Hrs. To Include</b>	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup>	<b>Starting Date</b>
<b>Dept.</b>	<b>Rate of Pay</b>	<b>Differential</b>			<b>M T W T H F</b>	<input type="checkbox"/> Rot.	<b>Orient Date</b>
	\$ _____	\$ ___ Per Hr.			<b>Sat. Sun. Hol.</b>		
					<b>(CIRCLE)</b>		

**Department Head** \_\_\_\_\_ **Date** \_\_\_\_\_

**Human Resources Rep** \_\_\_\_\_ **Date** \_\_\_\_\_



850 W. Irving Park Road  
Chicago, Illinois 60613

## **NOTICE TO ALL APPLICANTS**

Thorek Memorial Hospital recognizes the need to set an example of healthful living to the community it service and provide a safe and healthy environment to its employees, patients and visitors. Because of this commitment to promote good health and to provide a safe work environment, Thorek Hospital is a smoke-free/drug-free hospital and participates in the VERIFIED criminal background investigation program conducted by the Metropolitan Chicago Healthcare Council.

By my signature, I understand that if offered a position at Thorek Hospital, I must undergo a pre-employment physical that includes a drug-screen, and a criminal background investigation will be conducted on me.

Also, by my signature, I understand that if hired, I will not be permitted to smoke in the hospital at any time and that if I violate this policy, disciplinary action will be taken.

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Date

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Signature



**Human Resources  
Reference Contact List**

**Professional References**

I authorize Thorek Memorial Hospital to seek information from my references concerning my former employment history. I release Thorek Hospital from any or all liability resulting from all reference checking.

\_\_\_\_\_  
*Signature*                                  *Date*                                  *Social Security No.*

Please provide below three professional references support your application of employment. Any information furnished relative to the application will be treated with the strictest confidence.

\_\_\_\_\_  
*(1) Name (Previous Manager/ Supervisor)*                                  *Title*                                  *Phone No.*

\_\_\_\_\_  
*(2) Name*                                  *Title*                                  *Phone No.*

\_\_\_\_\_  
*(3) Name*                                  *Title*                                  *Phone No.*



**Authorization for Release  
Of Prior Employment Information**

I have applied for employment with Thorek Memorial Hospital. I authorize you to furnish Thorek Hospital with any information you may have concerning my employment with this organization. I release you from any liability for damages for this information.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Social Security No.*

**Any information furnished relative to the application of the above individual will be treated with the strictest confidence. An applicant will not be eliminated or selected on the basis of a single reference.**

Organization: \_\_\_\_\_

Date of Employment:      From: \_\_\_\_\_      To: \_\_\_\_\_

What was his/her job title? \_\_\_\_\_

What was the nature of his/her job? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the overall quality of his/her work: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe situations, if any, relating to disciplinary, attendance and/or tardiness issues:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_



# Health Care Worker Background Check

## Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name \_\_\_\_\_ Full Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Other Names Used \_\_\_\_\_ Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

States Where You Have Lived? \_\_\_\_\_

Male  Female Race \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

(Enter a letter from below)

Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_ Place of Birth \_\_\_\_\_

- Race **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
- B** Black or African American (Not Hispanic or Latino)
- H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
- U** Of undeterminable race. Of Untold mixture.
- W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft?  Yes  No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)?  Yes  No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

\_\_\_\_\_  
(Signature of Parent or Guardian when applicable)

\_\_\_\_\_  
(Date)

**Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133**

**\*\*\* ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED\*\*\***



**DISCLOSURE AND AUTHORIZATION REGARDING BACKGROUND  
INVESTIGATION FOR EMPLOYMENT PURPOSES**

**Disclosure**

Thorek Memorial Medical Staff Svcs (the "Company") may request from a consumer reporting agency and for employment-related purposes, a "consumer report(s)" (commonly known as "background reports") containing background information about you in connection with your employment, or application for employment, or engagement for services (including independent contractor or volunteer assignments, as applicable).

HireRight, LLC ("HireRight") will prepare or assemble the background reports for the Company. HireRight is located and can be contacted at 3349 Michelson Drive, Suite 150, Irvine, CA 92612, (800) 400-2761, [www.hireright.com](http://www.hireright.com).

The background report(s) may contain information concerning your character, general reputation, personal characteristics, mode of living, or credit standing. The types of background information that may be obtained include, but are not limited to: criminal history; litigation history; motor vehicle record and accident history; social security number verification; address and alias history; credit history; verification of your education, employment and earnings history; professional licensing, credential and certification checks; drug/alcohol testing results and history; military service; and other information.

**Authorization**

I hereby authorize Company to obtain the consumer reports described above about me.

Applicant Name \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

EMPLOYMENT SCREENING FORM

<b>APPLICANT INFORMATION (please print clearly &amp; accurately)</b>											
Last Name			First Name				Middle Name				
Maiden Name			Any Other Name(s) Used				Phone (     )				
Home Address					E-Mail Address						
City		State		Zip		County		From Mth/Yr	To Mth/Yr		
Social Security Number					Date of Birth *						
Race:*					Sex:*	Male	Female				
Driver's License Number				State License was Issued							
High School			City/State Location			Year Graduated		Full Name Diploma Issued Under			
If GED received, in what State		City/State Location			Date Received		Name Used for GED				
College			City/State Location				Year Graduated				
<input type="checkbox"/>	Free Rec'd	<input type="checkbox"/>	Associate	<input type="checkbox"/>	Bachelor	<input type="checkbox"/>	Master	<input type="checkbox"/>	Other _____	Student ID Number:	Full Name Used
<b>Professional License Verification</b>				Type of License				License Number		State Issued	
List Previous Addresses (to cover last 7 years – If needed, please use back of this form.)											
Address					City/State			Zip			
County			From Mth/Yr			To Mth/Yr					
Address					City/State			Zip			
County			From Mth/Yr			To Mth/Yr					