



Comanche County Medical Center

Thank you for your interest in employment with our facility. We appreciate your application and look forward to the possibility of you joining our team. This sheet is for your information. Please tear it off and keep it for your reference.

Please complete the attached application and authorization for release of information forms. Please print all information so it may be easily read. Be certain all forms are completely filled out and signed. Use the abbreviation "NA" if a particular provision or section in the form is not applicable to you.

Your application will remain in our active files for a period of six months. Should an appropriate opening occur, your application will be reviewed along with others. It is not necessary for you to contact this office regarding openings after you have completed your application. If you are among the most qualified applicants for a position, an interview will be arranged.

Employment decisions are made solely on the basis of qualifications to perform the work for which you are applying. Qualifications include education, training, and work experience. Credentials and experience will be verified through schools, former employers and any licensing/ certification agencies, if applicable.

As an equal opportunity employer, decisions to hire and promote are made without regard to race, color, creed, national origin, sex, physical or mental handicap (unrelated to ability to do the job), or age (as defined by law).

We appreciate your interest,

Comanche County Medical Center

Please return application to:
Human Resource Department
Comanche County Medical Center
P.O. Box 847
Comanche, Texas 76442
or fax to:
254-879-4990

What are your reasons and goals for seeking the position you indicated? _____

EMPLOYMENT RECORD		Start with the most recent employment and list all the jobs you have held. Additional information may be placed on a separate sheet of paper and attached.	
FROM	TO	EMPLOYER	TELEPHONE (including area code)
JOB TITLE		ADDRESS	
IMMEDIATE SUPERVISOR		JOB RESPONSIBILITIES	
REASON FOR LEAVING		HOURLY RATE / SALARY START \$ _____ PER _____ END \$ _____ PER _____	
FROM	TO	EMPLOYER	TELEPHONE (including area code)
JOB TITLE		ADDRESS	
IMMEDIATE SUPERVISOR		JOB RESPONSIBILITIES	
REASON FOR LEAVING		HOURLY RATE / SALARY START \$ _____ PER _____ END \$ _____ PER _____	
FROM	TO	EMPLOYER	TELEPHONE (including area code)
JOB TITLE		ADDRESS	
IMMEDIATE SUPERVISOR		JOB RESPONSIBILITIES	
REASON FOR LEAVING		HOURLY RATE / SALARY START \$ _____ PER _____ END \$ _____ PER _____	

Comments: (including any gaps in employment): _____

May we contact the employers listed above or on your resume, if applicable? _____ Yes _____ No

REFERENCES List Personal References (Other than relatives or former employers) who know your abilities

NAME	ADDRESS	PHONE #	OCCUPATION	YEARS KNOWN

Applicant Certification:

I certify that all information given in this application is true, correct, and complete. I understand that misrepresentation or omission of facts will be cause for cancellation of my consideration for employment, or dismissal, if employed. I authorize any inquiry to be made on any information contained in this application if I am considered for employment.

I understand that this is an application for employment and that no employment contract is being offered.

Applicant signature

Date

COMANCHE COUNTY MEDICAL CENTER
AUTHORIZATION FOR PRIOR EMPLOYER TO RELEASE INFORMATION

(Please read the following statements, sign below, and return to the Human Resource office)

I, _____, hereby authorize any investigator or duly accredited representative of Comanche County Medical Center bearing this release to obtain any information from schools, residential management agents, employers, criminal justice agencies, or individuals, relating to my activities. This information may include, but is not limited to, academic, residential, achievement, performance, attendance, personal history, disciplinary, arrest, and conviction records. I hereby direct you to release such information upon request of the bearer. I understand that the information released is for official use by Comanche County Medical Center and may be disclosed to such third parties as necessary in the fulfillment of official responsibilities.

I hereby release any individual, including record custodians, from all and any liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or any attempts to comply, with this authorization.

(Applicant's signature)

(Date)