



Mail Application to:  
 West Park Hospital  
 Attn: Human Resources  
 707 Sheridan Ave.  
 Cody, WY 82414

## EMPLOYMENT APPLICATION

Please (  ) check below position type you are interested in

<input type="checkbox"/> Certified Nursing Assistant	<input type="checkbox"/> Maintenance
<input type="checkbox"/> Clerical	<input type="checkbox"/> Managerial
<input type="checkbox"/> Dietary	<input type="checkbox"/> Other (Please indicate)
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Women's Health <input type="checkbox"/> Medical Surgical <input type="checkbox"/> Dialysis <input type="checkbox"/> LTCC <input type="checkbox"/> Surgical Svcs. <input type="checkbox"/> ICU <input type="checkbox"/> Emergency Room <input type="checkbox"/> Cedar Mtn. Center <input type="checkbox"/> Urgent Care Clinic <input type="checkbox"/> Home Health/Hospice	<input type="checkbox"/> Registered Nurse <input type="checkbox"/> Women's Health <input type="checkbox"/> Medical Surgical <input type="checkbox"/> Dialysis <input type="checkbox"/> LTCC <input type="checkbox"/> Surgical Svcs. <input type="checkbox"/> ICU <input type="checkbox"/> Emergency Room <input type="checkbox"/> Cedar Mtn. Center <input type="checkbox"/> Urgent Care Clinic <input type="checkbox"/> Home Health/Hospice
<input type="checkbox"/> Laundry	<input type="checkbox"/> Technologist <input type="checkbox"/> Laboratory <input type="checkbox"/> Rehabilitation Svcs. <input type="checkbox"/> Radiology <input type="checkbox"/> Pharmacy <input type="checkbox"/> Surgical

**Please complete each section of this application. Incomplete applications will not be considered for hire.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_ E-Mail \_\_\_\_\_

Available to work:    Full Time    Part Time    Casual Relief    Temporary

This facility operates 24 hours a day, 365 days a year. Are you available to work on:

Shift Rotation? \_\_\_\_\_                      Holidays/Weekend Hours? \_\_\_\_\_

Are you capable of performing the necessary assignments of this position, (as stated in the job description) in a safe manner?  
 Yes \_\_\_\_\_ No \_\_\_\_\_

Are you over 18 and under 70 years of age? \_\_\_\_\_ If not, state date of birth. \_\_\_\_\_

Date you are available to begin work: \_\_\_\_\_

Have you ever been convicted of any criminal offense including traffic violations within the past seven (7) years? \_\_\_\_\_

Have you been released from confinement following a conviction for any criminal offense including traffic violations within the past seven (7) years? \_\_\_\_\_

How long have you been a Wyoming resident? \_\_\_\_\_ Previous states as resident? \_\_\_\_\_

Have you been licensed or certified in the past? \_\_\_\_\_ What type of license? \_\_\_\_\_  
 What state? \_\_\_\_\_ What year? \_\_\_\_\_

Any restrictions on that licensure/certification? \_\_\_\_\_ (If yes, please describe)

Have you ever been excluded from participation in Medicare or Medicaid programs    Yes    No

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**EDUCATIONAL BACKGROUND Please indicate name of schools and locations**

High School: \_\_\_\_\_ Did you graduate? ( ) Yes ( ) No  
(If not, indicate grade completed) \_\_\_\_\_

College: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Major subject: \_\_\_\_\_

School of Nursing: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Special School of Training: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Degree Obtained – Please indicate ( )

- ( ) Associates
- ( ) BS/BA
- ( ) MA
- ( ) PhD
- ( ) Other \_\_\_\_\_
- ( ) None

**PROFESSIONAL LICENSES AND CERTIFICATION:**

Type	State	Issued	Date	Number

Has your license ever been revoked or encumbered in any way? \_\_\_\_\_

**REFERENCES:**

List name and telephone number of three business/work references who are not related to you and are not previous supervisors. If not applicable, list three school or personal references who are not related to you.

Name	Telephone	Years Known

List professional, trade, business or civic associations and any office held. (Exclude information which would reveal sex, race, religion, national origin, age, ancestry or other protected status).

Organization	Offices Held

List special accomplishments, publications, awards. (Exclude information which would reveal sex, race, religion, national origin, age ancestry, handicap or other protected status).

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List any additional information you would like us to consider.

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**LAST TEN (10) YEARS OF EMPLOYMENT HISTORY: LIST MOST CURRENT FIRST. VERY IMPORTANT PLEASE FILL OUT EVEN IF YOU HAVE A RESUME ATTACHED.**

\*Have you ever been employed by any West Park Hospital facility? \_\_\_\_\_ YES \_\_\_\_\_ NO  
If yes, please give name at the time of employment, position and dates below.

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Dates: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Employed from \_\_\_\_\_ to \_\_\_\_\_

Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Supervisor: \_\_\_\_\_ If changed, name under which you were employed? \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Employed from \_\_\_\_\_ to \_\_\_\_\_

Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Supervisor: \_\_\_\_\_ If changed, name under which you were employed? \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

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Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Employed from \_\_\_\_\_ to \_\_\_\_\_

Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Supervisor: \_\_\_\_\_ If changed, name under which you were employed? \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Employed from \_\_\_\_\_ to \_\_\_\_\_

Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Supervisor: \_\_\_\_\_ If changed, name under which you were employed? \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

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Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Employed from \_\_\_\_\_ to \_\_\_\_\_  
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Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_  
Supervisor: \_\_\_\_\_ If changed, name under which you were employed? \_\_\_\_\_  
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Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Employed from \_\_\_\_\_ to \_\_\_\_\_  
Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_  
Supervisor: \_\_\_\_\_ If changed, name under which you were employed? \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

West Park Hospital District is an Equal Opportunity Employer, and all employee applicants are treated courteously and given fair consideration. No employee or applicant will be discriminated against or be given preference with respect to their compensation, terms, conditions or privileges or employment because of such individual's race, color, religion, sex, age, national origin, ancestry, physical or mental handicap, marital status or sexual orientation.

**PLEASE READ THE STATEMENTS BELOW CAREFULLY BEFORE SIGNING:**

I understand that this employment application and other Hospital/Long Term Care Center documents are not contracts of employment, and that if employed, I may terminate my employment at any time without notice or cause, and that the facility may terminate or modify the relationship at any time without notice or cause. In consideration of my employment, I agree to conform to the rules and regulations of the Hospital/Long Term Care Center. I understand that no department head or representative of the facility, other than the Chief Executive Officer has any authority to enter into any agreement contrary to this agreement.

I understand and agree that: If I misrepresent or deliberately leave out a fact in my application, I will be removed from consideration for this job opening or, if employed, may be terminated. I understand that this application will be active only 1 year from the date below. I also understand that I will only be considered for the job I specifically applied for as noted above on this application form. After one year, this application will become inactive, and if I wish to be considered for another job opening, I must reapply by completing a new application form. The Hospital/Long Term Care Center has my authorization to thoroughly investigate my work history. I will hold no person liable for giving or receiving information in this investigation. Any doctor, hospital, or past employer may release all information necessary for the facility to determine my abilities to perform specific job duties now and in the future. I give the facility permission to investigate previous employment, and release the facility and present and former employers, from any liability, which may result from such investigation.

I have read and understand the above and hereby certify that the facts I have provided in my employment application are true and complete.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date