Pre-Employment Checklist

PMC has provided a checklist below to assist you during pre-employment.

Please print and complete each document in its entirety. Use this sheet as a checklist to ensure you have completed all documents and are prepared for your pre-employment appointment.

Please note that any lacking information will delay the onboarding process and potentially postpone hiring decisions. If you have any questions please feel free to contact Recruitment Services at (606) 218-4908.

- ☐ Applicant's Agreement and Certification
- ☐ Background Check Authorization

APPLICANT'S AGREEMENT AND CERTIFICATION

To Applicant: Read this information carefully and sign below.

I certify that the information given by me in this application is true in all respects and I agree that if employed and it is found to be false in any way, that I may be subject to dismissal without notice. I authorize the use of any information in this application to verify my statements and I authorize the past employers, doctors, all references, and other persons to answer all questions asked concerning my ability, character, reputation, and previous employment record. I release all such persons from any liability or any damages on account of having furnished such information. I further agree, if employed, that I am to work faithfully and diligently, to be careful and avoid accidents, to come to work promptly, and I am not to be absent for any reason without prior notice to my supervisor, and that my employment is terminable at will of either the employee or employer.

I hereby certify that I have not been convicted of a criminal violation related to healthcare, nor have I been disbarred, have lost my professional license, excluded, or otherwise ineligible to participate in federal healthcare programs, nor am I presently under indictment for a violation(s) of the Health Care Financial Act or any other statutes, rules, or regulations pertaining to Medicare or Medicaid. I hereby certify that I have not been found by an administrative body or civil court to have violated any of the statutes, rules, or regulations of the Health Care Financing Act.

I authorize such background and personal reports as deemed necessary to verify that the information I have supplied is true and accurate and to determine my fitness for this job. A copy of this authorization is as valid as the original.

If employed and I appear to the employer to be unfit for duty due to suspected influence of alcohol or other drugs, am involved in an accident or safety incident or upon return from leave, I may be subject to further alcohol and other drug screening or face disciplinary consequences up to and including termination of employment. I hereby authorize any physician, laboratory, hospital, or medical professional retained by employer for program purposes to both conduct such screening and provide the results thereof to employer, and I release the employer, its agents, employees and such institution or person(s) from liability therefore.

I understand that all applicants for employment with Pikeville Medical Center who are offered positions will **be required** to complete a post-offer employment physical, and submit to a drug and alcohol test prior to the final employment date. **Please note-due to the number of applications received, not all applicants will be contacted. Applications will remain active for 6 months.**

I understand that I may be required to work overtime as a condition of being employed here. In addition, I may be required to work shifts other than the one I am applying for and agree to such scheduling changes as directed by my supervisor at Pikeville Medical Center.

In consideration of my employment, I agree to conform to the rules and regulations for employees. I understand that my employment and compensation can be terminated with or without cause at anytime at the option of either the Hospital or me. I understand that no representative of this Hospital has any authority to enter into any verbal agreement for employment for any specified period of time or to make any agreement contrary to the foregoing. I understand that this application is not and is not intended to be a contract of employment.

I understand that if employed, failure to maintain employee and/or patient confidentiality and/or any breaches of HIPAA regulations will result in my immediate dismissal.

Signature____ Date_____________________________

CONFIDENTIAL

Pikeville Medical Center Background Check Authorization

Print Name: ____
(First) (Middle) (Last)

Former Names, Maiden Names, or Alias and Dates Used: ______________________________

____

Current Address Since: ________ ____
(MM/YY) (Street) (City) (State/Zip)

Previous Address From: ________ ____
(MM/YY) (Street) (City) (State/Zip)

Previous Address From: ________ ____
(MM/YY) (Street) (City) (State/Zip)

Date of Birth: ____

Social Security Number: ____

Telephone Number: ____

Driver's License State/Number: ____

Email Address: ____

The information contained in this application is correct to the best of my knowledge
Pikevillle Medical Center and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and /or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/investigative
consumer report may include, but is not limited to the following areas: verification of social security number, credit reports, current and previous residences; employment history, education, background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Pikeville Medical Center or its agents. I further authorize the complete release of any records, or data pertaining to me which the individual, company, firm, corporation, or public agency may have to include information or data received from other sources. Pikeville Medical Center and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: ____Date:______________