

DELINQUENT HOSPITAL ACCOUNTS

All new hires (including rehires) who have a delinquent account or are guarantors of a delinquent account will be required to either pay the balance in full or agree to payroll deductions at a rate of 3% of the base rate of the appropriate pay grade. Refusal to do so will result in having the offer of employment withdrawn.

CRIMINAL RECORD CHECKS

Criminal background record checks will be performed on every applicant hired at UHS or its entities. If the information furnished is found to be false, you will be dismissed/disqualified. You will not be considered for future employment for eighteen (18) months.

Any applicant for employment in a nursing home, home health or adult care facility who willfully furnishes, supplies or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. [NCGS 131E-265 (e)]

SUBSTANCE ABUSE PREVENTION

This policy includes a zero tolerance provision: "Entities" intend to maintain a drug and alcohol free workplace. It is our belief that employees impaired by use of mind altering substances are harmful to themselves, our mission as health care facilities, the treatment of our patients, the performance of our jobs and the well being of our coworkers. Applicants for positions with these "entities" may be tested as part of the hiring process and hiring decisions are contingent upon pre-employment drug screening results.



UNIVERSITY HEALTH SYSTEMS

*of Eastern Carolina*SM

An Equal Opportunity/Affirmative Action Employer

Dear Applicant:

Thank you for your interest in employment with University Health Systems of Eastern Carolina (UHS) or with one or more of its subsidiary corporate entities ("Entities"). So that your application may receive appropriate attention, please read the following:

APPLICATION PROCESS

Carefully complete all parts of the application in detail. Applications must be completed in pen. Do not use a pencil. Resumes should not be substituted for the Employment Section of the application, but may be attached to application. Be specific when describing your education, work experience and other relevant data. You may check more than one entity, if so, please refer to the appropriate Employment Office listed in this brochure. We receive hundreds of applications every month. It is impossible to interview all applicants. You can expect to hear from us if you have been selected for an interview or if we need additional information.

Your application will remain in our active file for three (3) months. Applicants in the active file are reviewed on a regular basis. After three (3) months your application will become inactive. If you wish to extend this period an additional three (3) months, you must contact the appropriate Employment Office before your application becomes inactive.

A list of openings for which we are currently recruiting is posted at our office. If you wish to be considered for a specific area or are interested in a particular job, please indicate this on your application. Our job vacancies are also listed with the Employment Security Commission (ESC).

NURSING APPLICANTS

The Nurse Practice Act requires that nurses be licensed to practice before beginning employment. For information about licensure, contact the North Carolina Board of Nursing, P O Box 2129, Raleigh, NC 27602, (919)782-3211. New graduate nurses are required to provide two letters of reference from the school's placement office. At least one of these must be from a senior level nursing faculty member. These must be received prior to start date.

Please contact the appropriate Employment Office in reference to your application. You may check more than one entity. Each application is routed to the appropriate office and kept there. Equal Opportunity Employer. EOE/AA

PITT COUNTY MEMORIAL HOSPITAL

Employment Office
Mailing address: 2100 Stantonsburg Road
P O Box 6028
Greenville, NC 27834
Located at: Venture Tower Drive
1st Floor Venture Tower
Greenville, NC 27834
(252)816-4556 or (800)346-4307
Jobline: (252)816-4900
fax: (252)816-8225
website: www.uhseast.com
Hours: 8:00 a.m. - 5:00 p.m. (Monday-Friday)

BERTIE MEMORIAL HOSPITAL

Human Resources Office
401 Sterlingworth Street
P O Box 40
Windsor, NC 27983
(252)794-3141
fax: (252)794-9618
website: www.bertie.uhseast.com
Hours: 8:00 a.m. - 4:30 p.m. (Monday-Friday)

CHOWAN HOSPITAL

Human Resources Department
211 Virginia Road
P O Box 629
Edenton, NC 27932
(252)482-6401
fax: (252)482-6274
website: www.chowan.uhseast.com
All applications with exception of
Licensed positions are handled through
ESC

**East Carolina Health, HealthAccess, HealthEast
or HealthQuest**

Please refer to Pitt County Memorial Hospital Employment Office

HERITAGE HOSPITAL

Human Resources Department
111 Hospital Drive
Tarboro, NC 27886
(252)641-7139 or (252)641-7125
Jobline: (252)641-7140
fax: (252)641-7141
Website: www.heritage.uhseast.com
Hours: 8:30 a.m. - 5:00 p.m. (Monday-Friday)

ROANOKE-CHOWAN HOSPITAL

Human Resources Department
500 S. Academy Street
P O Box 1385
Ahoskie, NC 27910
(252)209-3185
Jobline: (252)290-3183
fax: (252)209-3252
Website: www.rch.uhseast.com
Hours: 8:00 a.m. - 4:30 p.m. (Monday-Friday)

THE OUTER BANKS HOSPITAL

Administration
5000 South Croatan Highway Suite 34B
Nags Head, NC 27959
(252)449-4500
fax: (252)449-4555
Website: www.uhseast.com
www.theouterbankshospital.com
Hours: 8:30 a.m. - 5:00 p.m. (Monday-Friday)

SURGICENTER SERVICES OF PITT, INC.

102 Bethesda Drive
Greenville, NC 27834
(252)816-7700
fax: (252)816-7780
Website: www.uhseast.com
Hours: 6:00 a.m. - 5:00 p.m. (Monday-Friday)

UNIVERSITY HEALTH SYSTEMS OF EASTERN CAROLINA

Please refer to PCMH Employment Office

Employment Application

Please check the box to the left of the entity to which you are applying:

- | | | |
|--|---|--|
| <input type="checkbox"/> Pitt County Memorial Hospital | <input type="checkbox"/> Bertie Hospital | <input type="checkbox"/> Outer Banks Hospital |
| <input type="checkbox"/> HealthAccess | <input type="checkbox"/> Chowan Hospital | <input type="checkbox"/> Roanoke-Chowan Hospital |
| <input type="checkbox"/> HealthEast | <input type="checkbox"/> East Carolina Health | <input type="checkbox"/> SurgiCenter |
| <input type="checkbox"/> HealthQuest | <input type="checkbox"/> Heritage Hospital | <input type="checkbox"/> University Health Systems of Eastern Carolina |
| | | <input type="checkbox"/> Other _____ |

Applications for University Health Systems (UHS) and its subsidiary corporate entities are accepted and employees are chosen for employment without regard to race, color, religion, sex, age, national origin, marital, citizenship or veteran status, or disability.

Please complete all questions, leaving nothing blank. Type or print neatly. Attach resume or extra sheet if desired.

This application will be on file for 3 months. You must submit a new application if you wish to apply after that time.

Please contact the appropriate employment office listed in the attached brochure if you need an accommodation to complete this application or to otherwise participate in the application or interview process.

APPLICATION NUMBER _____

NAME (PLEASE PRINT) LAST				FIRST	MIDDLE	MAIDEN	HAVE YOU EVER APPLIED OR SUBMITTED A RESUME/APPLICATION TO UHS OR ITS ENTITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHICH ENTITY? _____	
PRESENT STREET ADDRESS						COUNTY		
CITY			STATE		ZIP CODE		COUNTRY	
HOME TELEPHONE NUMBER ()		WORK TELEPHONE NUMBER ()		PHONE NO. FOR MESSAGES/NAME TYPE _____		SOCIAL SECURITY NUMBER		
IF HIRED, CAN YOU FURNISH PROOF THAT YOU ARE 18 YEARS OF AGE OR OLDER IF REQUESTED? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF HIRED, CAN YOU PROVIDE PROOF THAT YOU ARE ELIGIBLE TO WORK IN THE UNITED STATES? <input type="checkbox"/> YES <input type="checkbox"/> NO				
APPLICATION DATE		DESIRED START DATE			SALARY EXPECTED			CHOOSE ONE (hourly or annual)
DO YOU HAVE A RELATIVE WORKING FOR ANY AREA OF UHS OR ITS ENTITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE RELATIVES NAME (S), ENTITY (S), AND RELATIONSHIPS (S) HAVE YOU EVER WORKED FOR UHS OR ITS ENTITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE DATE(S), DEPARTMENT(S), ENTITY								
CHECK DESIRED STATUS: <input type="checkbox"/> ANY <input type="checkbox"/> FULL TIME <input type="checkbox"/> VARIABLE FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> POOL <input type="checkbox"/> TEMPORARY WORK DAYS: <input type="checkbox"/> ANY <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY SHIFT: <input type="checkbox"/> ANY <input type="checkbox"/> DAY <input type="checkbox"/> EVENING <input type="checkbox"/> MIDNIGHT (CHECK ONE ONLY)								
POSITION(S) APPLIED FOR: FIRST CHOICE:		DEPARTMENT NAME			REQUISITION#			
POSITION(S) APPLIED FOR: SECOND CHOICE:		DEPARTMENT NAME			REQUISITION#			
PLEASE USE SEPARATE SHEET IF ADDITIONAL POSITIONS ARE DESIRED								

OTHER NAMES UNDER WHICH YOU HAVE BEEN EMPLOYED?

HOW WERE YOU REFERRED? (PLEASE BE SPECIFIC)

- | | |
|---|---|
| <input type="checkbox"/> AD-NEWSPAPER (SPECIFY) _____ | <input type="checkbox"/> EMPLOYEE REFERRAL (SPECIFY) _____ |
| <input type="checkbox"/> AD-PROFESSIONAL JOURNAL (SPECIFY) _____ | <input type="checkbox"/> EMPLOYMENT SECURITY COMMISSION |
| <input type="checkbox"/> AGENCY _____ | <input type="checkbox"/> FORMER EMPLOYEE (REHIRE) WHAT ENTITY _____ |
| <input type="checkbox"/> CAREER DAY (SPECIFY) _____ | <input type="checkbox"/> INTERNET |
| <input type="checkbox"/> CLINICAL ROTATION (SPECIFY SCHOOL) _____ | <input type="checkbox"/> JOB FAIR (SPECIFY) _____ |
| <input type="checkbox"/> CONVENTION (SPECIFY) _____ | <input type="checkbox"/> JOB POSTING |
| <input type="checkbox"/> CONFERENCE (SPECIFY) _____ | <input type="checkbox"/> OPEN HOUSE (SPECIFY) _____ |
| <input type="checkbox"/> DIRECT MAIL | <input type="checkbox"/> UNKNOWN |
| | <input type="checkbox"/> WALK - IN |

EDUCATION

CIRCLE LAST SCHOOL YEAR COMPLETED

NAME OF SCHOOL(S) AND COMPLETE ADDRESSES	HIGH			COLLEGE				GRADUATE				
	9	10	11	12	13	14	15	16	17	18	19	20
	FROM MO. YR.		TO MO. YR.		GRADUATE YES/NO		TYPE OF DEGREE		MAJOR		MINOR	
HIGH SCHOOL(S)												
UNDERGRADUATE COLLEGE(S)												
GRADUATE COLLEGE(S)												
OTHER PROFESSIONAL TRADE, SECRETARIAL, ETC.												

PLEASE LIST ANY AWARDS YOU HAVE RECEIVED IN THE LAST 10 YEARS

There may be a need to communicate with patients and others who do not speak English. If you are proficient in a language other than English, please complete the following section.

Language: _____
 Frequency: _____

<input type="checkbox"/> Read	<input type="checkbox"/> Write	<input type="checkbox"/> Speak
<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High

PROFESSIONAL REGISTRATION, LICENSE INFORMATION: (Must be completed if required by the position applied for.)

REGISTRATION NUMBER	RENEWAL NUMBER	DATE ISSUED	DATE EXPIRES	TYPE
STATE				
NATIONAL				

SPECIALIZED TRAINING AND/OR EXPERIENCE

CERTIFICATIONS: (ACLS, CCRN, EKG, CPR, NAI, NAI1 etc.)	Registration or Certificate#	Date issued	Expiration date	Renewal #

MILITARY SERVICE

Do you have any experience from military service that would be relevant to the job(s) for which you are applying? if yes, explain in detail?

PROFESSIONAL MEMBERSHIPS: Please exclude memberships of which would reveal your sex, race, religion, national origin, disability, or other protected status.

RECORD OF EMPLOYMENT

RECORD OF EMPLOYMENT List all employment for at least the last 10 years starting with your most recent position. Attach a separate sheet if needed. A resume may be attached, but the application is still required to be completed in its entirety.

Are you presently employed? Yes No May we contact your present employer for a work reference? Yes No After notice is given

FIRM NAME		JOB TITLE		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		JOB DUTIES		
TELEPHONE ()	SUPERVISOR'S NAME			
DATES EMPLOYED From: To:	SUPERVISOR'S TITLE	REASON FOR LEAVING		ENDING PAY RATE
FIRM NAME		JOB TITLE		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		JOB DUTIES		
TELEPHONE ()	SUPERVISOR'S NAME			
DATES EMPLOYED From: To:	SUPERVISOR'S TITLE	REASON FOR LEAVING		ENDING PAY RATE
FIRM NAME		JOB TITLE		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		JOB DUTIES		
TELEPHONE ()	SUPERVISOR'S NAME			
DATES EMPLOYED From: To:	SUPERVISOR'S TITLE	REASON FOR LEAVING		ENDING PAY RATE
FIRM NAME		JOB TITLE		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		JOB DUTIES		
TELEPHONE ()	SUPERVISOR'S NAME			
DATES EMPLOYED From: To:	SUPERVISOR'S TITLE	REASON FOR LEAVING		ENDING PAY RATE
FIRM NAME		JOB TITLE		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		JOB DUTIES		
TELEPHONE ()	SUPERVISOR'S NAME			
DATES EMPLOYED From: To:	SUPERVISOR'S TITLE	REASON FOR LEAVING		ENDING PAY RATE

UNEMPLOYMENT Please account for all periods of unemployment for a minimum of the past 10 years. Attach a separate sheet if needed.

Dates		STATE WHAT YOU WERE DOING	PERSONAL REFERENCE WHO WILL VERIFY THIS INFORMATION	
FROM	TO		NAME	ADDRESS
Mo. Yr.	Mo. Yr.			PHONE
FROM	TO		NAME	ADDRESS
Mo. Yr.	Mo. Yr.			PHONE
FROM	TO		NAME	ADDRESS
Mo. Yr.	Mo. Yr.			PHONE

PERSONAL REFERENCES			
List two people who are NOT related to you and are NOT previous employers.			
NAME	ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE	OCCUPATION
1. _____			
2. _____			
TECHNICAL / CLINICAL REFERENCES Please list two people familiar with your technical ability whom we may contact, No relatives, please.			
NAME	ADDRESS	BUSINESS/POSITION	TELEPHONE
EMERGENCY CONTACTS			
NAME	RELATIONSHIP	TELEPHONE NUMBER ()	NAME
ADDRESS (STREET, CITY, STATE, ZIP, CODE)		ADDRESS (STREET, CITY, STATE, CODE)	
EMPLOYER	TELEPHONE NUMBER & EXT. ()	EMPLOYER	TELEPHONE NUMBER & EXT. ()
HAVE YOU EVER BEEN CONVICTED IN A COURT OF LAW OR PLEADED NOLO CONTENDERE TO AN OFFENSE OTHER THAN A MINOR TRAFFIC VIOLATION?			
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN IN DETAIL, ON ATTACHED CRIMINAL RECORD BACKGROUND CHECK FORM.			
ANSWERING THIS QUESTION "YES" WILL NOT NECESSARILY RESULT IN DENIAL OF EMPLOYMENT. FACTORS, SUCH AS AGE AT TIME OF OFFENSE, DATE OF OFFENSE, REMOTENESS OF OFFENSE AND TERMS OF ADJUDICATION WILL BE TAKEN INTO ACCOUNT.			

READ THE FOLLOWING SECTIONS CAREFULLY BEFORE SIGNING
Acknowledgment and Release: Application and Records

It is the goal of UHS and its entities to employ the qualified individual who best matches the requirements for the position to be filled. I certify that the statements herein are made truthfully without evasion and agree that the statements may be investigated and if found false may subject me to disqualification for employment or be sufficient reason for my dismissal. I authorize all schools which I have attended and all previous employers to furnish to UHS and its subsidiary corporate entities my employment record, reason for leaving and all information they may have concerning me and hereby release them and UHS and its subsidiary corporate entities from all liability for any damage whatsoever arising therefrom.

Acknowledgment and Release: Substance Prevention Policy

I have been informed and acknowledge that University Health Systems of Eastern Carolina (UHS) and its subsidiary corporate entities have a Substance Abuse Prevention Policy which includes a **Zero Tolerance Provision**. I understand that applicants for positions with these corporations may receive **pre-employment drug screening** as part of the hiring process and that hiring decisions are contingent upon the results.

I specifically consent to and agree to provide body fluid samples (blood and/or urine) for drug and/or alcohol screening in accordance with this policy as part of the application process.

I understand that if I am not hired because of a positive drug screen, I will not be reconsidered for employment at UHS or any of its subsidiary corporate entities until I can document twelve (12) continuous months of treatment for drug abuse.

I understand and specifically consent and agree that any positive drug screening results will be furnished to the appropriate UHS employment office and to my professional licensing board, if appropriate. I further understand that once hired, subsequent positive screens or refusal to provide samples when requested will make me subject to disciplinary action up to and including termination.

Applicant Signature & Date

Witness Signature & Date



UNIVERSITY HEALTH SYSTEMS
of Eastern Carolina

Criminal Record Check Form

Criminal record checks will be performed on every applicant hired at University Health Systems (UHS) or its subsidiary corporate entities.

If the information you furnish on this form is found to be false, you will be disqualified/dismissed. You will not be considered for future employment/service for 18 months.

Please answer the following questions concerning your past history (Check all that apply):

1. Have you ever been
 - a. Convicted of a misdemeanor? Not necessary to include minor traffic infractions. Yes No
 - b. Convicted of a worthless check(s) (if you have paid off a check at Magistrate's office or Courthouse this is probably a worthless check conviction)? Yes No
 - c. Convicted of any DWI's (Driving While Impaired)? Yes No
 - d. Convicted of violation or violations of any drug laws, the Controlled Substances Act of North Carolina or similar laws of any state or nation? Yes No
 - e. Convicted of any crimes of violence such as assault, harassment, communicating threats, rape, kidnapping, manslaughter, murder? Yes No
 - f. Convicted of a felony? Yes No
 - g. Convicted of any crime involving child abuse, child neglect, or indecent liberties with a minor? Yes No
 - h. Convicted of a violation or violations of a Professional Practice Act? Yes No

IF THE ANSWER TO ANY OF THE FOREGOING QUESTIONS IS "YES", PLEASE EXPLAIN EACH CONVICTION ON THE BACK SIDE OF THIS FORM, INCLUDING DATE, COUNTY AND STATE OF CONVICTION. IF NEEDED, ADDITIONAL SHEETS ARE AVAILABLE UPON REQUEST IN THE OFFICE FROM WHICH YOU OBTAINED THIS APPLICATION.

2. Please list all names you have ever been known by including birth name, previous marriage(s), legally changed, nicknames and aliases.

(1) _____ (2) _____
(3) _____ (4) _____

3. Please list street, city and state where you have lived for the last ten (10) years including military addresses (use additional sheet if more space is needed).

Street	Street	Street
City	County	City
State	State	State
Dates from _____ to _____	Dates from _____ to _____	Dates from _____ to _____

I hereby certify that the answers on this application and this insert are true and correct, and that any misrepresentation or false information on my part will disqualify me as a candidate for employment/service, or if employed, will be grounds for discipline up to and including termination.

In connection with this request, I authorize all law enforcement agencies, city, state, county and federal courts to release information they may have about me to the corporate entity of UHS to which I am applying or someone acting on their behalf.

Signature of Applicant	Date
Print Full Name	Social Security Number
Date of Birth	Valid Driver's License Number (if you do not have license state reason)
Current Address	State where license was issued
City, State Zip	
Dates: from _____ to _____	

Date of Birth is required solely for purpose of conducting a criminal record check and will not be used for any other reason in the employment/service or application process.

Please use this sheet to explain your conviction(s).

DATE of Conviction: _____

COUNTY & STATE of Conviction: _____

CONVICTION: (Crime for which you were convicted): _____

Explain: (Optional)

Please use this sheet to explain your conviction(s).

DATE of Conviction: _____

COUNTY & STATE of Conviction: _____

CONVICTION: (Crime for which you were convicted): _____

Explain: (Optional)

Please use this sheet to explain your conviction(s).

DATE of Conviction: _____

COUNTY & STATE of Conviction: _____

CONVICTION: (Crime for which you were convicted): _____

Explain: (Optional)

DISCLOSURE/AUTHORIZATION STATEMENT

By this document, University Health Systems of Eastern Carolina (UHS) and its subsidiary corporate entities disclose to you that a consumer report may be obtained for employment purposes as part of the pre-employment background investigation and at any time during your employment.

This shall authorize the procurement of a consumer report by University Health Systems and its subsidiary corporate entities as part of the pre-employment background investigation. If hired, this authorization shall remain on file and shall serve as an ongoing authorization for the appropriate corporate entity by which I am employed to procure consumer reports at any time during my employment period.

In connection with this request, I authorize all corporations, companies, former employers, supervisors, credit agencies, educational institutions, law enforcement agencies, city, state, county and federal courts, motor vehicle bureaus, military services and persons to release information they may have about me to the corporate entity of UHS with which this form has been filed or an agent acting on its behalf and release all parties involved from any liability and responsibility for doing so.

This authorization, in original or copy form, shall be valid for this and any future reports or updates that may be requested.

I understand that I have the right upon written request within a reasonable period of time, to request additional disclosure as to the nature and scope of the investigation.

I authorize the National Personnel Records Center, St. Louis, MO or other custodian of my military records to release to the corporate entity of UHS to which I am applying or its agent acting on its behalf, information or photocopies of my military personnel and related medical records or only the following information/records:

Applicant's Signature Print Name(Full Name) Date

Birth Name (Full Name) Social Security Number

Date of Birth Driver License Number State

Military Service #: _____ Branch of Service: _____

From _____ to _____

