Instructions for completing Job Application

1. Print application.

2. Complete all six (6) pages, which includes two (2) reference request forms and one (1) release of information form. Fill out Sections I and II only of the reference request authorization forms. Do Not send these forms to former employers. Make sure you have signed and dated the application.

3. Return the completed application for RN or LPN hospital positions in the Division of Nursing either by mail:

The Cleveland Clinic
Nurse Recruitment – TR34
1950 Richmond Road
Lyndhurst, Ohio 44124

Or Fax to:

216- 297-7705

If you have questions please contact Susie Vrabel at 216-297-7700 or email at vrabels@ccf.org

****Due to a large volume of applications received at the above address or fax for RN or LPN hospital nurse positions, we will NOT be able to process applications for other positions.** Positions are posted on our website at: www.clevelandclinic.org. Please use the fax number listed at the bottom of the posted position to submit your application. For additional information about job openings at the Cleveland Clinic main campus or Ambulatory Clinics please contact the employment office at 216-444-2705.

THE CLEVELAND CLINIC FOUNDATION

9500 Euclid Avenue, Cleveland, Ohio 44195

APPLICATION FOR EMPLOYMENT

(Please Print)

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE NUMBER: _(_____)_____ **ALTERNATE PHONE NUMBER:** _(_____)_____

BEST TIME TO CALL: _____ **E-MAIL ADDRESS:** _____

SOCIAL SECURITY NUMBER: _____•_____•_____

HAVE YOU LIVED OUTSIDE THE STATE OF OHIO DURING THE PAST 5 YEARS? ❑ YES ❑ NO

IF YES, PLEASE EXPLAIN: _____

ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.? ❑ YES ❑ NO

POSITION APPLIED FOR: _____ **DATE AVAILABLE:**_____

Check all employment conditions you are willing to accept:

❑ Full time ❑ Part time ❑ Temporary ❑ PRN (as needed) ❑ Summer

❑ Days ❑ Evenings ❑ Nights ❑ Weekends & Holidays ❑ Rotating Shifts

ARE YOU CURRENTLY, OR HAVE YOU PREVIOUSLY BEEN EMPLOYED BY:

YES	NO	FACILITY	DATE OF EMPLOYMENT	CURRENT OR LAST POSITION HELD
❑	❑	Cleveland Clinic	_____	_____
❑	❑	Cleveland Clinic Home Care Services	_____	_____
❑	❑	Cleveland Clinic Children's Hospital for Rehab	_____	_____
❑	❑	Clinic Care, Inc.	_____	_____
❑	❑	Euclid Hospital	_____	_____
❑	❑	Fairview Hospital	_____	_____
❑	❑	Hillcrest Hospital	_____	_____
❑	❑	Huron Hospital	_____	_____
❑	❑	Lakewood Hospital	_____	_____
❑	❑	Lutheran Hospital	_____	_____
❑	❑	Marymount Hospital	_____	_____
❑	❑	South Pointe Hospital	_____	_____

HOW WERE YOU REFERRED TO CCF:

❑ CCF Reputation ❑ Internet ❑ Newspaper ❑ Walk In ❑ Employment Agency

❑ Employee Referral ❑ CCF Website ❑ Journal ❑ On-Campus ❑ Telephone Directory

_____ ❑ Radio/TV ❑ Job Fair ❑ School Counselor ❑ Other _____

Name

DO YOU HAVE RELATIVES WORKING AT THE CLEVELAND CLINIC FOUNDATION: ❑ YES ❑ NO **(If Yes, please specify)**

NAME _____ DEPARTMENT_____ RELATIONSHIP_____

NAME _____ DEPARTMENT_____ RELATIONSHIP_____

The policy of The Cleveland Clinic Foundation is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment, transfers and promotions are made upon the basis of the best qualified candidate without regard to color, race, religion, national origin, age, sex, sexual orientation, marital status, ancestry, status as a disabled or Vietnam era veteran or any other characteristic protected by law.

EDUCATION (List All Schools Attended)

HIGH SCHOOL NAME	CITY, STATE	HIGHEST GRADE COMPLETED

COLLEGE AND/OR SCHOOL OF NURSING	CITY, STATE	MAJOR/ CREDIT HOURS COMPLETED	DEGREE/ YEAR COMPLETED

OTHER TRAINING (Trade, Technical, Vocational, Military)	COURSE	HOURS, CREDITS OR CERTIFICATES

SPECIAL TRAINING/SKILLS

OFFICE SKILLS OR EXPERIENCE: You may be asked to demonstrate skill in these areas.

❑ Word Processing _____wpm ❑ 10 Key ❑ Medical Transcription ❑ ICD9 + CPT Coding

❑ Shorthand _____wpm ❑ Medical Terminology (**where acquired:** _____)

Word Processing (what type): _____

Software/Computer Skills: _____

Other: _____

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS

Has your professional license ever been suspended or revoked? ❑ **YES** ❑ **NO**

IF YES, PLEASE EXPLAIN _____

Is any action currently pending that could result in suspension or revocation? ❑ **YES** ❑ **NO**

IF YES, PLEASE EXPLAIN _____

ARE YOU CURRENTLY: ❑ REGISTERED ❑ LICENSED ❑ CERTIFIED **TYPE**: _____

Which States?_____ If not in Ohio, have you applied? ❑ **YES** ❑ **NO**

Professional licensure and/or registration number in the state of Ohio: _____

Date of initial licensure: _____ Expiration date of licensure: _____

U.S. MILITARY SERVICE *(If Veteran, Please Complete)*

BRANCH OF SERVICE : _____

DATE ENTERED: _____ DATE OF SEPARATION: _____

SPECIAL TRAINING OR HONORS RECEIVED: _____

Starting with your most recent position, list all positions and activities including self employment and relevant volunteer experience

COMPANY ___ ADDRESS ___ ___ CITY ___ STATE ___ ZIP ___ PHONE (___)___	DESCRIBE YOUR POSITION DUTIES ___ ___ ___ ___ ___ ___	**FROM:** MO ___ YR ___ **TO:** MO ___ YR ___ JOB TITLE ___ DEPT ___ SALARY ___ SUPERVISOR ___ REASON FOR LEAVING ___ ___
COMPANY ___ ADDRESS ___ ___ CITY ___ STATE ___ ZIP ___ PHONE (___)___	DESCRIBE YOUR POSITION DUTIES ___ ___ ___ ___ ___ ___	**FROM:** MO ___ YR ___ **TO:** MO ___ YR ___ JOB TITLE ___ DEPT ___ SALARY ___ SUPERVISOR ___ REASON FOR LEAVING ___ ___
COMPANY ___ ADDRESS ___ ___ CITY ___ STATE ___ ZIP ___ PHONE (___)___	DESCRIBE YOUR POSITION DUTIES ___ ___ ___ ___ ___ ___	**FROM:** MO ___ YR ___ **TO:** MO ___ YR ___ JOB TITLE ___ DEPT ___ SALARY ___ SUPERVISOR ___ REASON FOR LEAVING ___ ___
COMPANY ___ ADDRESS ___ ___ CITY ___ STATE ___ ZIP ___ PHONE (___)___	DESCRIBE YOUR POSITION DUTIES ___ ___ ___ ___ ___ ___	**FROM:** MO ___ YR ___ **TO:** MO ___ YR ___ JOB TITLE ___ DEPT ___ SALARY ___ SUPERVISOR ___ REASON FOR LEAVING ___ ___

APPLICANT: PLEASE READ CAREFULLY BEFORE SIGNING

HAVE YOU EVER BEEN CONVICTED OF, OR PLED GUILTY TO, ANY FELONIES? ❑ **YES** ❑ **NO**
(A "Yes" answer will not automatically disqualify you from consideration.)
IF YES, PLEASE EXPLAIN:

___

HAVE YOU EVER BEEN DISQUALIFIED FROM OR DENIED PARTICIPATION IN ANY FEDERAL OR STATE HEALTH CARE PROGRAM (e.g. Medicare, Medicaid, Champus)?**:** ❑ **YES** ❑ **NO**
IF YES, PLEASE EXPLAIN:

___

My application for employment with The Cleveland Clinic Foundation is made with the understanding that nothing contained in this application or in the granting of an interview is intended to create a contract between The Cleveland Clinic Foundation and myself for either employment or for the providing of any benefit. Further, if The Cleveland Clinic Foundation and I enter into an employment relationship, I understand that I may terminate my employment at any time and for any reason and I understand that any false information, omissions, or misrepresentations of fact called for in this application may result in rejection of my application or discharge at anytime during my employment. I authorize The Cleveland Clinic Foundation to obtain information concerning me from current or former employers, references, education institutions and state and federal agencies for public records including, but not limited to, motor vehicle or criminal records. I release all concerned from any liability or damage whatsoever for issuing this information.

___ ___

APPLICANT SIGNATURE **DATE**

THE CLEVELAND CLINIC FOUNDATION
DIVISION OF HUMAN RESOURCES-TR34
9500 Euclid Avenue, Cleveland, OH 44195
Fax: 216/297-7705

Applicants please complete Sections I and II

I. Authorization:

Date: _____

I voluntarily authorize you to verify the information below and provide any other information requested regarding my job performance and service with ***(company name)*** _____ and release you from any liability for issuing such information.

I understand that any statement made on this form will be considered confidential and I hereby release The Cleveland Clinic Foundation from any liability related to the information provided by the above organization.

_____ _____
Signature of Applicant Social Security Number

_____ _____
Printed Applicant Name Other Name(s) Used

II. Employer Information:

Employer: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Dates of Employment: *From* _____ *To* _____

Position Title: _____ Department: _____

Supervisor's Name: _____ Title: _____

Reason for Leaving: _____

Employer: Please Complete Section III

To Whom It May Concern:

The above-named applicant has applied for employment with The Cleveland Clinic Foundation and has submitted the following information to be verified from his / her employment record. Please review Sections I and II and complete Section III providing any additional information regarding his / her performance.

III. To Current / Former Employer:

Are employment dates correct? ❑ Yes ❑ No From _____ To _____

Is position title correct? ❑ Yes ❑ No Other title: _____

Is reason for leaving correct? ❑ Yes ❑ No Other reason: _____

Is employee reemployable? ❑ Yes ❑ No Reason if not: _____

	EXCELLENT	GOOD	AVERAGE	BELOW AVERAGE
Quality of Work	☐	☐	☐	☐
Attendance	☐	☐	☐	☐
Cooperation	☐	☐	☐	☐

Additional Comments: _____

_____

_____

Signature: _____ Title: _____Date: _____

For CCF Representative:
HR: _____ Date: _____

THE CLEVELAND CLINIC FOUNDATION
DIVISION OF HUMAN RESOURCES-TR34
9500 Euclid Avenue, Cleveland, OH 44195
Fax: 216/297-7705

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_____ _____
Signature of Applicant Social Security Number

_____ _____
Printed Applicant Name Other Name(s) Used

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Address: _____

City: _____ State: _____ Zip: _____

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Is employee reemployable? ❑ Yes ❑ No Reason if not: _____

	EXCELLENT	GOOD	AVERAGE	BELOW AVERAGE
Quality of Work	☐	☐	☐	☐
Attendance	☐	☐	☐	☐
Cooperation	☐	☐	☐	☐

Additional Comments: _____

_____

_____

Signature: _____ Title: _____Date: _____

For CCF Representative:
HR: _____ Date: _____

THE CLEVELAND CLINIC FOUNDATION

REFERENCE RELEASE

I hereby authorize The Cleveland Clinic Foundation to contact any schools, current or former places of employment, credit organizations, law enforcement agencies, and/or persons who may aid the Foundation in determining any suitability for employment. Additionally, I release those individuals and/or organizations contacted from all liability whatsoever for issuing the requested information.

_____ _____

Applicant's Signature Date

_____

Social Security No.

If previous employment has been under another name, please print your former name here: _____