

**WESTERN HEALTH**  
**Human Resources Department**  
**P.O. Box 2005, Corner Brook, NL A2H 6J7**  
**Tel. (709) 637-5367 Fax: (709) 637-5456**  
**careers@westernhealth.nl.ca**

**Application for Employment**

Please indicate the site(s) for which you are applying:

- |   |  |
|---|--|
| <p>___ Bay St. George Long Term Care Centre</p> <p>___ Bonne Bay Health Centre</p> <p>___ Calder Health Centre</p> <p>___ Corner Brook Interfaith Home for Senior Citizens</p> <p>___ Dr. Charles L. LeGrow Health Centre</p> | <p>___ J.I. O'Connell Centre</p> <p>___ Rufus Guinchard Health Centre</p> <p>___ Sir Thomas Roddick Hospital</p> <p>___ Western Memorial Regional Hospital</p> <p>___ Population Health Branch</p> |
|---|--|

(Please Print)

I. \_\_\_\_\_  
Surname First Name Initial

Address \_\_\_\_\_  
# Street City/Town Province/State/Country Postal Code/Zip Code

Telephone No. \_\_\_\_\_

Are you over the age of 16 years? Yes \_\_\_ No \_\_\_ Are you legally entitled to work in Canada? \_\_\_\_\_

II. Have you ever been charged and/or convicted of a criminal offence? Yes \_\_\_ No \_\_\_

If yes, please specify \_\_\_\_\_

Has your name ever changed? \_\_\_ If yes, list previous name (s) \_\_\_\_\_

III. Education (Important: Attach copies of education certificates.)

Name of School	Address	Certificate or Grade	Date Obtained

Are you studying now? \_\_\_\_\_ What course and where? \_\_\_\_\_

Do you expect to take further courses? \_\_\_\_\_ If yes, state course \_\_\_\_\_

State position or type of employment desired \_\_\_\_\_

Permanent \_\_\_\_\_ Temporary \_\_\_\_\_ Vacation Relief \_\_\_\_\_ Casual \_\_\_\_\_

Date Available \_\_\_\_\_ Have you ever been employed by this Health Authority? \_\_\_\_\_

If Yes, Site \_\_\_\_\_ Dates employed \_\_\_\_\_

General Application

IV. Previous Employment (Account for all periods since leaving school, commencing with most recent period of employment.)

Employer	Full Address	Position Held	Date Started	Date Finished	Reason for Leaving

V. References (Former Employers, Clergy, Teachers or your supervisor in a volunteer program – **PLEASE INCLUDE YOUR MOST RECENT EMPLOYER AND SUPERVISOR(S).**)

1. Name _____	2. Name _____
Mailing Address _____	Mailing Address _____
_____	_____
Position _____	Position _____
Phone No. _____	Phone No. _____

VI. In case of Professional Staff (Important: Attach proof of registration)

Registration Number \_\_\_\_\_ Professional Association \_\_\_\_\_

VII. Use this space for any additional information in connection with your application.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare that the information provided by me to the foregoing questions and statements are true and correct. I agree that Western Health shall not be liable if my employment is terminated because of any false statement, answer, or omission made by me on this application form. I agree to submit to a medical examination, if hired. I also authorize all organizations, schools or persons to release any information they may have concerning me and hereby release such organizations, schools or persons from all liability that may result from such inquiries.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_