

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 - Nursing Service

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

- | | |
|---|---|
| <input type="checkbox"/> Bay St. George Long Term Care Centre | <input type="checkbox"/> Population Health Branch |
| <input type="checkbox"/> Bonne Bay Health Centre | <input type="checkbox"/> Rufus Guincharde Health Centre |
| <input type="checkbox"/> Calder Health Centre | <input type="checkbox"/> Sir Thomas Roddick Hospital |
| <input type="checkbox"/> Corner Brook Long Term Care Home | <input type="checkbox"/> Western Memorial Regional Hospital |
| <input type="checkbox"/> Dr. Charles L. LeGrow Health Centre | |

(Please Print)

I. _____
Surname First Name Initial

Address _____
Street City/Town Province/State/Country Postal Code/Zip Code

Telephone No. _____ (H) _____ (cell) _____ (E-mail Address)

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

***You will be required to provide proof if selected for employment**

II. Have you ever been charged and/or convicted of a criminal offence for which you did not receive a pardon.
Yes _____ No _____ If yes, please specify _____

***A current original and acceptable certificate of conduct will be required if selected for employment.**

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

Have you ever been sanctioned by your professional body (if applicable) ? Yes _____ No _____

If yes, please specify _____

III. In case of illness, please notify: Name _____

Address _____ Telephone No. _____

IV. Professional Status _____

Important: Attach a copy of Registration or Temporary License.

A. NURSE: Registration Number _____ Province or Country _____

School of Nursing _____

Address _____ Year Graduated _____

Have you ever been sanctioned by your professional association? Yes _____ No _____

B. LICENSED PRACTICAL NURSE: Registration Number _____

School _____

Address _____ Year Graduated _____

Have you ever been sanctioned by your professional association? Yes _____ No _____

C. HIGH SCHOOL: Successful Completion Yes / No If Yes, Date Completed _____

Please provide copy of High School diploma.

Post Basic Courses	Name and Address of University/Hospital	Length of Course	Year

Please provide documentation for post basic courses.

V. Were you previously employed by any sites listed on page 1 of this application? Yes _____ No _____

If Yes, Site _____ Dates employed _____

VI. What type of work are you seeking?

Permanent _____ Permanent Part-time _____ Temporary _____ Vacation Relief _____ Casual _____

Date Available: _____

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

A resume may be provided, however, all information requested below is required.

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

VIII. References (Former Supervisors - **PLEASE INCLUDE YOUR MOST RECENT EMPLOYER/SUPERVISOR AND/OR EDUCATIONAL INSTITUTION.**)

1. Name _____ 2. Name _____

Organization _____ Organization _____

Mailing Address _____ Mailing Address _____

Position _____ Position _____

Phone No. _____ Phone No. _____

E-Mail _____ E-Mail _____

Was this person your direct supervisor ___Yes ___No

Was this person your direct supervisor ___Yes ___No

IX. Please list Nursing Units/Departments in which you have experience.

_____	_____
_____	_____
_____	_____

X. The following information **is required** of all applicants seeking employment in Nursing Service. Your application is not complete without this information.

1. C.P.R.
Date of Certification or Recertification _____
(Attach certificate if available)

2. I.V. THERAPY
Date Course Completed _____

Name of Hospital (Attach Certificate) _____

3. BACK EDUCATION PROGRAM
Date Completed _____

Name of Hospital _____

4. OTHER _____

Date Completed _____

Name of Hospital _____

XI. This space may be used for additional information or comments.

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: _____

INCOMPLETE APPLICATIONS MAY NOT BE CONSIDERED.