



Mailing Address
1868 Lombardy Drive Rapid City, SD 57703
Fax: 605-721-4949 website: www.bhsh.com

Surgical Hospital
216 Anamaria Drive

Imaging/Pain Center
215 Anamaria Drive

Business Office
1868 Lombardy Drive

APPLICATION FOR EMPLOYMENT
An Equal Opportunity Employer

Applicants are considered without regard to race, color, religion, sex, national origin, age, disability or any other prohibited basis of discrimination, as provided under applicable state and federal law.

PLEASE PRINT Date of Application: ____/____/____ Position(s) Applied For: _____

Referral Source: ____ Advertisement ____ Friend ____ Employee ____ Walk-In ____ Private Agency ____ Other _____

Name of Source (if applicable): _____

Name: _____

Last

First

Middle

Address: _____

City

State

Zip Code

Home Telephone: (____) _____ Cell Phone: (____) _____ Social Security Number: _____/_____/_____

Have you ever been employed here before? ____ Yes ____ No If yes, give date: _____

Are you employed now? ____ Yes ____ No May we contact your present employer? ____ Yes ____ No

May we contact you at work? ____ Yes ____ No If yes, work number and best time to call: (____) _____ Time ____ AM/PM

On what date would you be available for work? _____ Expected Salary: _____

(When requesting to meet or exceed your current rate of pay, please attach a copy of your pay advice to validate your request.)

Are you available to work: ____ Full-Time ____ Part-Time ____ PRN (as needed) ____ Temporary

Are you available to work: ____ Days ____ Mornings ____ Afternoons ____ Evenings ____ Nights ____ Weekends ____ Holidays

Will you work overtime if required? ____ Yes ____ No Will you travel if required? ____ Yes ____ No

Is anyone related to you employed by Black Hills Surgical Hospital? ____ Yes ____ No If yes, please give their name and relationship to you: _____

Have you ever been convicted of a felony? ____ Yes ____ No If yes, please explain: _____

Have you been convicted of a criminal offense related to health care or have you been debarred, excluded, or otherwise determined ineligible for participation in governmental health care programs? ____ Yes ____ No If yes, please explain: _____

If hired, you will be required to submit documents sufficient to establish employment authorization and identity in compliance with the Immigration Reform and Control Act of 1986. While you need not provide this proof of citizenship or immigration status at the time you are interviewed, please be prepared to assure us that you can do so immediately upon being hired.

EDUCATION: School: Name/Address Course of Study Circle Last Year Completed Did You Graduate? Diploma/Degree

High School or GED			1 2 3 4		
College			1 2 3 4		
College			1 2 3 4		
Technical, Business or Professional			1 2 3 4		

LIST ALL PROFESSIONAL LICENSES/CERTIFICATIONS EVER HELD (start with the most current):

Type	State	Expiration Date	Registration No.

For additional writing space, please use the backside of this page →→→ →→→ →→→

Has your professional license ever been suspended, conditioned or revoked in any state? ___No ___Yes If yes, please explain:

List professional, trade, business or civic activities and offices held. (You may exclude those which indicate race, color, religion, sex, age, national origin, disability.) _____

EMPLOYMENT

Start with your present or last job. Include military service assignments and volunteer activities. Exclude organization names which indicate, for example, race, color, religion, sex, age, disability, or national origin.

Employer Name	Telephone ()	Dates Employed		Summarize the nature of the work you performed
Address		From	To	
Job Title		Hourly Rate/Salary		
Immediate Supervisor/Title		Starting	Final	
Reason for Leaving				
May we contact for reference? ___ Yes ___ No ___ Later				

Employer Name	Telephone ()	Dates Employed		Summarize the nature of the work you performed
Address		From	To	
Job Title		Hourly Rate/Salary		
Immediate Supervisor/Title		Starting	Final	
Reason for Leaving				
May we contact for reference? ___ Yes ___ No ___ Later				

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Job Title		Hourly Rate/Salary		
Immediate Supervisor/Title		Starting	Final	
Reason for Leaving				
May we contact for reference? ___ Yes ___ No ___ Later				

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Job Title		Hourly Rate/Salary		
Immediate Supervisor/Title		Starting	Final	
Reason for Leaving				
May we contact for reference? ___ Yes ___ No ___ Later				

Employer Name	Telephone ()	Dates Employed		Summarize the nature of the work you performed
Address		From	To	
Job Title		Hourly Rate/Salary		
Immediate Supervisor/Title		Starting	Final	
Reason for Leaving				
May we contact for reference? ___ Yes ___ No ___ Later				

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PROFESSIONAL REFERENCES: List names and telephone numbers of three professional references who are not related to you and are not previous supervisors. If not applicable, list three school or personal references who are not related to you.

Name & Address	Telephone Number	Years Known
	()	
	()	
	()	

State any additional information you feel may be helpful to us in considering your application: _____

APPLICANT'S STATEMENT

I understand and agree that any misrepresentation by me in this application will be sufficient cause for rejection of this application and/or termination of employment if I am hereafter employed by Black Hills Surgical Hospital, LLP (BHSB). In consideration of my employment, I agree to conform to the policies and procedures of BHSB. Furthermore, if I am hired, I understand that I am free to resign at any time, and that BHSB reserves the right to terminate my employment at any time, with or without cause, and without prior notice. I understand that no representative of BHSB has authority to make any representations or assurances to the contrary.

I understand that if you make an offer of employment to me it will be a conditional offer of employment and I may be required to submit to a pre-employment work screen and to provide information in response to your medical inquiries, the results of which might disqualify me from employment. If requested, I agree to furnish such information and to submit to such a pre-employment work screen.

In accordance with the Drug-Free Workplace Act of 1988, BHSB has established a Drug-Free Workplace company-wide policy. It is our policy to maintain a work environment that is safe for all employees and conducive to attaining high work standards. Therefore, if an offer of employment is made, hiring is contingent upon me, the applicant, passing a urine drug test. I understand that I will be requested to submit to a test to detect the current illegal use of drugs and, if the test results identify that I am a current illegal user of drugs, I will not be eligible for employment by BHSB. I further understand that I have the right to refuse to submit to such tests of my own free will, but that such refusal may be used as grounds to withdraw any conditional offer of employment.

I understand that BHSB may obtain a Consumer Report / Investigative Consumer Report for the purpose of evaluating me for employment, promotion, reassignment, or retention. I understand that I am entitled to obtain, by written request, disclosure of the nature and scope of the report.

BHSB is an equal opportunity employer and BHSB does not discriminate in employment. No question on this application is used for the purpose of limiting or excluding BHSB's consideration of me for employment on a basis prohibited by federal, state or local law, nor is it used by BHSB for the purpose of attempting to obtain information prohibited by federal, state or local law.

I understand that BHSB will consider this application to contain current information for a period of only sixty (60) days. At the expiration of sixty (60) days, if I have not heard from BHSB and if I still desire to be considered for employment, I understand that it will be necessary for me to complete a new application.

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

Signature

Date



We comply with all Family and Medical Leave Act rules and regulations.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy, or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV



VOLUNTARY SELF-IDENTIFICATION FORM

The following statistical information is used only for compliance with federal laws assuring equal employment opportunity without regard to race, color, sex, national origin, religion, age, disability, veteran status or any other classification protected by federal, state, or local law. Completion of this data is voluntary and will not affect your opportunity for employment or terms or conditions of employment, if hired.

Name: _____

Address: _____

Position Applied For: _____ Gender: Male Female

Referral Source:

Unsolicited Advertisement Employee Referral
 Employment Agency College Recruitment Other-Specify _____

Race/Ethnic Identification: (Please check one of the descriptions below corresponding to the ethnic group with which you identify.)

Hispanic or Latino: A persons of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

If you check the above, which race do you consider yourself Hispanic or Latino?

If you did not check "Hispanic or Latino" above, please check one of the following race/ethnic identifications.

White (Not Hispanic or Latino): A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

Black or African American (Not Hispanic or Latino): A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino): A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Asian (Not Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

American Indian or Alaska Native (Not Hispanic or Latino): A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Two or More Races (Not Hispanic or Latino): All persons who identify with more than one of the above five races.

Regulations issued by the U.S. Department of Labor with respect to disabled individuals, disabled veterans, and Vietnam Era veterans require that federal contractors provide an opportunity for self-identification to candidates seeking employment. Such self-identification is submitted on a voluntary basis, on a confidential basis, for use only in accordance with regulations, and without subjecting the individual to adverse treatment.

Disabled/Veteran Status: (Please check one if it describes your veteran status.)

Disabled Individual: Federal regulations define a disabled person as one who (1) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) has a history of such impairment, or (3) is regarded as having such an impairment.

Vietnam Era Veteran: Federal regulations define a veteran of the Vietnam Era as one who (1) served on active duty for a period of more than 180 days, any part of which occurred between August 5, 1964, and May 7, 1975, and was discharged or released with other than a dishonorable discharge, or (2) was discharged or released from active duty for a service connected disability if any part of such active duty was performed between August 5, 1964, and May 7, 1975.

Special Disabled Veteran: Federal regulations define a special disabled veteran as one who (1) is entitled to compensation under laws administered by the Veterans' Administration for a disability rated 30% or more, or (2) was discharged or released from active duty because of a service-connected disability.

Applicant's Signature: _____ Date: _____

BLACK HILLS SURGICAL HOSPITAL, LLP

An Equal Opportunity Employer