

APPLICATION FOR EMPLOYMENT

Office Use Only

INSTRUCTIONS: This application may be considered for any suitable posted vacancy in the Vancouver Island Health Authority (VIHA). Please complete all sections in full, in your own handwriting, even if you are attaching a resume. Scan completed document to PDF format and email to jobs@viha.ca.

PERSONAL INFORMATION	NAME AND ADDRESS OF APPLICANT (PLEASE PRINT)				
	LAST	FIRST	MIDDLE	PREFERRED FIRST NAME	PREVIOUS LAST NAME
	STREET ADDRESS			HOME PHONE ()	
	CITY OR TOWN	PROVINCE	POSTAL CODE	BUSINESS/ALTERNATE PHONE ()	
	MAILING ADDRESS (IF DIFFERENT)			CELL/PAGER/FAX ()	
				PRIMARY/HOME EMAIL	
	ARE YOU LEGALLY ENTITLED TO WORK IN CANADA? YES <input type="checkbox"/> NO <input type="checkbox"/> LEGAL STATUS TO WORK IN CANADA – DOCUMENTATION MAY BE REQUIRED				
	<input type="checkbox"/> CANADIAN CITIZEN <input type="checkbox"/> LANDED IMMIGRANT <input type="checkbox"/> WORK PERMIT <input type="checkbox"/> OTHER, PLEASE SPECIFY _____				
	DO YOU HAVE ANY MEDICAL/PHYSICAL CONDITIONS WHICH WOULD PREVENT YOU FROM PERFORMING SPECIFIC KINDS OF DUTIES REQUIRED AS PART OF THE POSITION YOU HAVE APPLIED FOR? (E.G. LATEX ALLERGY, MUSCULOSKELETAL INJURY)				
	YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, DESCRIBE AND EXPLAIN WORK LIMITATIONS: _____				
ARE YOU WILLING TO UNDERGO A MEDICAL EXAMINATION FOR THE PURPOSE OF EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					

POSITION APPLIED FOR	POSTING # OF POSITION DESIRED: _____				
	FACILITY <input type="checkbox"/> COMMUNITY <input type="checkbox"/> SPECIFIC WORK LOCATION _____				
	FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> CASUAL <input type="checkbox"/> DATE AVAILABLE TO START WORK _____				
	SHIFTS AVAILABLE FOR: DAYS <input type="checkbox"/> EVENINGS <input type="checkbox"/> NIGHTS <input type="checkbox"/> ALL SHIFTS <input type="checkbox"/> SHORT NOTICE? YES <input type="checkbox"/> NO <input type="checkbox"/>				
	IF NO, HOW MUCH NOTICE WILL YOU REQUIRE? _____				
	ARE YOU CURRENTLY EMPLOYED WITH THE VIHA? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	IF YES, EMPLOYEE NUMBER: _____, AT WHICH SITE(S) AND POSITION: _____				
	HAVE YOU BEEN PREVIOUSLY EMPLOYED AT A VIHA FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	IF YES, WHERE _____, FROM _____ TO _____ AND POSITION _____				
	HOW DID YOU FIRST LEARN ABOUT THE VIHA? <input type="checkbox"/> WALK IN <input type="checkbox"/> VIHA WEB SITE <input type="checkbox"/> JOB FAIR <input type="checkbox"/> WORD OF MOUTH <input type="checkbox"/> MAIL OUT <input type="checkbox"/> NEWSPAPER AD <input type="checkbox"/> PROFESSIONAL JOURNAL <input type="checkbox"/> ON-LINE JOB BOARDS <input type="checkbox"/> OTHER _____				
IF REFERRED FOR EMPLOYMENT BY A CURRENT VIHA EMPLOYEE, PHYSICIAN OR VOLUNTEER, PLEASE INCLUDE THEIR NAME AND CONTACT INFORMATION, IF KNOWN:					
NAME: _____ CONTACT INFORMATION (EG. PHONE/EMAIL): _____					
WHAT IS THEIR POSITION IN VIHA? _____ WHAT VIHA SITE ARE THEY BASED AT? _____					
HAVE YOU DONE A STUDENT PLACEMENT WITHIN VIHA WITHIN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO					

EDUCATION	NAME & LOCATION OF INSTITUTION ATTENDED	DATES ATTENDED FROM	TO	CERTIFICATE OBTAINED	PROGRAM
	LAST GRADE SUCCESSFULLY COMPLETED 7 8 9 10 11 12 13				
	COLLEGE				PRACTICUM AT:
	UNIVERSITY				PRACTICUM AT:
	SCHOOL OF NURSING				PRECEPTORSHIP AT:
	TRADES TECHNICAL COMMERCIAL				
	OTHER TRAINING OR EDUCATION				
ARE YOU ATTENDING SCHOOL NOW? YES <input type="checkbox"/> NO <input type="checkbox"/> INSTITUTION _____ F/T, P/T, OR EVENING CLASSES? _____ COURSE OR AREA OF SCHOOLING _____					

REGISTRATION INFORMATION	LIST ANY ACTIVE MEMBERSHIPS OR REGISTRATIONS IN A PROFESSIONAL CAREER RELATED ORGANIZATION OR SOCIETY: _____					
	CURRENT B.C. REGISTRATION:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	TYPE & NUMBER OF REGISTRATION: _____	ACTIVE <input type="checkbox"/>	INACTIVE <input type="checkbox"/>
	CURRENT CANADIAN REGISTRATION:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	TYPE & NUMBER OF REGISTRATION: _____	ACTIVE <input type="checkbox"/>	INACTIVE <input type="checkbox"/>
	INTERIM OR TEMPORARY:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	EXAMINATION DATE: _____		
ARE YOU REGISTERED ELSEWHERE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, INDICATE WHERE REGISTERED, STATUS OF REGISTRATION & NUMBER _____ _____						
(PROVINCE/STATE REGISTERED)		ACTIVE/INACTIVE		REGISTRATION NUMBER		
Please attach copy of your registration.						
<input type="checkbox"/>	CPR – BASIC RESCUER CERTIFICATION	_____	EXPIRY DATE	<input type="checkbox"/>	ACLS	_____
<input type="checkbox"/>	BASIC ARRHYTHMIA COURSE	_____	DATE	<input type="checkbox"/>	1 ST AID CERTIFICATE/EXPIRY DATE	_____
<input type="checkbox"/>	VALID DRIVER'S LICENSE	_____	PROVINCE	_____	CLASS	_____

EMPLOYMENT SKILLS/CERTIFICATIONS	PATIENT/CLIENT CARE <input type="checkbox"/> NURSING <input type="checkbox"/> PARAMEDICAL _____ <input type="checkbox"/> OTHER _____													
	(✓ WHERE APPROPRIATE)													
	<input type="checkbox"/>	MEDICAL	<input type="checkbox"/>	SURGICAL	<input type="checkbox"/>	EMERGENCY	<input type="checkbox"/>	CRITICAL CARE	<input type="checkbox"/>	COMMUNITY	<input type="checkbox"/>	NURSERY	<input type="checkbox"/>	OBSTETRICS
	<input type="checkbox"/>	OPERATING ROOM	<input type="checkbox"/>	RECOVERY ROOM	<input type="checkbox"/>	ONCOLOGY	<input type="checkbox"/>	CHEMOTHERAPY	<input type="checkbox"/>	MENTAL HEALTH	<input type="checkbox"/>	PEDIATRICS	<input type="checkbox"/>	LABOUR & DELIVERY
<input type="checkbox"/>	REHABILITATION	<input type="checkbox"/>	AMBULATORY CARE	<input type="checkbox"/>	TELEMETRY	<input type="checkbox"/>	PALLIATIVE CARE	<input type="checkbox"/>	GERONTOLOGY	<input type="checkbox"/>	RESPIRATORY	<input type="checkbox"/>	PUBLIC HEALTH	
<input type="checkbox"/>	ACLS	<input type="checkbox"/>	NEUROSCIENCES	<input type="checkbox"/>	CARDIO TECHNICIAN	<input type="checkbox"/>	1 ST AID CERT/EXPIRY DATE: _____	<input type="checkbox"/>	CPR LEVEL (_____)					
<input type="checkbox"/>	LAB ASSISTANT	<input type="checkbox"/>	OTHER: _____											
CLERICAL (INCLUDE COPY OF CERTIFICATION(S) WITH APPLICATION)														
<input type="checkbox"/>	MEDICAL TERMINOLOGY	<input type="checkbox"/>	TRANSCRIPTION	<input type="checkbox"/>	ACCOUNTING	<input type="checkbox"/>	PAYROLL	<input type="checkbox"/>	CASHIER	<input type="checkbox"/>	UNIT CLERK			
<input type="checkbox"/>	KEYBOARDING _____ WPM	<input type="checkbox"/>	HEALTH RECORDS TECH											
<input type="checkbox"/>	SWITCHBOARD (TYPE) _____	<input type="checkbox"/>	COMPUTER SKILLS/SOFTWARE: _____											
SUPPORT SERVICES (INCLUDE COPY OF CERTIFICATION(S) WITH APPLICATION)														
<input type="checkbox"/>	WHMIS	<input type="checkbox"/>	CLEANING-INSTITUTIONAL	<input type="checkbox"/>	FLOOR POLISHERS/AUTOSCRUBBERS	<input type="checkbox"/>	CENTRAL PROCESSING STERILIZATION CERT							
<input type="checkbox"/>	FOOD SAFE 1	<input type="checkbox"/>	FOOD SAFE ADVANCED	<input type="checkbox"/>	INDUSTRIAL 1 ST AID LEVEL: _____	<input type="checkbox"/>	POWER/STEAM CLASS: _____							
<input type="checkbox"/>	TRADE QUALIFICATION: _____													

OTHER	ADDITIONAL EXPERIENCE, SKILLS, OR QUALIFICATIONS THAT ARE RELEVANT TO THIS APPLICATION:
	_____ _____

WORK HISTORY - (PRESENT EMPLOYER FIRST)

LIST ALL EMPLOYERS YOU HAVE WORKED FOR IN YOUR LAST 6 YEARS OF EMPLOYMENT.

(COMPLETE ALL SECTIONS, EVEN IF YOU ARE ENCLOSING A RESUME. IF THE APPLICATION IS INCOMPLETE, THERE MAY BE A DELAY IN PROCESSING.)

NAME OF EMPLOYER:		ADDRESS OF BUSINESS (INCLUDE POSTAL CODE):	
SUPERVISOR'S NAME & TITLE:		BUS. TELEPHONE NO.: ()	FAX NO.: ()
		CELL TELEPHONE NO.: ()	
YOUR POSITION TITLE:		SUPERVISOR'S EMAIL ADDRESS:	
DESCRIBE IN DETAIL YOUR JOB DUTIES AND RESPONSIBILITIES:			
DATES EMPLOYED (D/M/Y) <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> CASUAL			
FROM: _____ TO: _____ _____ HOURS/WEEK TOTAL NO. HRS WORKED: _____			
REASON FOR LEAVING:			
MAY THIS EMPLOYER BE CONTACTED FOR A REFERENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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SUPERVISOR'S NAME & TITLE:		BUS. TELEPHONE NO.: ()	FAX NO.: ()
		CELL TELEPHONE NO.: ()	
YOUR POSITION TITLE:		SUPERVISOR'S EMAIL ADDRESS:	
DESCRIBE IN DETAIL YOUR JOB DUTIES AND RESPONSIBILITIES:			
DATES EMPLOYED (D/M/Y) <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> CASUAL			
FROM: _____ TO: _____ _____ HOURS/WEEK TOTAL NO. HRS WORKED: _____			
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MAY THIS EMPLOYER BE CONTACTED FOR A REFERENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			

NAME OF EMPLOYER:		ADDRESS OF BUSINESS (INCLUDE POSTAL CODE):	
SUPERVISOR'S NAME & TITLE:		BUS. TELEPHONE NO.: ()	FAX NO.: ()
		CELL TELEPHONE NO.: ()	
YOUR POSITION TITLE:		SUPERVISOR'S EMAIL ADDRESS:	
DESCRIBE IN DETAIL YOUR JOB DUTIES AND RESPONSIBILITIES:			
DATES EMPLOYED (D/M/Y) <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> CASUAL			
FROM: _____ TO: _____ _____ HOURS/WEEK TOTAL NO. HRS WORKED: _____			
REASON FOR LEAVING:			
MAY THIS EMPLOYER BE CONTACTED FOR A REFERENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			

REFERENCE INFORMATION	PLEASE LIST A MINIMUM OF THREE PREVIOUS/PRESENT SUPERVISORS WHO MAY BE CONTACTED TO PROVIDE REFERENCE INFORMATION. IF YOU ARE/WERE SELF EMPLOYED, PROVIDE NAMES OF CLIENTS AND/OR SUPPLIERS.			
	SUPERVISOR'S NAME	EMPLOYER AT THE TIME	TELEPHONE #	FAX/EMAIL
	1.			
	2.			
	3.			
	PRACTICUM INFORMATION: IF YOU HAVE RECENTLY COMPLETED A PRACTICUM ASSOCIATED WITH YOUR PROFESSION, PLEASE PROVIDE A MINIMUM OF THREE SUPERVISORS WHO MAY BE CONTACTED.			
	SUPERVISOR'S NAME	SUPERVISOR'S TITLE (INSTRUCTOR/PRECEPTOR)	TELEPHONE #	FAX/EMAIL
	1.			
	2.			
	3.			

PLEASE READ CAREFULLY

- I have completed this application in my own handwriting and understand that any misrepresentation made by me in connection with this application will be just and sufficient cause for rejection of this application or for separation from the Vancouver Island Health Authority.
- I agree to complete a pre-employment health screening (including TB skin test and/or chest x-ray) in order to document that I meet an acceptable standard of health which is a condition of employment.
- I understand that if hired, I will be required to serve the probationary period.
- If employed, I agree to abide by all the policies of the Vancouver Island Health Authority and that any breach of said policies may result in dismissal. In addition, if I am offered employment I agree to sign a confidentiality acknowledgement as a condition of my employment.
- I understand that any job offer will be conditional upon the consent to and the result of a criminal record check where applicable. I further understand that I will be responsible for the cost of that criminal record check.
- I understand that VIHA has a policy whereby an employee may not report directly to, or supervise, a relative. Will this application put you in conflict with this policy? Yes _____ No _____. If yes, please indicate the name of and position that your relative holds within VIHA that, if hired, will put you in conflict with this policy. _____
- I hereby consent and authorize the VIHA to obtain reference information from my present and/or previous employer(s) and/or education facilities and that no act of libel or damages shall be instigated by me against same by the release of such information.
- Please note: Personal information contained on this form is collected under the Freedom of Information and Protection of Privacy Act and will be used only for the purpose of your application for employment.

Date: _____ Signature of Applicant: _____

Office Locations:

- HR Service Centre, Victoria: Room 102, Begbie Hall, 2101 Richmond Avenue, Royal Jubilee Hospital Site, Tel: 1-250-370-8522 (Option 1)
Mailing Address: 1952 Bay Street, Victoria, BC V8R 1J8, Toll FreeTel: 1-888-296-3963
- HR Service Centre, Nanaimo: #300-6475 Metral Drive, Nanaimo, BC V9T 2L9, Tel: (250) 755-7615, Toll Free Tel: 1-888-758-7615
NOTE: please send all northern island applications/resumes to the Nanaimo office