



319 South Wilson Street Casper, WY 82601  
 Ph 307.577.4832 Fax 307.577.4841  
 www.cwhp.org

## APPLICATION FOR EMPLOYMENT

*Please complete this form in your own handwriting. Incomplete applications will not be considered.*

<b>Name in Full:</b>		
<b>Phone Number:</b>	<b>E-mail Address:</b>	
<b>Mailing Address:</b>		
<b>City/State/Zip:</b>		
<b>Applying for the Position of:</b>	<b>I am seeking:</b> Full-time    Part-time	<b>Salary Desired:</b>
<b>Professional Licensure valid in WY:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Received from where?</b>
<b>Have you ever been convicted of a felony?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Are you physically and mentally able to perform the essential functions of the position for which you are applying?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Have you received a copy of the job description for this position?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		

**I understand that Central Wyoming Hospice & Transitions is an EQUAL OPPORTUNITY EMPLOYER.**

Please Initial-

### **AT-WILL EMPLOYER STATEMENT**

I understand that my employment with CWHTP is AT-WILL and that my employment can be terminated by me or my employer at any time, without notice, for any reason or no reason at all. I also understand that no person employed by CWHP is authorized to make any promise or enter into any contract or implement any policy or procedure which states that I will be employed for any definite period of time, states that I cannot be discharged without notice or reason, or states that my employment is other than AT-WILL.

Please Initial-

### **EDUCATION**

Institution	Where Located	# Years Attended	Did You Graduate	Degrees Earned

### Our Mission:

*‘To companion the end of life journey  
with skill and compassion’*

Applicant's Name: \_\_\_\_\_

**OCCUPATIONAL HISTORY** (List most recent employer first, **do not omit** any employers)

<b>Employer Name:</b>			Salary:
Address:		City:	State: Zip:
Employment Dates: From:	To:	Supervisor's Name:	
Describe Job Duties:			
Reason for Leaving:			
May we contact this employer? (Please circle) Yes No			

<b>Employer Name:</b>			Salary:
Address:		City:	State: Zip:
Employment Dates: From:	To:	Supervisor's Name:	
Describe Job Duties:			
Reason for Leaving:			
May we contact this employer? (Please circle) Yes No			

<b>Employer Name:</b>			Salary:
Address:		City:	State: Zip:
Employment Dates: From:	To:	Supervisor's Name:	
Describe Job Duties:			
Reason for Leaving:			
May we contact this employer? (Please circle) Yes No			

<b>Employer Name:</b>			Salary:
Address:		City:	State: Zip:
Employment Dates: From:	To:	Supervisor's Name:	
Describe Job Duties:			
Reason for Leaving:			
May we contact this employer? (Please circle) Yes No			

**How many times have you missed work in the past year?** \_\_\_\_\_

**PERSONAL REFERENCES**

Name	Address	City/State/Zip	Phone
1.			
2.			
3.			

Applicant's Name: \_\_\_\_\_

**Attending Mandatory Meetings –**

I understand that fulltime and part-time employees of Central Wyoming Hospice & Transitions Program are required to participate in our Quality Assurance/Performance Improvement Program. Teams meet approximately 1 hour per month.

Please Initial- \_\_\_\_\_

I understand that Central Wyoming Hospice & Transitions Program employees are required to attend monthly staff meetings. Staff meets approximately 2 hours per month.

Please Initial- \_\_\_\_\_

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**Nursing Applicants –**

Central Wyoming Hospice Program is a 24/7 facility. While every attempt is made to honor shift preferences to include; straight days, straight nights, weekends & holidays, I understand that I may be assigned to an alternative shift or department if coverage is needed.

Please Initial- \_\_\_\_\_

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**How did you find out about this position?** (current employee, newspaper, on-line, WY at Work, other)

**If offered the position, when would you be available to start?** \_\_\_\_\_

**I authorize background checks and investigation of all statements contained in this application. I understand that misrepresentation or omission of facts may be cause for denial of employment or dismissal at a later date. I also authorize pre-employment testing if applicable.**

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**Applicant's Signature**

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**Date**

*This application will remain active and valid for a period of 1 year.*



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***EMPLOYEE REFERENCE "RELEASE OF INFORMATION"***

**The below-named person has applied for a position with the Central Wyoming Hospice Program. In considering him/her for the position, we are seeking past employment information. The applicant's signature below releases past employer(s) to provide employment history including but not limited to verification of employment dates, job performance, work habits, skill level and whether the individual is re-hirable. Please complete the following and return ASAP.**

Name of Applicant: \_\_\_\_\_  
*(Please print)*

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant Release of Information  
*(Copy of this form shall be used as if original)*

\_\_\_\_\_  
Date

COMMENTS: