

Please fully complete this form to ensure an accurate representation of your qualifications and the type of employment desired.

NOTE: If a resume and cover letter will be enclosed, please fill in the first page, sign the declaration and attach your documents.

Personal Information (Please Print)

Last Name:	First Name:	Initial:
Mailing Address (including postal code):		
Telephone(s): Home	Business	Other
E-Mail Address:		

Please notify us of all name, telephone and address changes. If you cannot be reached at the address given, your application will be withdrawn.

Position(s)/Work Desired

Position(s) Desired: _____

Competition Number (if Applicable): _____

Hours of interest (please indicate):

Full Time Part Time Temporary Casual

Location/Site Preferred, if any: _____

Date available to begin work: _____

Have you previously been employed in the health sector?

Yes No

If yes, please list the location(s) and date(s) of previous employment: _____

Formal Education

See Resume

Secondary Education:

Grade Achieved: **9** **10** **11** **12**

Post Secondary Education:

Name of institution(s): _____

Degree(s)/Diploma(s)/Certificate(s) achieved: _____

Date(s) completed: _____

Employment History

See Resume

Please list current and previous employment beginning with most current:

Name of Organization: _____ Phone: _____

Position Title: _____

Employment Dates: From: _____ To: _____

Reason for Leaving: _____

Name of Supervisor: _____

Occupation of Supervisor: _____

Name of Organization: _____ Phone: _____

Position Title: _____

Employment Dates: From _____ To: _____

Reason for Leaving: _____

Name of Supervisor: _____

Occupation of Supervisor: _____

Name of Organization: _____ Phone: _____

Position Title: _____

Employment Dates: From _____ To: _____

Reason for Leaving: _____

Name of Supervisor: _____

Occupation of Supervisor: _____

References

See Resume

Please provide names of persons able to judge your ability to perform the work for which you have applied or who would supply character references.

NOTE - If possible, please provide at least two employment references.

Name: _____

Telephone: _____

Address: _____

Occupation: _____

Name: _____

Telephone: _____

Address: _____

Occupation: _____

Name: _____

Telephone: _____

Address: _____

Occupation: _____

Representative Workforce Statement



The Cypress Health Region is committed to a Representative Workforce, which ensures that all members of society have fair and equal access to employment opportunities and where the workforce accurately reflects the community it serves.

Declaration

1. Are you legally entitled to work in Canada? Yes No
2. Are you fluent in English? Yes No
3. Have you ever been convicted of a criminal offense for which you have not been pardoned?

Yes No If yes, please explain: _____

4. Have you ever been employed by the Cypress Health Region, one of its family of facilities, one of its affiliates, and/or one of its predecessors? Yes No

If yes, list dates, position, site and name used if previously employed under a different name:

I, the undersigned, hereby agree to the release of any information to the Cypress Health Region regarding my previous employment or educational background. I have been assured that this information will be treated confidentially. The foregoing information is correct to the best of my knowledge. I understand that if I am employed, any misrepresentation or omission may result in my dismissal.

Date: _____ **Applicant Signature:** _____

Thank You

Thank you for your interest in employment with the Cypress Health Region. We will keep your application on file for four (4) months. Applications may be returned to:

Cypress Health Region
429 – 4th Avenue NE
Swift Current, SK S9H 2J9
Telephone: (306) 778-5100
Fax: (306) 778-5157
E-mail: careers@cypressrha.ca