



# Bermuda Hospitals Board

CARING FOR OUR COMMUNITY

## APPLICATION - SUMMER EMPLOYMENT

All columns to be completed in applicants own handwriting regardless of whether applications have been submitted for this or other hospital positions in the past.

Typewritten documents will not be accepted for consideration.

### 1. PERSONAL DETAILS:

Surname	First Name	Second Name
_____		
Email Address: _____		Mobile #: _____
Bermuda Home #: _____		
Bermuda Address: _____		
Bermuda Contact Name & Daytime Contact #: _____		
Overseas Home #: _____		
Overseas: Address: _____		
Date of Birth: (DD/MM/YR) _____	Age: _____	Male: <input type="checkbox"/> Female: <input type="checkbox"/>
Bermuda Social Insurance No. (Call 441-295-5151 ext 1117) _____		
Are you Bermudian? Yes <input type="checkbox"/> No <input type="checkbox"/> / Do you possess a Permanent Resident Certificate? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If your answer is 'No' to both questions, please state your nationality. _____		
Does any member of your family have Bermudian status? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If 'Yes', state relationship e.g. wife, husband... _____		

### 2. EDUCATION (TO BE COMPLETED BY ALL APPLICANTS IN FULL):

CURRENT INFORMATION
School Attending: CIRCLE ONE
Home School --- High School --- Vocational School --- College --- University --- Other: _____
TICK ONE: Full Time ( <input type="checkbox"/> ) Part-time ( <input type="checkbox"/> )
Name of School: _____
School Address: _____
School Admissions Office #: ( <input type="checkbox"/> ) _____
School Entry Date: ___D ___M ___Y      Expected Graduation Date: ___D ___M ___Y

### 3. BHB EMPLOYMENT INFORMATION REQUIRED:

Area of Study: _____ Career Interest: _____
Expected Date of return to Bermuda for Employment: _____
Have you ever been employed by the Bermuda Hospitals Board? If yes, provide details below.
Last Position Held: _____ Department: _____
Date started: (MM/YR) _____ Date left: (MM/YR) _____ Supervisor Name: _____
Reason For Leaving: _____
Are you a Bermuda Hospitals Board Scholarship Recipient? If yes, Year Awarded: _____ Year Expires: _____
Have you served as a volunteer for the Bermuda Hospitals Board? If yes, how long? # years: _____
Health Insurance Provider Name: _____ Certificate # - Group/Account #: _____

**Note:** Successful applicants must undergo and pass a health screening before being processed for employment. This may take up to two (2) weeks before results are received. Please obtain and bring your childhood immunization record (up to High School) and a record of their last tuberculin skin test if contacted. Failure to do so will delay your start date. Additionally, an official letter from the current place of education to verify the current active and future status at the named institution is required.