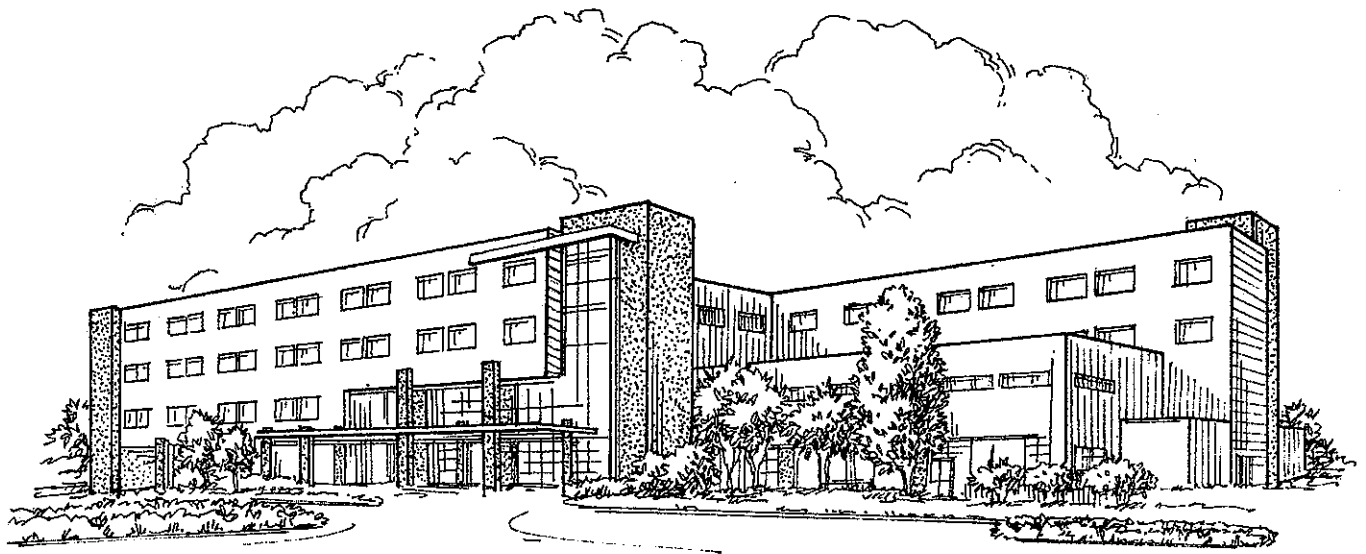


Application for Employment



Wayne Memorial Hospital

865 South First Street

P.O. Box 410

Jesup, Georgia 31598

Phone: (912) 530-3138 or (912) 530-3139

Fax: (912) 530-3274

Date

Position

Name

WAYNE MEMORIAL HOSPITAL IS AN EQUAL OPPORTUNITY EMPLOYER. IN COMPLIANCE WITH ALL APPLICABLE STATE AND FEDERAL LAWS, WE CONSIDER APPLICANTS FOR ALL POSITIONS WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, GENDER, NATIONAL ORIGIN, AGE, DISABILITY, MARITAL OR VETERAN STATUS, OR ANY OTHER LEGALLY PROTECTED STATUS.

PLEASE ANSWER ALL QUESTIONS. IF NOT APPLICABLE, SO INDICATE. PLEASE PRINT IN INK OR TYPE.

P E R S O N A L	Position(s) Applied For _____				Date of Application _____
	Name (as listed on Social Security Card)		Last	First	Middle
	Mailing Address	P.O. Box or Other	City	State	Zip Code
	Residence Address	Number	Street	City	State
	Telephone Number(s)		Social Security Number		
	What prompted you to apply for employment with Wayne Memorial Hospital? <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Internet <input type="checkbox"/> Walk-In <input type="checkbox"/> College Ad <input type="checkbox"/> TV Ad <input type="checkbox"/> WMH Employee Referral Referral Employee's Name _____ <input type="checkbox"/> Other (Please specify) _____				

J O B D A T A	State age if under 18: _____
	Are you a U.S. citizen or an alien who has the legal right to work in the job for which you are applying? <input type="checkbox"/> YES <input type="checkbox"/> NO (Pursuant to the Immigration Reform & Control Act of 1986, all applicants upon being made an offer of employment, must produce documents, which are specified by the federal government, establishing their identity and authorization for employment in the United States.)
	Have you ever filed an application with us before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give date _____
	Have you ever been employed with us before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give date _____
	Are you currently employed? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Are you currently on "lay-off" status and subject to recall? <input type="checkbox"/> YES <input type="checkbox"/> NO
May we contact your current employer? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you available to work (check all that apply): <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Shift Work <input type="checkbox"/> Temporary	
Shifts you can work: <input type="checkbox"/> 7 AM - 3 PM <input type="checkbox"/> 3 PM - 11 PM <input type="checkbox"/> 11 PM - 7 AM <input type="checkbox"/> 7 AM - 7 PM <input type="checkbox"/> 7 PM - 7 AM	
<input type="checkbox"/> Other _____	
Do you have a valid drivers license? <input type="checkbox"/> YES <input type="checkbox"/> NO License No. _____ State _____ Exp. _____	

	Name & Address of School	Years Completed	Major Course of Study	Diploma Degree
E D U C A T I O N	Elementary School			
	High School			
	College / University			
	Technical / Business			
	Other (Specify)			

E D U C A T I O N	Describe any specialized training, apprenticeship, skills, and extra-curricular activities. You may exclude information which would reveal gender, race, religion, national origin, age, ancestry, disability, or other protected status.

EMPLOYMENT RECORD DATA

Begin with you PRESENT or most recent job and describe ALL periods of employment. Account for your time during any intervals of employment other than when attending school. Please include both the month and year for all periods of employment.

Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
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Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP
Dates of Employment From _____ To _____	Company Name _____ Supervisor _____ Are you presently employed? Yes No May we call your current employer? Yes No Address _____ Telephone () _____ Street City State/ZIP

If you need additional space, please continue on a separate sheet of paper

L I C E N S E	Professional Licenses, Registrations, and Certificates:				
	TYPE	STATE	NUMBER	ISSUED DATE	EXPIRATION DATE

M I S C E L L A N E O U S	Are there any Medical sanctions against you? YES <input type="checkbox"/> NO <input type="checkbox"/>
	Do you understand that due to the nature of the service we provide, an exceptional record of attendance, promptness, and dependability is required of all hospital employees? YES <input type="checkbox"/> NO <input type="checkbox"/>
	Do you understand that employment is contingent upon passing a drug, tobacco use, health screening examination, satisfactory education, prior employment, and reference certification? YES <input type="checkbox"/> NO <input type="checkbox"/>
	I hereby state that information given by me in this application is true in all respects. I understand I may be terminated for falsification of information provided to Wayne Memorial Hospital, whether it is by omission or misrepresentation of the facts.

	DATE SIGNATURE
	Please use the space below to make comments or provide pertinent information that you would like for us to know.

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE IF APPLICANT IS EMPLOYED.

F O R O F F I C E U S E	Employee's Name _____ Birth Date _____ Date Hired _____
	Race _____ Sex _____ Full Time _____ Part Time _____
	Marital Statue _____ If married, Spouse's Name _____
	IN CASE OF EMERGENCY CONTACT:
	Name _____ Relationship _____
	Address _____ Phone No. _____

Thank you for applying for a position with Wayne Memorial Hospital.
Please provide us with the following information:

NAME: _____ DATE: _____

ADDRESS: _____

TELEPHONE: (HOME) _____ (ALTERNATE) _____

POSITION APPLYING FOR: _____

**PLEASE PROVIDE THE ORIGINALS OF THE FOLLOWING.
WE WILL MAKE COPIES AND RETURN THE ORIGINALS TO YOU.**

*Professional license or certificate *CPR card and/or other advanced certification card

*Driver's license *Social security card

Do you want full-time work? yes no

Do you want part-time work? yes no

A PRN and part-time employee must work two times per month to remain an employee. If you want only part-time or PRN work, please explain what days, shifts, etc. you would be available.

Do you have another job? yes no

If hired, you are required to complete all hospital health requirements, which the hospital provides, and complete a self-study packet prior to your first day of work. You will also be required to attend a one-day general orientation session. (Orientation will be paid time). **Initial here** _____

On an annual basis, you will be required to complete health requirements and attend annual updates for fire/safety, universal precautions, hazardous materials, CPR, etc. Annual update will be paid time. **Initial here** _____

If you work nonconventional scheduling not mentioned, please describe the schedule guidelines. _____

Signature

Date

JOB APPLICANT'S AGREEMENT TO AND CERTIFICATION OF INFORMATION

Wayne Memorial Hospital is an equal opportunity employer. It is the policy of this company to consider all applicants for employment based on their qualification for job vacancies. Our company fully complies with all applicable laws which prohibit discrimination on the basis of race, color, religion, sex, national origin, age, gender, and veteran, or disability status.

1: I certify that the information given by me in this application is true in all respects, and I agree that if the information given is found to be false in any way or if there is material misrepresentation or deliberate omission of a fact, it shall be considered sufficient cause for denial of employment or discharge. I authorize the use of any information in this application to verify my statements and I authorize the past employers, all references, and any other persons to answer all questions asked concerning my education, ability, character, and previous employment record. I understand that this information will be used solely for the purpose of determining my qualifications for employment and hereby release from liability my previous employers, educational institutions, references, and Wayne Memorial Hospital.

2: I understand that nothing contained in this employment application or in the granting of an interview is intended to create an employment contract between Wayne Memorial Hospital and myself for either employment or for the providing of any benefit. No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon Wayne Memorial Hospital unless made in writing. I understand that I have the right to terminate my employment at any time and that Wayne Memorial Hospital retains the same right.

3: I further understand that if an offer of employment is tentatively made to me, it is conditioned upon my successful completion of a medical examination and pre-employment test that includes verification of ability to meet physical standards and perform essential functions of the job for which I am applying. In the event I have a disability which will affect my ability to take the pre-employment test, I will so inform Wayne Memorial Hospital prior to the administration of the test so that reasonable accommodation can be considered. Requested accommodations may include accessible testing sites, modified testing conditions, and accessible testing formats. Wayne Memorial Hospital reserves the right to require medical documentation concerning the need for the accommodation.

4: I understand that if employed, abiding by policies, procedures, and rules are conditions of employment and that the employer may revise policies or procedures, in whole or in part, at any time.

5: I agree that my employment is "AT WILL" and may be terminated by Wayne Memorial Hospital at any time without liability except for wages that may have been earned to the date of such termination. I agree to submit to search of my person, packages, briefcases, purse, or of any locker that may be assigned to me, and I hereby waive all claims for damages on account of such examination. I understand that the Hospital reserves the right to test to determine the presence of any controlled substances such as illegal drugs or alcohol to any applicant or employee at any time; I give my consent to such test.

6: Although the Hospital makes every effort to accommodate individual preferences, business needs may, at times, make the following conditions mandatory: overtime, shift work, work in another department or unit, a rotating work schedule, or shift change. I understand and accept these as conditions of any continuing employment.

7: I also understand that employment is conditional upon furnishing verification of eligibility for employment in the United States in compliance with the Immigration Reform and Control Act of 1986.

8: I understand that this application will be kept active for six (6) months from the date completed, after which time I would have to reapply in accordance with established company procedures.

REFERENCE FORMS INSTRUCTIONS

On the top of the reference forms, please insert the names and addresses of your former employers you wish to use as references, insert your name and address, and forward them to two former employers. Each employer is to complete the form and mail it directly to the Human Resource Administrator, WAYNE MEMORIAL HOSPITAL, in the envelope provided. Also insert on each reference form the position(s) for which you are applying so they will know how to evaluate you.

PLEASE NOTE: You are required to send these reference forms to employers for whom you have worked, including your most recent employer.

If you have no work experience, you are requested to send the reference forms to persons who would be familiar with your qualifications for the position for which you are applying rather than personal friends.

I have read and understand the preceding statements.

Signature of Applicant

Date

Witness

Date

Caring for the Community-----AN EQUAL OPPORTUNITY EMPLOYER

**WAYNE MEMORIAL HOSPITAL
REFERENCE RELEASE FORM**

Applicant Name: _____

Former Employer: _____

Position Applying for: _____

The above named applicant is being considered for employment with Wayne Memorial Hospital and has listed your organization as a former employer. We would appreciate your completion of this form at your earliest convenience. Information provided will be treated in confidence. Please return this form to us in the enclosed envelope. Thank you for your assistance.

Applicant's Authorization

I consent to and authorize the above named former employer, its agents and employees, to furnish any information concerning me, including achievement, wage history, performance, attendance, personal history, disciplinary information and reason for separation of employment. I hereby release the above named former employer, its agents and employees, from all liability claims which arise or result from any information provided pursuant to this authorization.

Applicant's Signature: _____ Date: _____

Record of Employment

Position Held: _____ Date Employed: _____

Summary of Essential Duties: _____

Reason for Leaving: _____

Eligible for Rehire: Yes ___ No ___

Please rate the following:

	Excellent	Good	Average	Fair	Poor
Job Knowledge	_____	_____	_____	_____	_____
Accuracy	_____	_____	_____	_____	_____
Productivity	_____	_____	_____	_____	_____
Dependability	_____	_____	_____	_____	_____
Attendance	_____	_____	_____	_____	_____

Comments: _____

Signature: _____ Title: _____ Date: _____

**WAYNE MEMORIAL HOSPITAL
REFERENCE RELEASE FORM**

Applicant Name: _____

Former Employer: _____

Position Applying for: _____

The above named applicant is being considered for employment with Wayne Memorial Hospital and has listed your organization as a former employer. We would appreciate your completion of this form at your earliest convenience. Information provided will be treated in confidence. Please return this form to us in the enclosed envelope. Thank you for your assistance.

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Applicant's Signature: _____ Date: _____

Record of Employment

Position Held: _____ Date Employed: _____

Summary of Essential Duties: _____

Reason for Leaving: _____

Eligible for Rehire: Yes No

Please rate the following:

	Excellent	Good	Average	Fair	Poor
Job Knowledge	_____	_____	_____	_____	_____
Accuracy	_____	_____	_____	_____	_____
Productivity	_____	_____	_____	_____	_____
Dependability	_____	_____	_____	_____	_____
Attendance	_____	_____	_____	_____	_____

Comments: _____

Signature: _____ Title: _____ Date: _____

WAYNE MEMORIAL HOSPITAL
SUMMARY OF DRUG AND ALCOHOL POLICY

Effective Dec. 1, 1991

Wayne Memorial Hospital is absolutely committed to protect its employees and patients and to provide the highest caliber of patient care. Studies have confirmed that the presence of alcohol or habit-forming or illegal drugs in your system can affect your judgment, reaction time, memory, and motor skills even where impairment is not readily apparent.

Therefore, Wayne Memorial Hospital, as a condition of initial and continued employment, requires all employees to report to work and perform their duties without alcohol, illegal, habit-forming, or psycho-active drugs in their system. We also will not tolerate employees using, possessing, manufacturing, distributing, dispensing, or making arrangements to distribute illegal drugs while at work or on Hospital property. We prohibit outside conduct which is unlawful, affects your work, or reflects badly on the Hospital. Although properly using medication is not prohibited, you must consult with your supervisor or the employee health department when you are legitimately taking medication which may affect your work.

In order to enforce these rules, we reserve the right to require all employees to submit (at any time) to tests to determine the presence of drugs or alcohol. Employees may be subject to testing when: (1) involved in incident which caused or could have caused injury or property damage; (2) as part of any regularly scheduled physical examinations; and (3) where the Hospital has reasonable suspicion to believe that an employee has violated its Drug and Alcohol policy. Your job classification will determine the occasions on which you will be eligible for testing. Some employee classifications may be subject to testing on more occasions than others.

Where we have reasonable suspicion of a violation, we also reserve the right to search desks, cabinets, lockers, toolboxes, vehicles (including personal vehicles brought on Hospital property), bags, or any other property on Hospital property or where employees are performing Hospital duties.

Violation of these rules, including by testing positive, will subject you to discipline up to and including discharge. Refusal to cooperate with the Hospital in any test, search, or investigation may result in discipline, including discharge. Anyone who needs help for drug or alcohol problems should immediately seek assistance and quit abusing drugs and alcohol before he or she is caught in violation of the policy.

We greatly appreciate your cooperation. Any questions should be directed to the Human Resource Department.

I have read the above statement of policy and agree to abide by Wayne Memorial Hospital's drug and alcohol policy. I agree to submit to a drug and/or alcohol test at any time as a condition of my initial or continued employment. I authorize any laboratory or medical provider to release test results to Wayne Memorial Hospital.

I expressly authorize the Hospital to release any test-related information, including positive results, to the Unemployment Compensation Commission or other governmental agency or regulatory group, or where the Hospital is involved in adversarial or legal procedures.

I release any legal claims I may have against Wayne Memorial Hospital, its subsidiaries, officers, and employees for requiring the test, and for any adverse employment action taken as a result of the test or results. I understand that this agreement in no way limits my or the Hospital's right to terminate my employment at any time for any or no reason.

Employee

Witness

Date

Affirmative Action Voluntary Information

Completion of information below is voluntary.

We consider all applicants for positions without regard to race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, military/veteran status, or any other similarly protected status. We also comply with all applicable laws governing employment practices and do not discriminate on the basis of any unlawful criteria.

In an effort to comply with requirements regarding government recordkeeping, reporting and other legal obligations which may apply, we invite you to complete this applicant data survey. Providing this information is **STRICTLY VOLUNTARY**. Failure to provide it will not subject you to any adverse personnel decision or action. Your cooperation is appreciated.

Please be advised that this survey is *not* a part of your official application for employment. The information will be used and kept confidential in accordance with applicable laws and regulations.

Position(s) applied for: _____ Date: ____/____/____

Referral Source:

- Walk-in Government Employment Agency Private Employment Agency
 Employee Relative School
 Advertisement - Source: _____ Other _____

Name of person who referred you (if applicable) _____

Applicant Information

Name _____ Telephone # (____) _____
Last First Middle

Address _____
Street City State Zip Code

Male Female

EEO Self Identification

Please check the box (only one) that best applies to you:

- Hispanic or Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin; regardless of race.
- White** (Not Hispanic or Latino) - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- 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 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 maintains tribal affiliation or community attachment.
- Two or More Races** (Not Hispanic or Latino) - All persons who identify with more than one of the races above, excluding Hispanic or Latino.

Veteran Status Information

This employer is a government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, which requires government contractors to take affirmative action to employ and advance in employment qualified special disabled veterans, veterans of the Vietnam era, recently separated veterans, and other protected veterans. If you are a veteran of the Vietnam era, recently separated veteran, or other protected veteran, we would like to include you under our affirmative action program. If you would like to be included under the affirmative action program, please tell us. **Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment.** The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended. The information you submit will be kept confidential, except that: (i) supervisors and managers may be informed regarding restrictions on the work or duties of special disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) government officials engaged in enforcing laws administered by OFCCP, or enforcing the Americans with Disabilities Act, may be informed.

Veteran Status Information (continued)

Please check all boxes that apply to you:

- I am a veteran of the Vietnam era. A person who: (a) served on active duty for a period of more than 180 days, and was discharged or released therefrom with other than a dishonorable discharge, if any part of such active duty occurred in: (i) the Republic of Vietnam between February 28, 1961 and May 7, 1975 or (ii) between August 5, 1964 and May 7, 1975, in all other cases; OR (b) was discharged or released from active duty for a service-connected disability if any part of such active duty was performed during the times and places specified under (a).
- I am a recently separated veteran. Any veteran during the one-year period beginning on the date of such veteran's discharge or release from active duty.
- I am an other protected veteran. A person who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized, under laws administered by the Department of Defense.
- I would like to be included under the company's affirmative action program (if applicable) pertaining to veterans of the Vietnam era, recently separated veterans, and other protected veterans. (Note that you may make this request at this time and/or any time in the future.)
- None of the above apply to me.

Special Disabled Veterans (APPLICANT: Only complete this section if the company has checked "Yes" below)

EMPLOYER: Please indicate whether you are inviting applicants to participate in your company's affirmative action program benefiting special disabled veterans.

- Yes. The Company invites its applicants to provide information (on a voluntary basis) regarding their status as a "special disabled veteran" for inclusion in the company's affirmative action program.
Check this box ONLY if the company is actually undertaking affirmative action for special disabled veterans at the application state (pre-offer) or is otherwise authorized to collect this data to comply with federal, state, or local affirmative action obligations pertaining to special disabled veterans. Otherwise, it is advisable to wait until a conditional offer of employment has been extended before inquiring about disability status.

APPLICANT:

If the company has checked "Yes" to the question above, you are invited to provide additional information regarding your status as a "special disabled veteran." This information will assist us in placing you in an appropriate position and in making accommodations for your disability. The law defines a "special disabled veteran" as:

- a) a veteran who is entitled to compensation (or who, but for the receipt of military retired pay, would be entitled to compensation) under laws administered by the Department of Veterans Affairs for a disability rated at 30 percent or more, or related at 10 or 20 percent in the case of a veteran who has been determined by the Department of Veterans Affairs to have a serious employment handicap, or
- b) a person who was discharged or released from active duty because of a service-connected disability.

If you are a special disabled veteran, please indicate whether you would like to be included under the company's affirmative action program for special disabled veterans. You may elect to be included at this time or any time in the future.

- Yes. I would like to be included under the company's affirmative action program for special disabled veterans. (If a job offer is extended, you may be asked to provide more information to assist with placement and accommodation issues.)
- No. At this time, I would not like to be included in the company's affirmative action program for special disabled veterans.

If you are a special disabled veteran, it would assist us if you tell us about any special methods, skills, and procedures which qualify you for positions that you might not otherwise be able to do because of your disability so that you will be considered for any positions of that kind.

Applicant's Signature: _____

For Administrative Use Only

Hired Yes No

Position hired for _____

From the EEO job classifications listed below, which one best describes the position filled (or applied for, if applicant rejected)?

- | | | |
|------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Executive/Senior Level Officials and Managers | <input type="checkbox"/> Technicians | <input type="checkbox"/> Craft Workers |
| <input type="checkbox"/> First/Mid-Level Officials & Managers | <input type="checkbox"/> Sales Workers | <input type="checkbox"/> Operatives |
| <input type="checkbox"/> Professionals | <input type="checkbox"/> Administrative Support Workers | <input type="checkbox"/> Laborers and Helpers |
| <input type="checkbox"/> Service Workers | | |

Notes: _____

Completed by: _____

Date: ____/____/____

To be filed separately from employment application.



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720 International Parkway, Sunrise, FL 33325
800-999-9111 • www.gneil.com to reorder
Affirmative Action Voluntary Information #A0273

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**Reference Letters & Completed
Applications should be mailed to:**

**HUMAN RESOURCE DEPARTMENT
WAYNE MEMORIAL HOSPITAL
P.O. BOX 410
JESUP, GEORGIA 31598**

Or Faxed to:

(912) 530-3274