

# Employment Application

NAME \_\_\_\_\_  
POSITION DESIRED \_\_\_\_\_  
ALTERNATE POSITION DESIRED \_\_\_\_\_  
DATE \_\_\_\_\_

We do not discriminate against persons in our employment practices because of race, color, sex, religion, age, national origin, disability, equal pay and genetic information. We support all federal and state legislation regarding the absence of discrimination.





Are you presently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

1. Present or most recent Employer  Employment Dates  From _____ Mo. Yr.  To _____ Mo. Yr.	NAME OF EMPLOYER		ADDRESS		TELEPHONE NUMBER	
			Street		( ) -	
			City State			
	YOUR POSITION	LAST SUPERVISOR	STARTING SALARY	FINAL SALARY	FT/PT	
	DESCRIPTION OF WORK PERFORMED					
	REASON FOR LEAVING					
	MAY WE CONTACT THIS EMPLOYER? _____ Yes _____ No					
2. Next Previous Employer  Employment Dates  From _____ Mo. Yr.  To _____ Mo. Yr.	NAME OF EMPLOYER		ADDRESS		TELEPHONE NUMBER	
			Street		( ) -	
			City State			
	YOUR POSITION	LAST SUPERVISOR	STARTING SALARY	FINAL SALARY	FT/PT	
	DESCRIPTION OF WORK PERFORMED					
	REASON FOR LEAVING					
	MAY WE CONTACT THIS EMPLOYER? _____ Yes _____ No					
3. Next Previous Employer  Employment Dates  From _____ Mo. Yr.  To _____ Mo. Yr.	NAME OF EMPLOYER		ADDRESS		TELEPHONE NUMBER	
			Street		( ) -	
			City State			
	YOUR POSITION	LAST SUPERVISOR	STARTING SALARY	FINAL SALARY	FT/PT	
	DESCRIPTION OF WORK PERFORMED					
	REASON FOR LEAVING					
	MAY WE CONTACT THIS EMPLOYER? _____ Yes _____ No					
4. Next Previous Employer  Employment Dates  From _____ Mo. Yr.  To _____ Mo. Yr.	NAME OF EMPLOYER		ADDRESS		TELEPHONE NUMBER	
			Street		( ) -	
			City State			
	YOUR POSITION	LAST SUPERVISOR	STARTING SALARY	FINAL SALARY	FT/PT	
	DESCRIPTION OF WORK PERFORMED					
	REASON FOR LEAVING					
	MAY WE CONTACT THIS EMPLOYER? _____ Yes _____ No					

**ADDITIONAL INFORMATION**

If applicable, list all professional licensure information:

Profession \_\_\_\_\_ State Issued \_\_\_\_\_ Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Profession \_\_\_\_\_ State Issued \_\_\_\_\_ Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

If applicable, list all professional registration/certification information:

Organization/Profession \_\_\_\_\_ Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Organization/Profession \_\_\_\_\_ Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

If applicable, please list any other professional credentials that you feel would relate to the position(s) for which you are applying

(i.e. ACLS, BCLS, CPR): \_\_\_\_\_

Please list any technical skills or knowledge you possess which are related to the position(s) for which you are applying (i.e., equipment, software, medical terminology): \_\_\_\_\_

If applicable, present level of typing \_\_\_\_\_ w.p.m.

Please state any additional information you believe would be important in considering your application. \_\_\_\_\_

**PROFESSIONAL REFERENCES**

Give Name(s) of person(s) we may contact to verify your qualifications for the position		
Name	Occupation	Organization
Relationship	Telephone Number	Address E-mail
Name	Occupation	Organization
Relationship	Telephone Number	Address E-mail
Name	Occupation	Organization
Relationship	Telephone Number	Address E-mail

**PLEASE READ AND SIGN**

To the best of my knowledge, all of the information I have submitted on this application is true and complete. I understand that any omission or falsification of information will be sufficient cause for disqualification from further consideration for employment or for dismissal.

I voluntarily give this organization the right to make a thorough investigation of my personal or past employment history and education, agree to cooperate in such investigation, and authorize any former employer, person, firm, or corporation to give this organization any information they may have regarding me. In consideration of this organization's review of this application, I release this organization and all providers of information from any liability as a result of furnishing and receiving this information. I understand that any offers of employment are contingent on successful completion of the post-offer exam and background checks.

I understand employment at this organization is "at will," which means employment may be terminated by the employee or by this organization at any time, with or without cause. I further understand employee benefits, terms and conditions of employment and the policies, procedures and work rules of the organization may be determined, changed and modified from time to time by this organization without limitation or agreement. I also understand any employment handbooks or manuals that may be distributed to me by this organization shall not be construed as a contract.

I hereby agree that if I become employed by this organization I consent to the release of all my future educational records involving classes, coursework, seminars and all other educational programs in which I am enrolled or attend and for which a portion or all of the enrollment fee or tuition will be paid by this organization.

Date \_\_\_\_\_ Applicant's Signature \_\_\_\_\_

**FOR COMPLETION BY MANAGEMENT STAFF MEMBER**

Job Title \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_  
Temporary \_\_\_\_\_ PRN \_\_\_\_\_ Other \_\_\_\_\_  
Department \_\_\_\_\_ Work hours: \_\_\_\_\_  
Effective Start Date \_\_\_\_\_ Total Hours/pay period \_\_\_\_\_  
Pre-employment physical date \_\_\_\_\_ Rate of Pay \_\_\_\_\_  
\_\_\_\_\_ Pay Configuration:  
General Orientation date \_\_\_\_\_ Exempt \_\_\_\_\_ Non-exempt \_\_\_\_\_  
Signature \_\_\_\_\_ Over-time 8/80 \_\_\_\_\_ 7/40 \_\_\_\_\_

Today's Date \_\_\_\_\_

Name on Name Badge should read as follows:

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If applicable, additional position to be held by employee

Job Title \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_  
Temporary \_\_\_\_\_ Contingent \_\_\_\_\_  
Department \_\_\_\_\_ Work hours: \_\_\_\_\_  
Rate of Pay \_\_\_\_\_ Total Hours/pay period \_\_\_\_\_  
Signature \_\_\_\_\_ Effective Date \_\_\_\_\_

Today's Date \_\_\_\_\_

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**FOR COMPLETION BY HUMAN RESOURCE STAFF**

Criminal Background Check: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ EPLS \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Dependent Adult Abuse Check: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Child Abuse Check: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Sexual Abuse Check: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

License Verification: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Office of Inspector General Check: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
(Medicare Fraud)

Employment Offer Made: \_\_\_\_\_ Date \_\_\_\_\_

Employment Offer Accepted: \_\_\_\_\_ Date \_\_\_\_\_