

Application for Employment

Equal Opportunity Employer

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Memorial Community Hospital
810 North 22nd Street
Blair, NE 68008
(402) 426-2182 | <input type="checkbox"/> Blair Clinic
812 North 22nd Street
Blair, NE 68008
(402) 426-4611 | <input type="checkbox"/> Fort Calhoun Clinic
4929 County Road P43
Fort Calhoun, NE 68023
(402) 468-4655 | <input type="checkbox"/> Cottonwood Clinic
120 S. 9th Street
Tekamah, NE 68061
(402) 374-1585 |
|--|---|--|--|

Personal

 Last Name First Name Middle Name

 Street Address/Apt. Number City State Zip

(____) _____ (____) _____
 Primary Phone Alternate Phone Email Address

Are you 16 years of age or over? Yes No

Position (s) applying for: 1. _____ 2. _____

Salary Expectations: _____

Job Type: Full Time Part Time PRN/On Call Hours per week: Minimum _____ Maximum _____

Specify hours available each day/night:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From:							
To:							

Have you worked under another name (s)?
 Yes No If yes, list name (s) _____

Have you ever worked for Memorial Community Hospital & Health System?
 Yes No If yes, dates worked (from month/year to month/year)? _____

Do you have any relatives employed with Memorial Community Hospital & Health System?
 Yes No If yes, who? _____ Relationship: _____

Are you a citizen of the United States or eligible to work in the United States?
 Yes No

Have you ever been convicted of a violation of the law other than a minor traffic violation?
 Yes No Date Convicted: _____ If yes, explain. _____

A conviction record will not necessarily disqualify an applicant from employment. The circumstances of a conviction will be considered in relation to the nature of the job for which you apply.

We greatly appreciate your interest. Only the most qualified candidates will receive a response. We are an Equal Opportunity Employer and do not discriminate based on race, color, religion, sex, national origin, age, disability, veteran status, or any other similarly protected status.

Education/Training

Type of School	Name of School, City, State, Zip	Course of Study or Major Field of Interest	Graduate Yes or No	Degree	Date
College or University					
Nursing School or Vocational					
High School/GED					
Other					

Please list any skills and qualifications that may relate to the job for which you are applying:

Professional Licenses, Registrations and/or Certifications (RN, LPN, CNA, Radiology Tech, Respiratory Therapist, Pharmacist, Etc.)

State Issued License: _____ Expiration Date: _____

Type: _____ License/Certificate Number: _____

Certification: _____ Date Received/Number: _____

Has your professional license ever been suspended, revoked or limited in any way? Yes No

Reason: _____

Has your license ever been on probationary status? Yes No

Reason: _____

Have you ever been subject to exclusion or penalties from Medicare as a participating provider? Yes No

If yes, explain: _____

Professional References

List at least two persons who have knowledge of your work skills and character (i.e. managers, supervisors, or co-workers).

Name: _____ Telephone: (____) _____

Name: _____ Telephone: (____) _____

How were you referred to Memorial Community Hospital & Health System?

Walk in Employee Referral School Internet Other

If referred by an employee, please list their name: _____

If advertisement, please identify source: _____

Work Experience

Please give a complete record of all employment. Start with the most recent employment.

COMPANY NAME: _____ Telephone: (_____) _____

Address: _____

Employed From: _____ To: _____ Hours per week: _____ Rate of Pay: \$ _____

Job title: _____

Reason for leaving: _____

Supervisor/Title: _____ May we contact? Yes No

COMPANY NAME: _____ Telephone: (_____) _____

Address: _____

Employed From: _____ To: _____ Hours per week: _____ Rate of Pay: \$ _____

Job title: _____

Reason for leaving: _____

Supervisor/Title: _____ May we contact? Yes No

COMPANY NAME: _____ Telephone: (_____) _____

Address: _____

Employed From: _____ To: _____ Hours per week: _____ Rate of Pay: \$ _____

Job title: _____

Reason for leaving: _____

Supervisor/Title: _____ May we contact? Yes No

COMPANY NAME: _____ Telephone: (_____) _____

Address: _____

Employed From: _____ To: _____ Hours per week: _____ Rate of Pay: \$ _____

Job title: _____

Reason for leaving: _____

Supervisor/Title: _____ May we contact? Yes No

Please give dates and reasons for any gaps in employment: _____

Please Read Carefully Before Signing

I understand that any false statements on this application or any other form that I complete shall be sufficient cause for rejection for employment or immediate discharge when discovered.

I understand that if I accept a position with MCH & Health System, my employment will be governed by all applicable policies and procedures as outlined in the MCH & Health System policy and procedure system and employee handbook. In addition, I understand that these policies and procedures may change periodically, and the handbook will be updated on an as-needed basis. It is my responsibility to remain informed on any and all such changes.

I hereby authorize this company to provide information regarding my employment to persons who have legitimate interest in the information.

I hereby authorize release of any and all information regarding my employment to assist in determining my suitability for employment.

I understand that this application is not a contract of employment. I understand that if I receive an offer of employment, it would be a conditional offer of employment, expressly subject to meeting certain requirements of the job, which may include a post offer physical assessment, drug test and background investigation. I further understand that my employment would be at will, that is, I would reserve the right to terminate my employment when I choose, and my employer would reserve the same right.

Signature of Applicant: _____ Date: _____

EEO Voluntary Information

COMPLETION OF INFORMATION BELOW IS VOLUNTARY

We consider all applicants for positions without regard to race, color, religion, sex, national origin, age, disabilities, veteran status, or any other similarly protected status.

In an effort to comply with requirements regarding government record keeping, 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** part of your official application for employment. It will not be used in any hiring decision. The information will be kept confidential in accordance with applicable laws and regulations.

Please Print

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

Applicant Information

Name _____ Phone (____) _____
Last First Middle

Address _____
Street City State Zip Code

Male Female

Please check the one that most applies from the following Equal Employment Opportunity Identification Groups:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> White (not of Hispanic origin) | <input type="checkbox"/> Black (not of Hispanic origin) | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Asian/Pacific Islander | |