



**MITCHELL COUNTY HOSPITAL HEALTH SYSTEMS  
APPLICATION FOR EMPLOYMENT**

Please fill in all spaces. Enter N/A if item does not apply to you.

**ATTACH COPIES OF PROFESSIONAL LICENSE (e.g. Nursing, CNA, CPR Card etc.)**

**PERSONAL INFORMATION**

Name – Last	First	Middle	Social Security No.	Today's Date
Address – Street				Telephone No.
City		State	Zip	
Position & Hours Desired	Department Applying To <small>(Acute, LTC, SCU etc.)</small>	Training For This Position (Formal education shown on other side of form)		
Other Specialized Training or Experience (Not Necessarily for this Job)				
Have you ever worked at MCHHS before? <small>(Either Acute or LTC)</small>	yes                      no <small>(Please circle)</small> Dates	Department Worked In:	Other names worked here under:	
Why Do You Choose Hospital Work?				
What Prompted You To Apply Here for Employment?				
Are You Related to Anyone In Our Employ? Who and How?				
Have you been convicted of a felony? Yes or No		Dates:	Explain:	
<b>IN CASE OF EMERGENCY NOTIFY</b>	Name		Relationship	
	Address		Telephone	

**EMPLOYMENT UNDERSTANDING (Please read and sign)**

This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, veteran status or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this institution the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical examination, and such future physical examinations including substance testing, as may be required by this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

I understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact on this application form.

If employed, I will be required to complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility for employment.

Signed \_\_\_\_\_

Date \_\_\_\_\_ \*

**EDUCATION**

Name & Location of Schools or Colleges	Did You Graduate?	Date of Graduation	Type of Degree / Certificate

**EMPLOYERS AND EXPERIENCE (References) Please list present job first. IF MORE ROOM NEEDED PLEASE ATTACH SHEET. IF RESUME ATTACHED, FILL IN ANY BLANKS NOT ANSWERED IN RESUME.**

Present or Last Employer Name		City, State	
Dates Worked	From	To	Reason For Leaving
			May we contact? YES or NO
Supervisor	Phone Number		Other Names Worked Under

Employer Name		City, State	
Dates Worked	From	To	Reason For Leaving
			May we contact? YES or NO
Supervisor	Phone Number		Other Names Worked Under

Employer Name		City, State	
Dates Worked	From	To	Reason For Leaving
			May we contact? YES or NO
Supervisor	Phone Number		Other Names Worked Under

Personal References List 2 People not related to you that we may contact.				
Name	Address	Phone	Friend / Coworker	How Long Have you known

**STOP – APPLICANT PLEASE DO NOT WRITE IN SPACE BELOW**

Interviewed by _____ Date _____ Department/Position _____ Remarks _____ _____ _____ _____	Date to Start Work _____ Status: Full Time _____ Part Time _____ Probation Wage _____ Post-Probation Wage _____ Shift/Shift Differential _____
Interviewed by _____ Date _____ Department/Position _____ Remarks _____ _____ _____ _____	Description of Position _____ For part time, number of shifts _____ Per week/month (Please circle) Time Clock # _____ Birthdate: _____