Attn: Human Resources
P.O. Box 160
Carthage, IL 62321
Phone: (217) 357-8574
Phone: (217) 357-8561
Fax: (217) 357-8564

EMPLOYMENT APPLICATION

This Facility is an equal opportunity employer and fully subscribes to the principles of Equal Employment Opportunity. It is the policy of this Facility to provide employment, compensation and other benefits related to employment based on qualifications, without regard to race, color, religion, national origin, age, sex, veteran status or disability, or any other basis prohibited by federal or state law. As an equal opportunity employer, this Facility intends to comply fully with all federal and state laws and the information requested on this application will not be used for any purpose prohibited by law. Disabled applicants may request any needed accommodation.

PLEASE PRINT PLAINLY—BE SURE TO SIGN THIS APPLICATION

PERSONAL INFORMATION

Date of Application: _____ Date Available: _____

Name: _____
Last First Middle

Address: _____
No. Street City State Zip

Contact Phone: (___) _____ Email Address: _____

Have you ever applied for a job with the facility? If yes, please give the date of application, the position for which you applied, and your name at the time: _____

☐ Yes ☐ No

Have you been previously employed by this facility? If yes, please give dates of employment, position held, and your name while employed: _____

☐ Yes ☐ No

Who referred you to this Facility: ☐ Our Advertisement _____ ☐ Job Service ☐ Friend/Relative
(Publication)

☐ Website ☐ Employment Agency ☐ Employee (name) _____ ☐ No One – Walk in

EMPLOYMENT DESIRED

Position applying for:

1st Choice _____ ☐ Full time ☐ Part time ☐ Temporary ☐ PRN

2nd Choice _____

Days and Hours Available to work: _____

Shift Preference ☐ Days ☐ Nights

EDUCATION

Schools Attended	Name and Address of School	Select Last Year Completed	Did you Graduate?	Type of Degree or Certificate Received	Major Course of Study and Your Name While Attending
High School		☐ 9 ☐ 10 ☐ 11 ☐ 12	☐ Yes ☐ No	☐ Diploma ☐ GED	
Jr. College Vocational or Military Training		☐ 1 ☐ 2	☐ Yes ☐ No	☐ Degree ☐ Diploma ☐ Certificate	
College or University		☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ Yes ☐ No	☐ Degree ☐ Diploma ☐ Certificate	
Graduate School		☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ Yes ☐ No	☐ Degree ☐ Diploma ☐ Certificate	

OFFICE SKILLS

Check those with which you have experience:

☐ Word ☐ Excel ☐ E-mail ☐ Medical Terminology ☐ Keyboarding Speed _____ wpm
☐ Switchboard ☐ Medical Transcription ☐ Shorthand Speed _____ wpm

List any special skills or qualifications which you feel are relevant to the job for which you are applying:

_____

PROFESSIONAL LICENSES and/or CERTIFICATIONS

License/Registration # Organization or State Issued Profession Date Issued Expiration Date

_____
_____
_____

Any Restrictions on your License? ☐ Yes ☐ No If yes, explain

_____

CPR Certified? ☐ Yes ☐ No NRP Certified? ☐ Yes ☐ No Other Certifications? ☐ Yes ☐ No
ACLS Certified? ☐ Yes ☐ No Please list_____
Are you currently on the Nursing Assistant Registry? ☐ Yes ☐ No

MILITARY

Were you in the Armed Forces? ☐ Yes ☐ No If yes, what Branch _____
From _____ to _____ Rank at Discharge_____
What were your duties? _____
Did you receive any specialized training? ☐ Yes ☐ No If yes, describe _____

LANGUAGE

_____ Speak ☐ Yes ☐ No Read ☐ Yes ☐ No Write ☐ Yes ☐ No

EMPLOYMENT RECORD (List last or present position first)

Present and Former Employers	Dates Employed	Position & Duties
Name of Present or Last Employer	From	
Address		
City/State/Zip	To	Your name when working there
Supervisor Phone		Reason for Leaving
Name	From	
Address		
City/State/Zip	To	Your name when working there
Supervisor Phone		Reason for Leaving
Name	From	
Address		
City/State/Zip	To	Your name when working there
Supervisor Phone		Reason for Leaving
Name	From	
Address		
City/State/Zip	To	Your name when working there
Supervisor Phone		Reason for Leaving

GENERAL INFORMATION

If hired, you will be required to provide documentation verifying citizenship or eligibility to work in the U.S.
Please list, sequentially, all the names by which you have been known _____

_____

If hired, can you furnish proof that you are you, at least 18 years of age, or if under 18, do you have a permit to work?

☐ Yes ☐ No

Do you have any commitments to another employer? If yes, please state with whom and explain how they may affect your employment with our facility?

☐ Yes ☐ No _____

Have you ever been convicted of or pleaded guilty to a crime (felony), or are any other criminal charges pending against you?

☐ Yes ☐ No

If yes, for what, when and where? _____

Conviction of a criminal offense will not necessarily preclude your employment.

Have you ever been excluded from providing services to Medicare or Medicaid patients/clients?

☐ Yes ☐ No _____

REFERENCES

Are you Employed Now? ☐ Yes ☐ No May We Communicate with your Present Employer? ☐ Yes ☐ No

List three professional references (no relatives) we may contact.

Name	Address	City, State, Zip	Phone
Name	Address	City, State, Zip	Phone
Name	Address	City, State, Zip	Phone

Names of friends or relatives employed by this Facility:

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

EMPLOYMENT UNDERSTANDING

Please read the following statements carefully before you initial each paragraph and sign your name.

"I HEREBY CERTIFY that the answers given by me to the above questions and statements are true and correct and hereby voluntarily authorize this Facility to contact references, past or present employers, persons, schools, law enforcement agencies and any other sources of information which may be relevant to my application for employment. Further, I release from all liability or responsibility all persons, companies or corporations supplying such information. I voluntarily grant this release to support my application for employment at Memorial Hospital & Hancock County Senior Services and agree to inform the Facility of any special concerns I may have related to information which may be discovered during this investigation in the space below. I further understand that all information and documents acquired by Memorial Hospital & Hancock County Senior Services will be maintained as confidential by the Facility, and that the Facility will not release such information to me. It is understood and agreed that any misrepresentation, false statement, or omissions by me in this Application will be sufficient reason for rejection of my application or for dismissal at any time during my employment, without liability to this Facility. I have read, understand and agree to the above statement. ***(Please initial here).*** **_____**

I further 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 no representative of the Facility has the authority to enter into any agreement for employment for any specified period of time and that this Facility is not guaranteeing employment for anyone. No employment contract is created by virtue of my being hired by this Facility. I have read, understand and agree to the above statement. ***(Please initial here).*** **_____**

If employed, I agree to abide by all of the work and safety rules of the Facility. If employed, I will be required to complete an Employment Verification Form (I-9). I agree to any and all pre-placement assessment(s) as may be deemed necessary by Memorial Hospital & Hancock County Senior Services, and further understand that my employment is contingent upon my completion of the Facility pre-placement assessment. I understand that this Facility is committed to maintain a drug-free workplace. I am aware that the Facility may require a drug test as part of the hiring process. Also, if employed, I realize that the Facility may conduct post-accident and reasonable suspicion drug and/or alcohol testing of its employees. I have read, understand and agree to the above statement." ***(Please initial here).*** **_____**

As a condition of employment and in accordance with patient safety standards Memorial Hospital requires all persons to have an annual influenza vaccination and full COVID-19 vaccination or to complete a statement of declination for qualified exemption. ***(Please initial here).*** **_____**

SIGNATURE: _____ DATE: _____