



## EMPLOYMENT APPLICATION

**Attn: Human Resources**

**P.O. Box 160**

**Carthage, IL 62321**

**Phone: (217) 357-8574**

**Phone: (217) 357-8561**

**Fax: (217) 357-8564**

**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 previously been employed by any of the following? (Check all that apply)

☐ Memorial Hospital ☐ Memorial Medical Clinics ☐ Hancock Village ☐ Willow Grove  
Hickory Grove Maple Grove

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

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

#### **EMPLOYMENT DESIRED**

☐ Memorial Hospital ☐ Memorial Medical Clinics ☐ Hancock Village ☐ Willow Grove ☐ No Preference

**Position applying for:**

1<sup>st</sup> Choice \_\_\_\_\_ ☐ Full time ☐ Part time ☐ Temporary ☐ PRN

2<sup>nd</sup> 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		<input type="checkbox"/> 9	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diploma <input type="checkbox"/> GED	
		<input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12			
Jr. College Vocational or Military Training		<input type="checkbox"/> 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate	
		<input type="checkbox"/> 2			
College or University		<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate	
		<input type="checkbox"/> 3 <input type="checkbox"/> 4			
Graduate School		<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate	
		<input type="checkbox"/> 3 <input type="checkbox"/> 4			

**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
<b>Name of Present or Last Employer</b>	From	
Address		
City/State/Zip	To	Your name when working there
Supervisor Phone		Reason for Leaving
<b>Name</b>	From	
Address		
City/State/Zip	To	Your name when working there
Supervisor Phone		Reason for Leaving
<b>Name</b>	From	
Address		
City/State/Zip	To	Your name when working there
Supervisor Phone		Reason for Leaving
<b>Name</b>	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
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Name	Address	City, State, Zip	Phone
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Name	Address	City, State, Zip	Phone
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Names of friends or relatives employed by this Facility:

Name	Relationship
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Name	Relationship
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Name	Relationship
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## 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, Memorial Medical Clinics, Hancock Village & Willow Grove 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, Memorial Medical Clinics, Hancock Village & Willow Grove 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, Memorial Medical Clinics, Hancock Village & Willow Grove, 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, Memorial Medical Clinics, Hancock Village & Willow Grove requires all persons to have an annual influenza vaccination or to complete a statement of declination for qualified exemption. *(Please initial here).* \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_