

NELSON COUNTY HEALTH SYSTEM APPLICATION FOR EMPLOYMENT

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

PERSONAL INFORMATION			
NAME: Last	First	Middle	Social Security No. Today's Date
Address: Street			Telephone No.
City		State	Zip
Position Desired		Training for this position (Formal Education shown on other side of form)	
Other Specialized training or experience (Not necessarily for his job)			
Current Employer		Reason for desiring change	
Why did you choose healthcare work?			
What prompted you to apply here?			
Are you related to anyone in our employ? Who and how?			
Professional License Number	Type	State	
Hobbies			
IN CASE OF EMERGENCY NOTIFY:	Name		Relationship
	Address		Telephone No.
STOP! EMPLOYMENT UNDERSTANDING (Please read and sign)			

This institution does not discriminate in hiring or any other decision based on race, color, sex, citizenship, national origin, ancestry, Vietnam era 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 in 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, as may be required by NCHS at such times and places as NCHS 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 appearing on this application form.

If employed, I will be required to complete an Employment Verification Form (I-9) and, within three (3) days, show satisfactory evidence of identity and eligibility for employment.

Signed _____

Date: _____

EDUCATION

Name and location of schools and colleges	Major subject	Did you graduate?	College Degree	Period of attendance	
				From	To

FORMER EMPLOYEERS AND EXPERIENCE (References)

Name and Address	Nature of Experience	Period		Salary/Wage	Phone Number
		From	To		

PERSONAL REFERENCES (Not Relatives)

Name	Address	Phone	Relationship

STOP! APPLICANT PLEASE DO NOT WRITE IN SPACE BELOW

Interviewed by:	Date:	Date to start work:
Department	Position	
Remarks:		

PRE-EMPLOYMENT CHECK

Nurse Aide Registry Check	Date	Time	Findings
Criminal Background Check	Date	Time	Findings
Professional License Check	Date	Time	Findings
Copy to file Yes No	Other Remarks		
Signed by:			Date completed

**NELSON COUNTY HEALTH SYSTEM
P O BOX 367
200 NORTH MAIN STREET
MCVILLE, ND 58254**

RELEASE OF EMPLOYMENT INFORMATION

To Whom It May Concern:

I have applied to Nelson County Health System, McVilIe, ND, for employment. I hereby authorize Nelson County Health System to conduct a general background check including my employment record together with any information you may have regarding me whether or not such information is on your records, but not limited to, verification of items disclosed on the application. I also authorize all of my former employers, school officials, and persons named herein as references to release this information to representatives of Nelson County Health System. I hereby release said companies and individuals from any liability for any damage whatsoever resulting from the giving of such information.

Signature: _____

Date: _____

**NELSON COUNTY HEALTH SYSTEM
P O BOX 367
200 NORTH MAIN STREET
MCVILLE, ND 58254**

INFORMED CONSENT

The following person has made application for employment at:

Nelson County Health System
P O Box 367
McVile, ND 58254

Full Name of Applicant:

Last	First	Middle/Maiden
- -	M F	
Social Security Number	Sex	Race
/ /		
Date of Birth		

For the purpose of compliance with Federal Regulation Vol 56, No. 187: No 483.13 (1) (ii) (A); I authorize the Bureau of Criminal Apprehension to disclose all information that could relate to criminal charges of abusing, neglecting, or mistreating individuals to Nelson County Health System for the purpose of employment with this facility.

This authorization shall expire one year from the date of my signature.

Signature of Applicant	Date
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