MACON COUNTY HEALTH DEPARTMENT
EMPLOYMENT APPLICATION

TITLE OF POSITION (S) APPLIED FOR _____ HOW DID YOU LEARN ABOUT THE POSITION _____ TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAIDEN NAME/OTHER ALIASES _____ COUNTY _____ ( ) - _____ - _____ (AREA CODE) (TELEPHONE)

EDUCATION

HIGHEST LEVEL ATTAINED

High School Diploma

OTHER _____

HIGH SCHOOL OR BUSINESS SCHOOL NAME & ADDRESS	SPECIALTY, IF ANY	DID YOU GRADUATE?	DATE GRADUATED OR LAST ATTENDED

ADVANCED EDUCATION - THIS INCLUDES SPECIALIZED TRAINING, TECHNICAL SCHOOLS, NURSING DIPOLMA, UNDERGRADUATES, GRADUATES, MEDICAL INTERNSHIPS, RESIDENCY, OTHER: _____

NAME & ADDRESS OF INSTITUTION OR AGENCY	CREDITS EARNED SEM.	CREDITS EARNED QTR.	MAJOR	MINOR	DATES ATTENDED FROM MO/YR	DATES ATTENDED TO MO/YR	TYPE OF DEGREE	DATE ISSUED

REGISTRATION, CERTIFICATION OR OTHER PROFESSIONAL LICENSE	NUMBER	STATE ISSUED	DATE ISSUED	DATE APPLIED FOR

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List your present employment followed by the history of changes in titles and employment with the degree of each change. If there is not sufficient space to list your work history, add the information on a separate piece of paper and attach.

COMPANY NAME ______________________ SUPERVISOR'S NAME ______________________

ADDRESS ______________________ CITY __________ STATE __________ ZIP __________

YOUR TITLE ______________ MONTHLY SALARY $__________ ☐ FULL TIME ☐ PART TIME SUPERVISORY ☐ YES ☐ NO

DATES OF EMPLOYMENT: MONTH __________ YEAR __________ TO MONTH __________ YEAR __________

YOUR DUTIES ____

REASON FOR LEAVING ____

COMPANY NAME ______________________ SUPERVISOR'S NAME ______________________

ADDRESS ______________________ CITY __________ STATE __________ ZIP __________

YOUR TITLE ______________ MONTHLY SALARY $__________ ☐ FULL TIME ☐ PART TIME SUPERVISORY ☐ YES ☐ NO

DATES OF EMPLOYMENT: MONTH __________ YEAR __________ TO MONTH __________ YEAR __________

YOUR DUTIES ____

REASON FOR LEAVING ____

COMPANY NAME ______________________ SUPERVISOR'S NAME ______________________

ADDRESS ______________________ CITY __________ STATE __________ ZIP __________

YOUR TITLE ______________ MONTHLY SALARY $__________ ☐ FULL TIME ☐ PART TIME SUPERVISORY ☐ YES ☐ NO

DATES OF EMPLOYMENT: MONTH __________ YEAR __________ TO MONTH __________ YEAR __________

YOUR DUTIES ____

REASON FOR LEAVING ____

MACON COUNTY HEALTH DEPARTMENT
EMPLOYMENT APPLICATION

MACON COUNTY HEALTH DEPARTMENT EXERCISES ITS RIGHTS AS AN EMPLOYER AT WILL IN COMPLIANCE WITH EMPLOYMENT LAW IN THE STATE OF ILLINOIS.

APPLICATION STATEMENT

I certify that all information I have provided in order to apply for and secure work with the Macon County Health Department is true, complete and correct.

I authorize any of the persons or employees or previous employees of the organizations referenced in this application packet to give you and any of them all information concerning my previous employment, education, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application, and I release all such parties from all liability for any damage which may result from furnishing such information to you.

In consideration of my possible employment with your organization, I agree to conform to the rules and regulations of the organization as set forth in the employee handbook and acknowledge that these rules and regulations may be changed, interpreted withdrawn or be added to by the employer at any time, at the employer's sole option and without any prior notice to me.

I understand that the Macon County Health Department does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration on a basis prohibited by local, state or federal law.

If I am hired, I understand that I am free to resign at any time with or without cause and without prior notice, and the Macon County Health Department reserves the same right to terminate my employment at any time with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no supervisor or representative of the Macon County Health Department is authorized to make any assurances to the contrary, and that no implied, oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the Administrator.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to cancel further consideration of this application, or immediately discharge me from the employer's service, whenever it is discovered.

DO NOT SIGN UNLESS YOU HAVE READ THE ABOVE STATEMENT.

I certify that I have read, fully understand and accept all terms of the forgoing Application Statement.

_____ _____

SIGNATURE OF APPLICANT DATE

The Macon County Health Department is an Equal Opportunity Employer and does not discriminate based on race, religion, sex, national origin, ancestry, citizenship status, age, marital status, physical or mental handicap or military service.

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APPLICANT'S CONSENT TO DRUG/ALCOHOL TESTING

I understand it is the policy of the Macon County Health Department, hereafter, referred to as the MCHD, to conduct drug and/or alcohol tests of job applicants for the purpose of detecting drug and/or alcohol abuse, and that one of the requirements for consideration of employment with the MCHD is the satisfactory passing of drug and/or alcohol test(s).

I understand that a rapid test for drug and/or alcohol will be given, and in the event that this test results in positive findings, I may request an additional lab conducted test at my own costs.

For the purpose of being further considered for employment, I hereby agree to submit to a drug and/or alcohol test. I understand that favorable test results will not guarantee that I will be employed by the MCHD.

If I am accepted for employment, I agree to take drug and/or alcohol tests whenever requested by the MCHD, and I understand that the taking of such tests is a condition of my continued employment.

I also give consent to the testing agency, HSHS Occupational Health and Wellness, to release to the MCHD and other necessary parties the results of my tests.

_____ _____

SIGNATURE OF APPLICANT DATE

_____ _____

PRINTED NAME OF APPLICANT DATE

APPLICANT'S CONSENT TO A CRIMINAL BACKGROUND CHECK

I understand it is the policy of the Macon County Health Department, hereafter, referred to as the MCHD, to conduct Illinois State Police non-fingerprint criminal background checks of job applicants, and that one of the requirements for consideration of employment with the MCHD is the satisfactory passing of an Illinois State Police non-fingerprint criminal background check. I understand that use of information obtained on the MCHD Employment Application, including, but not limited to, my date of birth and social security information may be used to conduct a background check.

For the purpose of being further considered for employment, I hereby agree to submit to an Illinois State Police non-fingerprint criminal background check. I understand that a favorable background check result will not guarantee that I will be employed by the MCHD.

_____ _____

SIGNATURE OF APPLICANT DATE

_____ _____

PRINTED NAME OF APPLICANT DATE