



Application for Employment

Position Applying for: _____

Applicant Information

Full Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Desired Salary: _____ Have you worked under another name? _____

If hired, can you provide proof of your eligibility to be employed in the United States? _____

Education & Training

Highest Education Completed? _____ Was a diploma received? _____

Name of College/ Vocational Education	Certificate/ Degree Received	Location	Major or Specialty	Graduated	Dates Attended

Professional Licenses, Registrations, and/or Certifications

(Skip this section for non-clinical applicants)

Profession: _____ State Issued: _____ Licenses Number: _____

Certification Number: _____ Registration Number: _____

Date of Issuance: _____ Expiration Date: _____

Have your professional licenses (in any state) ever been on probation, suspended, revoked, or limited in any way? _____

If yes, please explain circumstances and outcome: _____

Profession: _____ State Issued: _____ Licenses Number: _____

Certification Number: _____ Registration Number: _____

Date of Issuance: _____ Expiration Date: _____

Have your professional licenses (in any state) ever been on probation, suspended, revoked, or limited in any way? _____

If yes, please explain circumstances and outcome: _____

Previous Employment

List your present or most recent employer FIRST. Include U.S. Armed Forces experience. Account for ALL the time during the past seven years including period of unemployment. Include any unpaid work experience. Omit reasons for leaving if for reasons of health or disability. Resumes are acceptable but may NOT be substituted for the following information:

Company: _____ Phone: _____ City/State: _____

Job Title: _____ From: _____ To: _____ Reason for leaving: _____

Supervisor: _____ May we contact your supervisor for a reference? _____

Responsibilities: _____

Company: _____ Phone: _____ City/State: _____

Job Title: _____ From: _____ To: _____ Reason for leaving: _____

Supervisor: _____ May we contact your supervisor for a reference? _____

Responsibilities: _____

Company: _____ Phone: _____ City/State: _____

Job Title: _____ From: _____ To: _____ Reason for leaving: _____

Supervisor: _____ May we contact your supervisor for a reference? _____

Responsibilities: _____

Company: _____ Phone: _____ City/State: _____

Job Title: _____ From: _____ To: _____ Reason for leaving: _____

Supervisor: _____ May we contact your supervisor for a reference? _____

Responsibilities: _____

Skills

Please list any skills and abilities you wish to be considered. Include skills with equipment or machines you operate, special computer knowledge, laboratory techniques, etc. _____

References

List Three Professional References; please do not list relatives.

Name	Relationship	Daytime Phone & Email
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Employment Acknowledgement

By submitting this form, I certify the information contained in this application for employment is true to the best of my knowledge/belief. I understand that any omission of facts or misrepresentation is cause for denial of employment and/or dismissal (if hired) regardless of when discovered. I understand that additional record and background checks will be performed including SING, as well as other state and federal databases as required by law or policy.

I grant permission for Clarinda Regional Health Center to investigate my work references and release them any former employer from any and all liability resulting from such investigation. Upon my termination, I authorize the release of reference information on my work.

I agree to submit to a post-offer physical, including drug and/or alcohol screening and recognize employment is contingent upon successfully meeting physical requirements.

I further agree that if I have been convicted of a crime, Clarinda Regional Health Center may obtain details of my conviction to determine its relationship to the position I am applying for as a condition of my employment.

In consideration of my employment, I agree to conform to the rules and regulations of Clarinda Regional Health Center. My employment may be terminated, with or without cause, at any time, at the option of Clarinda Regional Health Center or myself.

Federal law requires evidence of identity and employment eligibility upon hire.

This facility does not discriminate in hiring or in any other decision based on race, creed, color, religion, sex, sexual orientation, gender identity (including gender expression), national origin, age, disability, veteran status, genetic information or any other protected group under applicable state, federal or local law. No question on this application is intended to secure information to be used for such discrimination.

Print Full Name: _____ Signature: _____

Date: _____

After you have completed filling out this application you may either:

- Drop it off at CRHC
- Email it to Tessie Lindburg at tlindburg@clarindahealth.com
- Fax it to (712) 542-8338

If you have any addition questions, contact Tessie at (712) 542-8320 or tlindburg@clarindahealth.com