



Application for Employment

It is the policy of this facility to provide equal opportunity to persons or race, religion, age, gender, disability or any other classification in accordance with federal, state and local statutes, regulations and ordinances.

Human Resources Department
609 SE Kent Street
Greenfield, Iowa 50849

www.adaircountyhealthsystem.org
email: ashafava@adaircountyhealthsystem.org

Date: _____

Last Name First Name Middle			Are You at Least 18 yrs old? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security Number	
Present address			Present City		Present State	Present Zip Code
Home Phone		Business or Number for Messages		E-mail Address		
Position(s) Applied For:			Date Available for Employment: ____/____/____			
1.			2.			
Applying For: Check All That Apply			Shift Preference: _____			
___ Full-Time ___ Part-Time			Check all that you are willing to work:			
___ PRN ___ Temporary			___ Days ___ Evening ___ Nights ___ Weekends			
___ Weekend Option			Rotating: _____			
How did you learn about this position? (Be specific with names if possible)						
___ Newspaper _____						
___ Referred by an employee _____						
___ Other _____						
Have you ever worked for Adair County Memorial Hospital, Home Health Care, Foundation, Medical Clinics or Ambulance before? ___ No ___ Yes						
Where/When? _____						
Have you worked before under another name(s)? (For employment verification) ___ No						
___ Yes—If yes, name(s) _____						

Education:

If you attended school under another name, please state name: _____

High School Name	Location	Courses of Study	Diploma/Degree
Business or Trade School	Location	Courses of Study	Diploma/Degree
College or University	Location	Courses of Study	Diploma/Degree
Military Training	Location	Courses of Study	Diploma/Degree Date of Discharge:

Please list any additional experience, skills and qualifications which may relate to the job for which you are applying.

Professional Licenses and/or Certificates:

Type	License/Certification Number	State Issued	Expiration Date

Employment: Give a complete record of all employment and reasons for period of unemployment. Include volunteer work, etc. Start with present or most recent employer.

From: (Mo) _____ (Yr) _____	To: (Mo) _____ (Yr) _____	Full-Time ___ Part-Time ___ Other ___
Employer: _____		
Address: _____		
Phone Number: _____	Job Title: _____	
Reason for Leaving: _____		
Starting Salary: _____	Last Salary: _____	Supervisor: _____
May we contact this employer? ___ Yes ___ No		

From: (Mo) _____ (Yr) _____	To: (Mo) _____ (Yr) _____	Full-Time ___ Part-Time ___ Other ___
Employer: _____		
Address: _____		
Phone Number: _____	Job Title: _____	
Reason for Leaving: _____		
Starting Salary: _____	Last Salary: _____	Supervisor: _____
May we contact this employer? ___ Yes ___ No		

From: (Mo) _____ (Yr) _____	To: (Mo) _____ (Yr) _____	Full-Time ___ Part-Time ___ Other ___
Employer: _____		
Address: _____		
Phone Number: _____	Job Title: _____	
Reason for Leaving: _____		
Starting Salary: _____	Last Salary: _____	Supervisor: _____
May we contact this employer? ___ Yes ___ No		

References: Give Name(s) of person(s) we may contact to verify your qualifications for the position

Name	Occupation	Organization
Relationship	Telephone Number	Address
Name	Occupation	Organization
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Relationship	Telephone Number	Address

Have you ever been excluded from participation in any federal or state Medicare, Medicaid or any other third party payor program or have such pending action? No Yes

If yes, a letter showing reinstatement is required for further consideration for employment. I understand that I am required to immediately notify Adair County Health System if any action is proposed to exclude me from participation in any federal or state Medicare, Medicaid or third party payor program.

Do you have a record of founded child or dependent adult abuse? No Yes

Have you ever been convicted of a crime in this state or any other state, or is there a charge which is still pending? No Yes -- If yes, to any, please explain:

I certify that the information contained in this application is correct and I understand and agree that the falsification, misrepresentation or omissions of any information in this application are grounds for refusal to hire or if I have been hired, grounds for termination. I authorize investigation of all matters contained in this application. I understand and agree that if, in the judgment of Adair County Health System, the results of the investigation are not satisfactory, any offer of employment may be withdrawn or my employment with Adair County Health System may be terminated. I authorize the references listed in this application, including personal and employment references and all prior employers, to provide you with all information pertinent to this application. I release all parties from liability for any damages that may result from the release of any information as a part of the employment verification process.

All successful applicants must pass a physical exam prior to beginning employment with Adair County Health System. I understand that an offer of employment is contingent upon my passing the health system's medical examination before starting work. The examination may include a demonstration of my ability to perform the essential functions of the job. If the examination discloses conditions that prevent me from safely and successfully performing the essential function of the job, Adair County Health System will attempt to make accommodations that will enable me to work. If no reasonable accommodations can be found, or if such accommodations impose undue hardship on the health system, the offer of employment will be withdrawn.

I further acknowledge that I understand Adair County Health System has a policy of employment at will and if I am hired by Adair County Health System my employment may be terminated either by myself or by the health system at any time.

I understand that employment is contingent upon successful completion of a job-required licensure, certification, or registration exam, if applicable and not already completed.

Signature: _____ **Date:** ____/____/____