



PERSONAL			
Position Applying For:			Date of Application
Last Name	First Name	Middle Initial	Social Security Number
Address	City	State	Zip
Have you ever been employed with us? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give date: _____			Are you age 16 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you available to work: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary			On what date would you be available for work?
Are you legally eligible for employment in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (Proof of citizenship or immigration status will be required upon employment.)			Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, a letter showing reinstatement is required for further consideration of employment			
Professional License/Registration and/or Certification: Type: _____ State Issued: _____ Number: _____ Expires: _____			Have you ever been employed as a Certified Nurse's Aide? <input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYMENT HISTORY List MOST RECENT Position First			
From	Name of Employer	Name/Title Last Supervisor	
MO. YR.			
To	Address	Position Held	Ending Salary
MO. YR.			
Briefly describe the work you preformed:			Telephone
Reason for leaving:			May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No

From	Name of Employer	Name/Title Last Supervisor	
MO. YR.			
To	Address	Position Held	Ending Salary
MO. YR.			
Briefly describe the work you preformed:			Telephone
Reason for leaving:			May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No

From	Name of Employer	Name/Title Last Supervisor	
MO. YR.			
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MO. YR.			
Briefly describe the work you preformed:			Telephone
Reason for leaving:			May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION

School	Name of School	Location	Years Completed	Course of Study	Did You Graduate	Diploma Degree
High School					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trade					<input type="checkbox"/> Yes <input type="checkbox"/> No	
College					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate					<input type="checkbox"/> Yes <input type="checkbox"/> No	

List Health Care, Business, or Industrial Equipment That You Operate Proficiently:

References (Names of Persons Not Related To You)

Name	Relationship	Address	Phone
1.			
2.			
3.			

Do You have a Friend or Relative Working Here?

Name	Dept.	Relationship

Special Skills/Qualifications/Certifications

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AN EQUAL OPPORTUNITY EMPLOYER

All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability, veteran status, or any other characteristic protected by law. Please direct any request for reasonable accommodations needed during the application process to administrator.

Applicant's Statement

I certify that all information contained in this application is true, and understand that any misleading or false information or willful omission will be sufficient cause for immediate dismissal or refusal of employment.

I understand that all information in this application is subject to verification and that St. Andrew's Health Center may investigate my work and personal history and verify data given on this application, on related papers, and in interviews. I also authorize all individuals, schools, businesses, employers (past and present), and references herein, except my current employer if so noted, to provide any information requested about me, and release them from all liability for damage in providing this information.

I further understand that employment is "at-will" and that nothing contained in this employment application or statements made during the interview process if an interview is granted, are intended to create an employment contract between St. Andrew's Health Center and myself for either employment or for the providing of any benefit.

I also understand that St. Andrew's Health Center may require pre-employment drug and alcohol testing. No prospective employee will be asked to submit to testing unless an offer of employment has been made. An offer of employment is conditioned on the prospective employee testing negative for illegal drugs and alcohol. I understand and agree to submit to the required pre-employment testing if an offer of employment is made to me.

I acknowledge and understand that I am required to immediately notify St. Andrew's Health Center if any action is proposed to exclude me from participation in any federal or state Medicare, Medicaid or third party payor program. I have read and understand the above.

Incomplete information could disqualify you from consideration. Please accurately and fully complete all fields/questions.

Signature: _____ Date: _____

IMPORTANT NOTICE TO ALL APPLICANTS

If you are selected for employment you must be prepared to verify your eligibility to work as required under the Immigration Reform and Control Act of 1986. This requirement applies to all new employees including U.A. citizens, permanent residents and nonimmigrants. You will have to provide documents within 3 days of your hire date to verify your identity and eligibility to work.