East-Central District Health Department

Employment Application

Date of Application: _____

Name (last, first, middle initial)	Social Security No. — —	Telephone No.

Other Telephone No.	E-mail Address	Address (include street, city, state, zip code)

Please answer all questions below:

Do you have the right to work in the United States? ☐Yes ☐No

Are you 18 years old or older? ☐Yes ☐No

Have you ever worked for ECDHD before? ☐Yes ☐No
If yes, when? _____ What department(s)?_____.

Do you have any relatives or friends who work for ECDHD? ☐Yes ☐No
If yes, what are their names? _____

Who referred you to our agency? ☐Newspaper ☐Agency ☐Relative/Friend ☐Other: _____

Are you a veteran? ☐Yes ☐ No If yes, what branch? _____

I would be available to work:

☐Full-Time ☐Day
☐ Part-Time ☐ Evening (some)
☐ Temporary ☐Weekend (some)

Exact position (s) you are applying for:
1. _____
2. _____

Rate of pay you expect: $ _____
Date available to start work: _____

CURRENT PROFESSIONAL REGISTRATION

Include driver's license ONLY IF applying for a position which requires driving. You must be able to provide a proof of license upon request.

Type:	License Number:	Expiration Date:	Granted By: (Licensing Board)	State:	Verified By: (Office use only)

Has your license ever been suspended /revoked? ☐Yes ☐No
If yes, date and reason:
_____

EDUCATION BACKGROUND

	Circle Level Completed	Diploma/Degree	Major/Course of Study
Elementary School Name/Location	4 5 6 7 8		
High School Name/Location	9 10 11 12		
College University Name/Location	1 2 3 4		
Graduate/Professional School Name/Location	1 2 3 4		

EMPLOYMENT RECORD

List your present or most recent employer FIRST. Include military, volunteer, and unpaid work experiences. Account for all time, including periods of unemployment. If additional space is needed, please use blank paper. Resumes may be attached, but we also request that the following information be completed.

Are you employed at the present time? ☐ Yes ☐ No If yes, may we contact your present employer? ☐ Yes ☐ No

Employer:		Address:	
City:	State:	Zip	Phone: ( )
Job Title:	Salary:	Employed From:	To:
Primary Duty/Responsibilities:			
Reason for Leaving:			
Supervisor:		Title:	

Employer:		Address:	
City:	State:	Zip	Phone: ( )
Job Title:	Salary:	Employed From:	To:
Primary Duty/Responsibilities:			
Reason for Leaving:			
Supervisor:		Title:	

Employer:		Address:	
City:	State:	Zip	Phone: ( )
Job Title:	Salary:	Employed From:	To:
Primary Duty/Responsibilities:			
Reason for Leaving:			
Supervisor:		Title:	

Employer:		Address:	
City:	State:	Zip	Phone: ( )
Job Title:	Salary:	Employed From:	To:
Primary Duty/Responsibilities:			
Reason for Leaving:			
Supervisor:		Title:	

Employer:		Address:	
City:	State:	Zip	Phone: ( )
Job Title:	Salary:	Employed From:	To:
Primary Duty/Responsibilities:			
Reason for Leaving:			
Supervisor:		Title:	

BUSINESS SKILLS

Typing?	Speed?	Other Skills
☐ Yes ☐ No	wpm	

What business machines can you operate?

List professional, trade, business or civic activities and offices held.
You may exclude membership which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status:

State any additional information you feel may be helpful to us in considering your application.

NURSING APPLICANTS: Please check if you have successfully completed any of the following:

☐ ACLS (exp. date): _____ ☐ PALS (exp. date): _____
☐ CPR/BLS Cert. (exp. date): _____ ☐ Other: _____
☐ NALS (exp. date): _____ ☐ Other: _____

REFERENCES (Please do not list relatives or past/present employers)

Name	Address	
E-mail Address	Phone # ( )	Fax # ( )
Name	Address	
E-mail Address	Phone # ( )	Fax # ( )
Name	Address	
E-mail Address	Phone # ( )	Fax # ( )

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THIS APPLICATION FORM.
ECDHD RESERVES THE RIGHT TO REJECT
ANY APPLICATION WHICH HAS NOT BEEN FULLY COMPLETED.
A NEW APPLICATION WILL BE REQUIRED AFTER 6 MONTHS. PLEASE PRINT OR TYPE IN BLACK INK.

1. I certify that the information contained in this application is complete and true to the best of my knowledge and that I have not knowingly withheld any facts or information which would affect my employment. I hereby authorize ECDHD or an agent of ECDHD to verify the information contained herein and to investigate my employment, education, personal history, criminal history, credit history, and motor vehicle operation history as applicable. I understand that any falsification or omission of material and/or information requested may result in denial of employment or termination if I am already employed. Upon my termination, I authorize the release of information on my work.
2. I understand that prior to my employment; I must pass a physical assessment, which will include a drug/alcohol screen and an essential functions assessment. I understand that the exam will be provided by ECDHD. Failure to pass this assessment will be grounds for denial of employment or termination if I am already employed.
3. ECDHD subscribes to a clean air policy. Smoking is not allowed anywhere inside the facilities, or on ECDHD property.
4. In accordance with the Drug-Free Workplace Act of 1988, it is the policy of ECDHD to provide a safe environment for clients, employees, and visitors. The illegal manufacture, possession, distribution or use of controlled substances by employees in the workplace is prohibited.
5. No person shall be denied employment or equal treatment in the administration of salary, benefits, opportunity for advancement or any other terms or conditions of employment because of race, religion, sex, age, national origin, disability, or veteran status.
6. If employed, I will comply with all rules and regulations for employees of ECDHD facilities. I understand and agree that neither this form, nor any other written policy or procedure of ECDHD and its facilities, shall constitute a contract of employment between ECDHD and myself for either a definite or indefinite period of time. I further understand that if employed, I may resign at any time and that ECDHD may terminate or modify the terms and conditions of my employment at any time.
7. I authorize any reference source to provide ECDHD with any and all information concerning my previous records, any pertinent information they may have, personal, or otherwise, and release parties from all liability for any damage that may result from furnishing to you.
8. I understand that weekend work, evening hours, or temporary changes may be required during my employment.

I HAVE READ AND AGREE TO THE ABOVE AND HEREBY CERTIFY THAT THE FACTS I HAVE PROVIDED IN MY EMPLOYMENT APPLICATION ARE TRUE AND COMPLETE.

SIGNATURE: _____ DATE: _____

FOR PERSONNEL DEPARTMENT USE ONLY

Arrange Interview: Yes No Date: _____ Time: _____

Interviewers: _____

Employed: Yes No Date of Hire: _____

Department: _____ Step: _____ Supervisor: _____

Step 3 or above, Executive Director Approval: _____

Notes:

Revised: 5/05/2015