



Memorial
Health Care Systems
Seward, Nebraska

Application for Employment

300 North Columbia Avenue – Seward, NE 68434 – Phone 402/646-4618 – Fax 402/646-4621 – www.mhcs-seward.org

IF YOU ARE APPLYING FOR POSITIONS AT DIFFERENT MEMORIAL HEALTH CARE SYSTEMS FACILITIES, YOU ONLY NEED TO COMPLETE ONE APPLICATION FORM

We are an equal opportunity employer and do not unlawfully discriminate on the basis of race, color, religion, national origin, marital status, age, gender, disability, or veteran status. No question on this application is used for the purpose of limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Equal access to employment, services, and programs is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the organization.

Due to the patient care components associated with health care, it is an absolute requirement that individuals considered for employment can provide verifiable references that may include work history, education, copies of certifications and/or licensure. Along with these references, it will be required of the applicant to understand that any job offer from Memorial Health Care Systems will be contingent upon a criminal history background investigation and an investigation with the Nebraska Department of Health and Human Services Adult/Child Protective Services Central Registries. Further, the nature of health care employment involves dealing with patients' personal issues that are confidential in nature. It is necessary to have employees who have integrity and are committed to maintaining the confidentiality that is required in such an environment. Any employee who does not abide by the intent of this statement will be subject to dismissal.

THIS APPLICATION WILL BE ACTIVE FOR SIX MONTHS. IF YOU ARE STILL INTERESTED IN A POSITION WITH MEMORIAL HEALTH CARE SYSTEMS AFTER SIX MONTHS YOU WILL NEED TO SUBMIT ANOTHER APPLICATION.

Applicant name: _____ Date: _____

Position(s) applied for (a separate application does not need to be completed for each position you are applying for): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone/Message #: _____ Social Security #: _____

Referral source: Advertisement Employee Relative Employment Agency Walk-in
 Job Hotline Other/name of referral source: _____

Type of employment desired: Regular Temporary Full-time Part-time PRN (as needed)

Shift preference: Days Evenings Nights No preference

Are you willing/available to work: Weekends Holidays Rotating shifts No preference

Date you will be available to start work: _____

Can you perform the essential functions of the job (s) for which you are applying, as you understand them, with or without reasonable accommodation? Yes No
Are you able to meet the attendance requirements? Yes No
Do you have any objection to working overtime if necessary? Yes No
Can you travel if required by this position? Yes No
Have you ever been previously employed by our organization? Yes No If "yes," which entity:

Sundermann Homes Memorial Hospital Milford Family Medical Center
 Seward Family Medical Center Utica Family Medical Center Dates of employment: _____

Can you submit proof of legal employment authorization and identity? Yes No
Are you over 18 years of age? Yes No If not, are you over 16 years of age? Yes No
Have you ever been convicted of a crime? Yes No If yes, please explain: _____

If you are presently employed, why do you wish to leave your present position: _____

Employment History *Please provide all employment information for your past and current employers, starting with the most recent (please use additional sheets if necessary). Explain any gaps in employment in the comments section below.*

Employer: _____ Position held: _____
Address: _____ Telephone #: _____
Immediate supervisor and title: _____
Dates employed (from – to): _____ Salary: _____
Job summary: _____
Reason for leaving: _____
May we contact this employer for a reference? Yes No

Employer: _____ Position held: _____
Address: _____ Telephone #: _____
Immediate supervisor and title: _____
Dates employed (from – to): _____ Salary: _____
Job summary: _____
Reason for leaving: _____
May we contact this employer for a reference? Yes No

Employer: _____ Position held: _____
Address: _____ Telephone #: _____
Immediate supervisor and title: _____
Dates employed (from – to): _____ Salary: _____
Job summary: _____
Reason for leaving: _____
May we contact this employer for a reference? Yes No

Employer: _____ Position held: _____
Address: _____ Telephone #: _____
Immediate supervisor and title: _____
Dates employed (from – to): _____ Salary: _____
Job summary: _____
Reason for leaving: _____
May we contact this employer for a reference? Yes No

Comments (including gaps in employment): _____

Additional skills and/or qualifications: _____

Educational History *List school name and location, years completed, course of study, and any degrees earned, starting with the most recent.*

<u>School (City, State)</u>	<u>Years Completed</u>	<u>Degree/Diploma</u>	<u>Major</u>	<u>Minor</u>

Are you presently attending school or taking classes? Yes No If "yes," where are you enrolled and what course of study are you pursuing?: _____
What is your estimated graduation date: _____

Licensure/Certification *If your profession requires registration, licensure or certification, please provide the necessary information.*

In your profession, are you currently: Registered Licensed Certified
If not, are you eligible for: Registration Licensure Certification

If registered, licensed or certified please indicate:

<u>Type</u>	<u>Issuing State</u>	<u>License Number</u>	<u>Expiration Date</u>

References *List three business/work references' names, addresses, phone numbers, and number of years known (do not include relatives or previous supervisors). If not applicable, list three school or personal references who are not related to you.*

<u>Name</u>	<u>Daytime Phone</u>	<u>City, State</u>	<u>Years known</u>

Additional Information *List professional, trade, business, or civic association memberships; accomplishments, awards, or publications. You may exclude information that reveals race, color, religion, national origin, marital status, age, gender, disability, or veteran status.*

APPLICANT'S DISCLOSURE & CONSENT RELEASE OF INFORMATION

Applicant Information (Please Print)

Applicant Name: (First Middle Last)	Current Address: (street address)
Other Name(s) Used: (like Maiden)	City: State: Zip:
2.Other Name(s) Used:	Former Address: (1)
Social Security No: Sex: Race:	City: State: Zip:
Driver's License No.: State:	Former Address: (2)
Month, Day and Year of Birth: Place of Birth: (City, State, Country)	City: State: Zip:

References (Please Print)

Name:	Company:	Phone:
Name:	Company:	Phone:
Name:	Company:	Phone:

Applicant Instructions: Please read this disclosure and consent form carefully before signing. You will be provided with a copy of this form at any time upon request.

Disclosure and consent concerning consumer reports for employment applicants and employment purposes.

You should read carefully. This consent and release has been provided to you for this employer to request a consumer report or investigate consumer reports in connection with your application for employment, resume or during the course of your employment, if any.

The Applicant acknowledges that Memorial Health Care Systems may now, or at any time while employed, verify information within the application, resume or contract for employment. The verifications and/or checks may include but not limited to: driving record, workers compensation records, credit bureau files, employment references, personal references, any educational and licensing institution and to receive any criminal record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in Nebraska or any other State. A photocopy or telephonic facsimile (Fax) of this Disclosure and Consent authorization for Release of Information shall be as valid as the original. The results of this verification process will be used to determine employment eligibility. All results will be kept CONFIDENTIAL. The information obtained will not be provided to any parties other than to designated company personnel.

According to the Fair Credit Reporting Act, if any adverse decision is made with regard to application for employment, based entirely or in part on the information contained in a consumer report or investigative consumer report prepared by a consumer reporting agency, you are entitled to receive a copy of this report upon written request, and a disclosure of the nature and scope of the investigative report. Your signature below indicates that you have carefully read and understand that a consumer report or investigative consumer report regarding you may be requested and reviewed for employment purposes, including any future decisions concerning your employment, promotion, or retention as an employee. Additionally, your signature below reflects your understanding that such consent will remain in effect indefinitely until you revoke it in writing.

Consent Statement

I have carefully read and understand this disclosure and consent form and by my signature consent to the release of consumer or investigative consumer reports, as defined above in conjunction with my application for employment. I further understand this consent will apply during the course of my employment, should I obtain such employment, and that such consent will remain effect until revoked in a written document signed by me. In the event that I wish to refuse or revoke my consent at any time, I understand that I may do so. I further understand that any and all information contained in my job application, or otherwise disclosed to this company by me may be utilized for the purpose of obtaining the consumer reports or investigative consumer reports requested by the Employer and confirm that all such information is true and correct.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as a cause for possible dismissal.

I authorize Hirease, Inc. and any of its Agents/designated Company Personnel, to disclose orally and in writing the results of this verification process and/or interview to authorized representatives. I do hereby agree to forever release and discharge This Memorial Health Systems, our agent, Hirease, Inc. and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint arising from the retrieving and reporting of information.

Applicant Signature

Date

Applicant Name Typed or Printed



Fax to (910) 693-1785

PLEASE FILL OUT COMPLETELY AND LEGIBLY

I understand that as a condition of my employment, my name will be checked against the Nebraska Department of Health and Human Services Adult/Child Protective Services Central Registries. A check of these registries is necessary to ensure that I meet provider standards. One copy of this form will be sent to the Adult Registry and one will be sent to the Child Protective Service Registry, as they are two separate areas.

The purpose of this check will be to determine if my name is being maintained on either registry as a result of previous abuse/neglect allegations, which have been investigated and have not been determined to be unfounded.

To the best of my knowledge, I do not have a conviction or prior history of adult or child abuse/neglect or maltreatment. Neither have I been convicted of a crime involving moral turpitude.

I hereby authorize the Nebraska Department of Health and Human Services to release information contained on the Adult and Child Protective Services Central Registry including the information that a record has been found to:

HirEase, Inc.
PO Box 2559, Southern Pines, NC 28388
1-866-693-1785

(Signature of Applicant/Employee)

(Date Signed)

(Printed or Typed Name of Applicant/Employee)

(Social Security Number)

Other Names Used
(Please Print or Type)

Other Addresses in Past Twenty (20) Years
(Please Print or Type)

Name of Children Who Have Lived With You
(Please Print or Type)

(Applicants Date of Birth)

(Current Street Address/City/Zip-**Do Not** use a PO Box #)

(Witness Signature)

(Date Witnessed)

This release becomes void ninety (90) days after signature by Applicant/Employee

MEMORIAL HEALTH CARE SYSTEMS

SEWARD, NE 68434