Adair County Health System
we surround you with care

Application for Employment

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

Human Resources Department
609 SE Kent Street
Greenfield, Iowa 50849

www.adaircountyhealthsystem.org
email: afrankl@adaircountyhealthsystem.org

Date:_____

Last Name	**First Name**	**Middle**	**Are You at Least 18 yrs old?** ☐ Yes ☐ No

Social Security Number
DO NOT COMPLETE IF SUBMITTING BY UNSECURED EMAIL

Present Street address	**Apart.No.**	**Present City**	**Present State**	**Present Zip Code**

Home Phone	**Business or Number for Messages**	**E-mail Address**

Position(s) Applied For:

1.

2.

Date Available for Employment:

_____/_____/_____

Applying For:
Check All That Apply

☐ **Full-Time** ☐ **Part-Time**
☐ **PRN** ☐ **Temporary**
☐ **Weekend Option**

Shift Preference:_____

Check all that you are willing to work:

☐ **Days** ☐ **Evening** ☐ **Nights** ☐ **Weekends**

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**
Relationship	**Telephone Number**	**Address**
Name	**Occupation**	**Organization**
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:** ____/____/____