



ST. FRANCIS HEALTH CARE CENTRE

401 North Broadway Green Springs, OH 44836 (419) 639-2626 FAX (419) 639-6221

APPLICATION FOR EMPLOYMENT

(Please Print Clearly)

Today's Date: _____ Date Available to Start Work: _____

NAME: _____
Last First Middle

ADDRESS: _____
Street P.O. Box # City State Zip Code

TELEPHONE NO. () _____ County _____ Date of Birth _____
if under 18

Previously employed here? Yes No If yes, under what name? _____

If yes, Dates: FROM _____ TO _____ FROM _____ TO _____

POSITION DESIRED: 1) _____ 2) _____

Shift Preference: First (days) Part Time Interim (Temporary) Contingency
 Second (afternoons) Full Time Dates Available:
 Third Either FROM: _____ TO: _____

Would you: Rotate Shifts (if needed) Yes No Work overtime (if needed) Yes No

PROFESSIONAL LICENSE, REGISTRATION, AND/OR CERTIFICATION(S): Type: _____

Date Expires: _____ Organization or State Issued By: _____ Number: _____

Have you ever been convicted of a crime (misdemeanor or felony)? Yes No If yes, please explain: _____

Please note that background checks are performed. Disclosure of a criminal record will not necessarily disqualify you for employment.

What or who prompted you to apply here? _____

Are you related to a St. Francis employee? Yes No If yes, who: _____

EDUCATION:	SCHOOL NAME	LOCATION (CITY, STATE)	SUBJECTS/MAJOR	LAST GRADE COMPLETED	GRADE POINT AVERAGE
High School/					
Vocational:					
College/					
University:					
Nursing					
Education:					
Other:					

This application is current only for six (6) months, at the conclusion of which time, if you have not heard from us and still wish to be considered for employment, it will be necessary for you to fill out a new application.

Applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, disability, marital or veteran status.

PERSONAL REFERENCES (not relatives):

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

WORK HISTORY REFERENCES (most recent):

Company Name: _____ **Complete Address:** _____

Dates Employed: FROM _____ TO _____ Salary Range: START _____ END _____ Supervisor Name: _____

Position and Duties: _____
Reason for Leaving: _____

Company Name: _____ **Complete Address:** _____

Dates Employed: FROM _____ TO _____ Salary Range: START _____ END _____ Supervisor Name: _____

Position and Duties: _____
Reason for Leaving: _____

Company Name: _____ **Complete Address:** _____

Dates Employed: FROM _____ TO _____ Salary Range: START _____ END _____ Supervisor Name: _____

Position and Duties: _____
Reason for Leaving: _____

If I am employed, I understand that I will be given a physical examination, drug screen and a TB test, and will need proof of negative results of both tests. Any falsifications on my application and medical history form may be considered cause for discharge by the employer. I also agree that if I am employed I will serve to the best of my ability and to abide by the policies and mission established by the Facility. I understand that nothing in this employment application or in the granting of an interview is intended to create an employment contract between St. Francis Health Care Centre and me.

Signature: _____

REFERENCE CHECK:

Name of Company/Individual	Date Sent	Date Received

_____ Hired: _____ Date to Start: _____ Position: _____

Full Time Part Time _____/pp Contingency Interim

Shift: _____ Unit/Dept.: _____

Rate: \$ _____ Hourly Salaried Replacing: _____

PHYSICAL: Date: _____ Time: _____