McKENZIE HEALTH SYSTEM
Experience Our Difference

APPLICATION FOR EMPLOYMENT

(Pre-Employment Questionnaire)

McKenzie Health System offers equal employment opportunity to all qualified persons, without regard to race, religion, color, national origin, age, sex, height, weight, familial status, marital status, disability, or any other characteristic protected by law. Assistance will be provided to you in completing this application and/or job interview upon request.

PERSONAL INFORMATION (PLEASE PRINT) DATE

NAME
LAST FIRST MIDDLE

OTHER NAME(S) IF ANY, UNDER WHICH YOU HAVE WORKED OR ATTENDED SCHOOL

ADDRESS
STREET Apt. # CITY STATE ZIP

PHONE NO. ( ) ARE YOU 18 YEARS OR OLDER? ☐ YES ☐ NO

EMAIL ADDRESS

HOW DID YOU LEARN ABOUT US?
☐ Friend ☐ Advertisement ☐ Employment Agency ☐ Walked in ☐ College Placement Source ☐ Other

DO YOU HAVE ANY PAST OR CURRENTLY PENDING FELONY CHARGES, IN EITHER FEDERAL OR STATE COURT AGAINST YOU? ☐ Yes ☐ No Please Explain:

ARE YOU LEGALLY ELIGIBLE FOR WORK IN THE UNITED STATES ☐ Yes ☐ No If you are not a U.S. Citizen, please list the type of VISA you possess and the expiration date:

HAVE YOU EVER BEEN TEMPORARILY OR PERMANENTLY INELIGIBLE OR EXCLUDED FROM PARTICIPATION IN MEDICARE, MEDICAID OR ANY OTHER FEDERAL OR STATE HEALTHCARE PROGRAM?
☐ Yes ☐ No If yes, please explain the cause or reason for exclusion or ineligibility, the date of exclusion, the jurisdiction, any penalty, and any other relevant information:

TO YOUR KNOWLEDGE, HAVE ANY OF YOUR PRIOR EMPLOYERS BEEN TEMPORARILY OR PERMANENTLY INELIGIBLE OR EXCLUDED FROM PARTICIPATION IN MEDICARE, MEDICAID OR ANY OTHER FEDERAL OR STATE HEALTHCARE PROGRAM?
☐ Yes ☐ No If yes, to the best of your ability, please indicate which employer, the dates of exclusion, and any other relevant information:

EMPLOYMENT DESIRED

POSITION APPLYING FOR DATE YOU CAN START

TYPE OF EMPLOYMENT DESIRED:
☐ Full Time ☐ Part Time ☐ Temporary ☐ Summer Only (Specify Dates Available)

SHIFT PREFERENCE: ☐ Days ☐ Afternoons ☐ Nights ☐ Any

ARE YOU EMPLOYED NOW? ☐ Yes ☐ No If so, may we inquire of your present employer? ☐ Yes ☐ No

CAN YOU TRAVEL IF A JOB REQUIRES IT? ☐ Yes ☐ No

EVER APPLIED AT MCKENZIE HEALTH SYSTEM BEFORE? ☐ Yes ☐ No If yes, WHEN?

EVER BEEN EMPLOYED BY MCKENZIE HEALTH SYSTEM BEFORE? ☐ Yes ☐ No If yes, WHEN?

EDUCATION	Name and Address of School	# of Years Completed	Did you Graduate?	COURSE OF STUDY	LIST DEGREE COMPLETED
HIGH SCHOOL					
COLLEGE					
COLLEGE					
COLLEGE					
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL					

If you are registered or certified in a profession or trade, please indicate the following:

PROFESSION OR TRADE:_____

LICENSE OR REGISTRY NUMBER (OR ATTACH A COPY):_____

STATE:_____ EXPIRATION DATE:_____

MILITARY

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK:		
U.S. MILITARY SERVICE	DATES RANK:	PRESENT MEMBERSHIP IN NATIONAL GUARD OR RESERVES?

EMPLOYMENT HISTORY (LIST ALL PREVIOUS EMPLOYERS, STARTING WITH THE MOST RECENT PLACE OF EMPLOYMENT)

DATE (month and year)	NAME AND ADDRESS OF EMPLOYER	HOURLY RATE/ SALARY	POSITION/ DUTIES	REASON FOR LEAVING	PHONE #
FROM TO					( )
FROM TO					( )
FROM TO					( )
FROM TO					( )
FROM TO					( )
FROM TO					( )

IF YOU NEED ADDITIONAL SPACE PLEASE CONTINUE ON A SEPARATE SHEET OF PAPER

PROFESSIONAL REFERENCES: GIVE THE NAME OF THREE PERSONS YOU HAVE WORKED UNDER THE DIRECTION OR SUPERVISION OF.

	Professional Reference #1	Professional Reference #2	Professional Reference #3
Name			
Phone			
Email Address			
Address			
Business			
Years Known			

PERSONAL REFERENCES: GIVE THE NAME OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST THREE YEARS.

	Personal Reference #1	Personal Reference #2	Personal Reference #3
Name			
Phone			
Email Address			
Address			
Business			
Years Known			
Relationship			

PHYSICAL RECORD: Do not answer this question unless you have been informed about the requirements of the job for which you are applying. DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT PRECLUDE YOU FROM PERFORMING ANY WORK FOR WHICH YOU ARE BEING CONSIDERED / APPLYING FOR? ☐ YES ☐ NO

If yes, what can be done to accommodate your limitation?_____

_____

_____

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME RELATIONSHIP PHONE NO.

I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR IMMEDIATE DISMISSAL.

I AUTHORIZE MCKENZIE HEALTH SYSTEM AND ITS AGENTS TO INVESTIGATE ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES LISTED ABOVE, INCLUDING RECORDS OF ANY FORMER EMPLOYERS, EDUCATIONAL INSTITUTIONS, POLICE DEPARTMENTS, CREDIT OR CONSUMER REPORTS, AND ANY OTHER REFERENCES OR SOURCES RELATED TO THIS APPLICATION. I AUTHORIZE ALL SUCH REFERENCES AND SOURCES TO RELEASE THIS INFORMATION WITHOUT LIABILITY FOR DAMAGE INCURRED IN PROVIDING IT, FURTHER, I RELEASE MCKENZIE HEALTH SYSTEM AND ITS AGENTS FROM LIABILITY AND DAMAGES RELATED TO OR ARISING OUT OF ANY REASONABLE BACKGROUND INVESTIGATIONS.

I UNDERSTAND THAT AN OFFER OF EMPLOYMENT WILL BE CONTINGENT UPON MY ABILITY TO DEMONSTRATE MY LEGAL RIGHT TO REMAIN AND WORK IN THE UNITED STATES.

I UNDERSTAND THIS APPLICATION IS CURRENT FOR ONLY 60 DAYS. AT THE CONCLUSION OF THIS TIME, IF I HAVE NOT HEARD FROM THE EMPLOYER AND STILL WISH TO BE CONSIDERED FOR EMPLOYMENT, IT WILL BE NECESSARY TO FILL OUT A NEW APPLICATION.

DATE: **SIGNATURE:** _____

MHS PERSONNEL ONLY

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY: DATE:

COMMENTS:

START DATE: DEPARTMENT: JOB CLASSIFICATION:

PAY GRADE LEVEL: STARTING WAGE: ☐ EXEMPT ☐ NON-EXEMPT

☐ REPLACEMENT ☐ TEMPORARY ☐ SUMMER ONLY ☐ DEPARTMENT TRANSFER

HOURS PER WEEK: SHIFT HOURS:

APPROVED FOR EMPLOYMENT: DATE:

(DEPARTMENT DIRECTOR/MANAGER SIGNATURE)

FINAL APPROVAL FOR EMPLOYMENT: DATE:

(HR ADMINISTRATOR OR DESIGNEE SIGNATURE)