MARQUETTE COUNTY MEDICAL CARE FACILITY
200 SAGINAW
ISHPEMING, MI 49849

APPLICATION FOR EMPLOYMENT

Personal Information Date of Application:_____ Date Available: _____

Name_____
Last First Middle

Present Address_____ Phone Number _____
Street City State Zip Code

Email Address_____

Are you legally eligible for employment in the United States? Yes_____ No_____

Employment Desired

- ☐ Full-time
- ☐ Part-time
- ☐ On-call/contingent

	Position	Shift	Salary
1st Choice			
2nd Choice			
3rd Choice			

☐ **I wish to be considered for next Nurse Aide Class**

How did you learn of this vacancy?_____

Are you currently employed? _____
May we contact your present employer? _____
If no, why?_____

Have you ever worked here before? _____
If yes, give most recent date: _____

Are you 18 years of Age or Older? _____

Education

Circle Level of Education Completed:
High School/GED Some College Associate's level Bachelor's level Graduate level

	Name of School	City, State	Field of Study	Date Completed	Degree Received
High School					
College					
Professional Education					

Professional Licenses and/or Certificates

Type	Organization or State Issued	Date Issued	Document Number

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Employment History (list last or present position first)

Name of Employer	Dates (From/To)	Position Held	Reason for Leaving
Name:	From:		
Address:	To:		
Supervisor:			
Phone: Email address:			
Name:	From:		
Address:	To:		
Supervisor:			
Phone: Email address:			
Name:	From:		
Address:	To:		
Supervisor:			
Phone: Email address:			
Name:	From:		
Address:	To:		
Supervisor:			
Phone: Email address:			

Please explain all periods of unemployment _____

_____

_____

_____

_____

If your former employment references, education or military service are under any name other than the name indicated on the front of the application, please indicate below.

_____

Lastname Firstname Middle Initial

It is required that we conduct fingerprint-based criminal background checks on all employees. Do you agree to participate in this? Yes___ No___

Do you agree to consent to a pre-employment physical and drug screen prior to hire? Yes___ No___

Have you ever been found guilty of, or disciplined or discharge for, neglect or abuse of a nursing home resident, or any other person, or misappropriation of their property? Yes___ No___

Have you ever been disciplined or discharge for theft, unauthorized removal of company property or related offenses? Yes___ No___

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Have you ever been disciplined or discharged for absenteeism, tardiness, failure to notify your employer when absent or any other attendance related reasons? Yes_____ No_____

Have you ever been disciplined or discharged for insubordination? Yes_____ No_____

Have you ever been disciplined or discharged for violating a safety rule(s)? Yes_____ No_____

If you answered yes to any of the preceding questions, please explain below:

References

Include individual's name, address, telephone number, email address, occupation and years known. *Do not use relatives.*

Name	Address	Telephone	Email	Occupation	Years Known

PLEASE BE SURE TO READ, SIGN AND DATE THE BACK PAGE

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Acknowledgement and Certification

All applicants will be given equal opportunity without unlawful regard for race, color, religion, national origin, sex, age, marital, dependent or veteran status, physical or mental disability, height, weight, or any other legally protected status. No question on this application is intended to secure information to be used for such discrimination.

I understand that if I have a disability, and need accommodation in any step of the hiring process, or to assist me in any demonstration (required of all applicants for the job) of qualifications to perform the duties of the job for which I am applying, I should inform the Personnel Office. Failure to notify Marquette County Medical Care Facility may preclude any claim that the Facility failed to reasonably accommodate my disability.

Any misrepresentation in this application or other information submitted by me, any refusal by me to sign lawfully required releases, consents, or waivers, and any failure by me to properly complete any lawfully required forms (I-9, W-4, etc.) may result in cancellation of this application for employment and/or separation from Marquette County Medical Care Facility's employ, if I have been employed.

I acknowledge that consideration for employment is contingent upon the results of a reference and background check and, if I am offered employment, that my employment is conditional until the results of any required criminal records checks and/or post-offer physicals are known. I hereby consent to required fingerprinting and criminal records checks and, should I be offered employment, to required post-offer physicals, including drug screening. I authorize you to investigate the truthfulness of all statements in this application or in connection with any post-offer physicals, to contact former employers and other listed references or any other persons who can verify information, and to discuss the results of any investigation with the employees of Marquette County Medical Care Facility involved in the hiring process. I give my consent for all contacted persons to provide any information concerning this application, including any post-offer physicals, and authorize release of information concerning disciplinary action without any obligation to give me written notice of such disclosure. I agree to execute any lawful releases, consents and waivers required by you. I hereby release you and any other person from any liability whatsoever as a result of such inquiries and disclosures.

I certify that I have read and understand the above stated policies and that I will, if I accept employment with Marquette County Medical Care Facility, comply with these and all other Facility policies, rules and regulations. Unless otherwise provided in writing, my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at the option of either Marquette County Medical Care Facility or myself. I understand that no representative of Marquette County Medical Care Facility, except by specific written authority of the Administrator, has authority to enter into any agreement of any specified time or make any agreement contrary to the foregoing.

I certify that I have read this entire application and all other information provided by me and that all information is true and correct.

Signature of Applicant _____ Date _____

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.

This application will be kept on active file for six (6) months.

Rev. 12/2018