**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 Are you currently employed? _____
☐ Part-time May we contact your present employer? _____
☐ On-call/contingent If no, why?_____

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

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

Are you 18 years of Age or Older? _____

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

How did you learn of this vacancy?_____

**Are you aware that this job may likely require Mandatory Overtime?**
Yes _____ No _____

## 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:<br>Email address: | | | |
| **Name:** | From: | | |
| Address: | To: | | |
| Supervisor: | | | |
| Phone:<br>Email address: | | | |
| **Name:** | From: | | |
| Address: | To: | | |
| Supervisor: | | | |
| Phone:<br>Email address: | | | |
| **Name:** | From: | | |
| Address: | To: | | |
| Supervisor: | | | |
| Phone:<br>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___

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

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 authorize Marquette County Medical Care Facility to contact the references listed on this application to discuss questions regarding my employment/character. I hereby release the references/Marquette County Medical Care Facility from liability or damages for providing such information.

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. 07/27/2023*

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**I, (Name of Applicant):_____,**

have applied to Marquette County Medical Care Facility (MCMCF) for employment. I respectfully request that you complete the following reference questionnaire. I hereby release you from any liability or damages for providing the reference information that is requested by MCMCF.

Signature of Applicant: _____

**Marquette County Medical Care Facility**

PROFESSIONAL REFERENCE REQUEST

The above named individual has applied for a position with Marquette County Medical Care Facility. **Please complete this form** and return to MCMCF as soon as possible. Thank you for your cooperation. Please rate the applicant in the following areas:

| | **Above Average** | **Average** | **Below Average** |
|---|---|---|---|
| Dependability: | _____ | _____ | _____ |
| Attendance: | _____ | _____ | _____ |
| Punctuality: | _____ | _____ | _____ |
| Knowledge of work: | _____ | _____ | _____ |
| Quality of work: | _____ | _____ | _____ |
| Quantity of work: | _____ | _____ | _____ |
| Initiative: | _____ | _____ | _____ |

**Would you rehire this employee?** Yes_____ No_____
If not, why?_____
_____

**Dates of employment with your organization:** From:_____ To:_____

Signature:_____ Title:_____

Organization:_____

Date:_____ Telephone:( )_____

**Please return to Human Resources**
**Email: mbazinette@mqtcmcf.org**
**Fax: 906-485-4080**
**Mail: 200 Saginaw Street, Ishpeming, MI 49849**