



Ortonville Area Health Services

Monitoring our Communities Health

Ortonville, MN 56278

- **Ortonville Hospital** 450 Eastvold Avenue
- **Northridge Residence** 1075 Roy Street
- **OAHS Home Health Agency** 450 Eastvold Avenue

Employment Application

PLEASE PRINT CLEARLY IN INK

ORTONVILLE AREA HEALTH SERVICES EMPLOYMENT APPLICATION

POSITION APPLIED FOR: _____

Date of Application: _____

PERSONAL

LAST NAME		FIRST NAME		M. I.	SOCIAL SECURITY #	
HOME ADDRESS		APT #	CITY		STATE	ZIP CODE
TEL # with Area Code		ARE YOU A U.S. CITIZEN Yes No IFNO, VISA TYPE AND #			IS YOUR AGE UNDER 18 Yes No	
List any reason known to you why you might not be able to perform consistently and promptly any of the duties applied for:						
DATE AVAILABLE	STARTING SALARY NEEDED		WILL YOU ACCEPT ANOTHER POSITION Yes No IF YES, PLEASE SPECIFY:			
HAVE YOU PREVIOUSLY BEEN EMPLOYED AT ANY DIVISION OF OAHS? Yes no IF YES, WHAT DEPT? _____ WHEN? _____						
HAVE YOU EVER BEEN CONVICTED OF A CRIME? Yes No IF YES, GIVE DATE(S), OFFENSE(S), AND DISPOSITION:			DO YOU HAVE A FRIEND OR RELATIVE WORKING HERE? Yes No NAME DEPT. RELATIONSHIP			

EMPLOYMENT HISTORY

Please list **MOST RECENT** position first

FROM Mo Yr	NAME OF EMPLOYER	NAME/LAST SUPERVISOR	TEL #
TO Mo Yr	ADDRESS: Street City State	POSITION HELD	ENDING SALARY _____per _____
Briefly describe the work you performed			
Reason for LEAVING?			
LIST OTHER NAMES USED WHILE W/THIS EMPLOYER		MAY WE CONTACT THIS EMPLOYER? Yes No	
FROM Mo Yr	NAME OF EMPLOYER	NAME/LAST SUPERVISOR	TEL #
TO Mo Yr	ADDRESS: Street City State	POSITION HELD	ENDING SALARY _____per _____
Briefly describe the work you performed			
Reason for LEAVING?			
LIST OTHER NAMES USED WHILE W/THIS EMPLOYER		MAY WE CONTACT THIS EMPLOYER? Yes No	
FROM Mo Yr	NAME OF EMPLOYER	NAME/LAST SUPERVISOR	TEL #
TO Mo Yr	ADDRESS: Street City State	POSITION HELD	ENDING SALARY _____per _____
Briefly describe the work you performed			
Reason for LEAVING?			
LIST OTHER NAMES USED WHILE W/THIS EMPLOYER		MAY WE CONTACT THIS EMPLOYER? Yes No	

EDUCATION

SCHOOL	NAME OF SCHOOL LOCATION	# of YEARS COM- PLETED	COURSE OF STUDY	DID YOU GRAD- UATE?	DIPLOMA or DEGREE?	TYPE OF DIPLOMA/ DEGREE
ELEMENTARY				Yes No	Yes No	
HIGH SCHOOL				Yes No	Yes No	
TRADE				Yes No	Yes No	
COLLEGE				Yes No	Yes No	
GRADUATE				Yes No	Yes No	
PROFESSIONAL				Yes No	Yes No	
BUSINESS				Yes No	Yes No	
OTHER				Yes No	Yes No	

LIST OF HEALTH CARE, BUSINESS, OR INDUSTRIAL EQUIPMENT THAT YOU OPERATE PROFICIENTLY:

LANGUAGE SKILLS (where related to the position sought)

LANGUAGE	Do you SPEAK GOOD FAIR FLUENT	Do you READ GOOD FAIR FLUENT	Do you WRITE GOOD FAIR FLUENT
LANGUAGE	Do you SPEAK GOOD FAIR FLUENT	Do you READ GOOD FAIR FLUENT	Do you WRITE GOOD FAIR FLUENT

Professional Licenses, Registrations, and/or Certifications

DO NOT INCLUDE DRIVER'S LICENSE

TYPE	STATE ISSUED	DATE ISSUED	EXPIRES	NUMBER	ELIGIBLE
TYPE	STATE ISSUED	DATE ISSUED	EXPIRES	NUMBER	ELIGIBLE
TYPE	STATE ISSUED	DATE ISSUED	EXPIRES	NUMBER	ELIGIBLE
TYPE	STATE ISSUED	DATE ISSUED	EXPIRES	NUMBER	ELIGIBLE

APPLICANT'S CERTIFICATION

I certify that all matters contained in this application are true and agree that any misleading or false statements would render this application void and would be sufficient cause for immediate dismissal in the event of employment.

I further understand that this is an application for employment and that no employment contract is being offered.

I agree, if employed, to abide by all Ortonville Area Health Services rules and regulations. I understand that such employment is for an indefinite period of time and that the company can change wages, benefits, and conditions of employment at any time.

I hereby authorize OAHS to investigate all matters contained in this application and to contact prior employers to obtain any and all information related to my past work performance.

I have read and understand the above.

SIGNATURE: _____ DATE _____

For office use only:

POSITION HIRED FOR _____

DATE HIRED _____ STARTING WAGE _____ PER _____

SCHEDULED HOURS _____ PER WEEK COST CENTER _____ EMPL TYPE CODE _____

APPROVED BY _____ TITLE _____

Please list at 3-4 REFERENCES that we [OAHS] may contact.

- Please include at least 2 professional references.
- Personal references may not be relatives.

Company Name: _____
Contact: _____
Address: _____
City/State/Zip: _____
Phone # _____ Fax # _____
E-mail: (optional) _____

Company Name: _____
Contact: _____
Address: _____
City/State/Zip: _____
Phone # _____ Fax # _____
E-mail: (optional) _____

Company Name: _____
Contact: _____
Address: _____
City/State/Zip: _____
Phone # _____ Fax # _____
E-mail: (optional) _____

Company Name: _____
Contact: _____
Address: _____
City/State/Zip: _____
Phone # _____ Fax # _____
E-mail: (optional) _____

I authorize Ortonville Area Health Services to check these references that I have provided as required as part of the interview process.

Your Signature

Date