

Application for Employment

Thank you for your interest in employment with our organization. We are an equal opportunity employer and give employment and promotional consideration without regard to race, color, sex, religion, age, national origin, marital or veteran status, disability, sexual orientation, gender identity, or any other protected class as defined by local, state, or federal law. We seek applicants for employment who are qualified, dedicated, hardworking, and who seek fulfilling employment.

Applicants seeking reasonable accommodation in the application and/or interview process should contact the hiring manager.

Applicants may be subject to a background check and drug testing. If applicable, employment is conditional based upon the results of the background and drug screenings.

Applications are active for 30 days, but remain on file for one year.

PERSONAL INFORMATION			
Name:		Date of Application:	
Address:		Phone:	
City, State, Zip:		Email:	
Are you 18 years or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Upon employment, can you provide genuine documentation establishing your identity and employment eligibility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYMENT DESIRED			
Availability:		Position Desired:	
<input type="checkbox"/> Full time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary <input type="checkbox"/> Weekdays <input type="checkbox"/> Weekends		Date you can start:	
<input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Nights <input type="checkbox"/> Varies			
Referred by:		Pay Desired:	
Have you ever applied to this company before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where and when?	
EDUCATION			
Did you graduate from High School or receive an equivalent degree? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other Formal Education	Name of School, City, and State	Degree Obtained	
HIGHEST LEVEL			
SECOND HIGHEST LEVEL			
THIRD HIGHEST LEVEL			
PROFESSIONAL TRAINING OR CERTIFICATIONS			
GENERAL			
<small>Omit any organization or activity which reflects your race, color, sex, religion, age, national origin, marital or veteran status, disability, sexual orientation, gender identity, or any other protected class as defined by local, state, or federal law.</small>			
List any special course, seminars, training or volunteer experience that relates to the position for which you are applying.			
List any professional, trade, or civic organizations that relate to the position for which you are applying.			
List any additional information you feel may be helpful to us in considering your application:			

FORMER EMPLOYERS				List your last three employers, starting with most recent. "See Attached Resume" is not accepted.			
Dates of Employment			Name of Employer:				
From:		To:		Employer Address:			
Last Position Held:							
Reason for Leaving:							
List jobs held, duties performed, skills used or learned, advancements, or promotions, and what you liked most and least about this job.							
Dates of Employment			Name of Employer:				
From:		To:		Employer Address:			
Last Position Held:							
Reason for Leaving:							
List jobs held, duties performed, skills used or learned, advancements, or promotions, and what you liked most and least about this job.							
Dates of Employment			Name of Employer:				
From:		To:		Employer Address:			
Last Position Held:							
Reason for Leaving:							
List jobs held, duties performed, skills used or learned, advancements, or promotions, and what you liked most and least about this job.							
PROFESSIONAL REFERENCES				Provide Names Of Three Non-Relative Professional References, Whom You Have Known For At Least 1 Year.			
Name		Phone		Business / Relationship		Years Acquainted	

I certify that the above information is true and correct and give authorization for investigation of all statements and information contained in this application, my resume, and other documents or verbally obtained during an employment interview. I voluntarily consent to allow the Employer or any of its designated representatives or agents to check my references by contacting any persons, company or governmental entity they deem to be an appropriate reference. I understand these questions may pertain to my personal or educational background, work experience, character and behavior. I understand my employment is subject to satisfactory verification of this information and agree that deliberate falsification of this document or significant omissions shall be grounds for employment consideration disqualification or dismissal from employment, if discovered at a later date.

I understand that completion of this Application for Employment does not imply or guarantee employment. All employment with the Employer is at-will and as such the relationship may be terminated by either the Employer or myself, at any time, with or without notice and with or without cause. I understand that company policies, procedures, practices or statements made during an interview or employment do not create an employment contract by implication or otherwise.

This application will be active for thirty days. If not contacted during that period of time, it may be necessary to complete another application to receive further employment consideration.

Applicant's Signature _____ Date _____



State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City: _____ State: _____ Zip Code _____

Other Names Used _____ Telephone _____

States Where You Have Lived? _____

Male Female Race _____ Height _____ Weight _____ Date of Birth _____ Social Security Number _____

(Enter a letter from below)

Hair Color _____ Eye Color _____ Place of Birth _____

- | | |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Race | A Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander
B Black or African American (Not Hispanic or Latino)
H Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
I American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
U Of undeterminable race. Of Untold mixture.
W Caucasian (not Hispanic or Latino) |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Have you ever had an administrative finding of Abuse, Neglect or Theft? Yes No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? Yes No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

(Signature)

(Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

(Signature of Parent or Guardian when applicable)

(Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****