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# APPLICATION FOR EMPLOYMENT

NAME

LAST

FIRST

MIDDLE INITIAL

POSITION

DATE

 CATHOLIC HEALTH  
INITIATIVES

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St. Joseph's Hospital and Health Center

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30 West Seventh Street Dickinson, ND 58601-4399

AN EQUAL OPPORTUNITY EMPLOYER

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**DEMOGRAPHICS**

Last Name	First	Middle	
Present Address	City	State/Zip Code	Telephone Numbers Home: Work: Cell: Fax: E-mail:
Mailing Address (if different)			Salary Desired
Position and Department Applying For (must be completed in order for application to be valid)			Applying for: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary <input type="checkbox"/> On Call
How were you referred to this facility?			Date Available for Work:
Relatives employed in this facility? ___Yes ___No List Name(s)/Department(s):			Would you consider: (Circle all that apply) Overtime Yes No Weekends Yes No Rotating Shifts Yes No On Call Yes No Holidays Yes No Any Shift Yes No
Have you ever been employed by this facility? (When)		Are you younger than 18 years old? _____	
Are you prevented from lawful employment because of your Visa or immigration status? <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate Visa type or other immigration status if applicable Visa type _____ Other _____			
(Proof of citizenship or immigration status will be required upon your employment)			
Have you been convicted of a felony within the last 7 years? Yes <input type="checkbox"/> No <input type="checkbox"/> (Conviction will not necessarily disqualify applicant from employment.)			
If yes, please explain _____			

**EDUCATION/SKILLS**

SCHOOL	NAME OF SCHOOL COMPLETE ADDRESS OF SCHOOL	COURSE OF STUDY	DID YOU GRADUATE?	LIST DIPLOMA OR DEGREE
HIGH				
COLLEGE				
COLLEGE				
OTHER: Business College, Other Special Courses:				
Area of Specialization or Major Interest			TYPING: APPROX. WPM	
List Health Care, Business or Industrial Equipment Operated:			PROGRAMS AND WORK EXPERIENCE:	
			<input type="checkbox"/> Word <input type="checkbox"/> Access <input type="checkbox"/> Excel <input type="checkbox"/> Publisher <input type="checkbox"/> Meditech	
SPECIAL SKILLS AND QUALIFICATIONS: Summarize special skills and qualifications acquired from employment or other experience:				

**LICENSURE**

**PROFESSIONAL LICENSES AND/OR CERTIFICATIONS**

Are you currently:  Registered  Licensed  Certified  
 Eligible for:  Registration  Licensure  Certification

Type	State Issued	Date:	No.
Type	State Issued	Date:	No.
Type	State Issued	Date:	No.

**MEMBERSHIP IN PROFESSIONAL OR CIVIC ORGANIZATIONS**  
 (Exclude those that may disclose your age, race, color, religion or national origin) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PLEASE LIST NAME, ADDRESS AND PHONE NUMBER OF PREVIOUS EMPLOYERS WITH <b><i>MOST RECENT EMPLOYER FIRST.</i></b>	FROM	TO	IMMEDIATE SUPERVISOR	LAST SALARY (per hour)
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JOB TITLE: _____				
EMPLOYER NAME AND ADDRESS _____ _____				
PHONE NUMBER _____				
DUTIES: _____ _____				
REASON FOR LEAVING: _____				

JOB TITLE: _____				
EMPLOYER NAME AND ADDRESS _____ _____				
PHONE NUMBER _____				
DUTIES: _____ _____				
REASON FOR LEAVING: _____				

JOB TITLE: _____				
EMPLOYER NAME AND ADDRESS _____ _____				
PHONE NUMBER _____				
DUTIES: _____ _____				
REASON FOR LEAVING: _____				

**PREVIOUS EXPERIENCE**

**REFERENCES**

LIST AT LEAST THREE (3) PROFESSIONAL REFERENCES WHO ARE NOT RELATIVES			
NAME	TITLE	EMPLOYER	TELEPHONE

**SIGNATURE**

**CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW.**

I understand that my employment can be terminated at any time with or without cause, at the option of either the facility or me. I understand that no one has any authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing, except for a written employment agreement signed by the President/CEO of this facility.

I understand if I work in a position that involves Medicare and/or Medicaid, and it is identified that I was convicted of Medicare/Medicaid fraud, this is just cause for immediate termination.

I hereby affirm that the information provided on this application (and accompanying resume, if any) is true and complete. I understand that any false or misleading representations or omissions may disqualify me from further consideration for employment and may result in discharge even if discovered at a later date.

I hereby authorize persons, schools, my current employer (if applicable), Law Enforcement and previous employers and organizations named in this application (and accompanying resume, if any) to provide this facility and all affiliates with any relevant information regarding an employment decision, and I release all such persons from any liability regarding the provision or use of such information.

All job offers are contingent upon the review of references, background checks, OIG Excluded Providers, and other relevant information. Any misleading or incorrect statements, omissions or failure to disclose any health care related criminal conviction or any threatened or actual debarment, exclusion or other ineligibility of participation in federally funded health care programs *may* remove this application from further consideration for employment and, if employed, may be cause for termination. **I therefore authorize St. Joseph’s Hospital and Health Center to complete a criminal reference/history check.**

\_\_\_\_\_  
Signature