Ortonville Area Health Services

Ortonville , MN 56278

- **Ortonville Hospital** 450 Eastvold Avenue
- **Northridge Residence** 1075 Roy Street
- **Northside Medical Clinic** 450 Eastvold Avenue
- **OAHS Home Health Agency** 450 Eastvold Avenue
- **Fairway View Senior Communities** 215 Lundell Avenue

Employment Application

OAHS is an Equal Opportunity Employer

PLEASE PRINT CLEARLY IN INK

ORTONVILLE AREA HEALTH SERVICES

EMPLOYMENT APPLICATION

POSITION(s) APPLIED FOR: ________________________________ Date of Application: ____________________

PERSONAL

LAST NAME	FIRST NAME	M. I.	

HOME ADDRESS	APT #	CITY	STATE	ZIP CODE

TEL # with Area Code	ARE YOU A U.S. CITIZEN Yes ☐ No ☐ IF NO, 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?_______________

DO YOU HAVE A FRIEND OR RELATIVE WORKING HERE? Yes ☐ No ☐

NAME	DEPT.	RELATIONSHIP	NAME	DEPT.	RELATIONSHIP

EMPLOYMENT HISTORY (attach additional page if needed)

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 GRADUATE?	DIPLOMA or DEGREE?	TYPE OF DEPLOMA/ 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☐	certi

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

LANGUAGE SKILLS (where related to the position sought)

LANGUAGE	Do you **SPEAK**	Do you **READ**	Do you **WRITE**
english	☐ FAIR ☐ GOOD ■ FLUENT	☐ FAIR ☐ GOOD ■ FLUENT	☐ FAIR ☐ GOOD ☐ FLUENT
spanish	☐ FAIR ☐ GOOD ☐ FLUENT	☐ FAIR ☐ GOOD ☐ FLUENT	☐ FAIR ☐ GOOD ☐ FLUENT

Professional Licenses, Registrations, and/or Certifications * DO NOT INCLUDE DRIVER'S LICENSE

TYPE	STATE ISSUED	DATE ISSUED	EXPIRES	NUMBER	ELIGIBLE
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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. I understand my electronic signature is accepted as a handwritten signature for the purpose of this application.

SIGNATURE: _____ DATE _____

For office use only:

POSITION HIRED FOR _____

DATE HIRED _____ STARTING WAGE _____ PER _____

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

APPROVED BY _____ TITLE _____

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

- Professional references may be supervisors, co-workers, or those you've supervised
- A personal reference may be used *only* when there is no work history; i.e. a high school student might list a teacher or coach.
- References may not be a relative.

Company Name: _____

Contact: _____

Address: _____

City/State/Zip:_____

Daytime Phone # _____ Fax # _____

E-mail: (optional)_____

Company Name: _____

Contact: _____

Address: _____

City/State/Zip:_____

Daytime Phone # _____ Fax # _____

E-mail: (optional)_____

Company Name: _____

Contact: _____

Address: _____

City/State/Zip:_____

Daytime Phone # _____ Fax # _____

E-mail: (optional)_____

Company Name: _____

Contact: _____

Address: _____

City/State/Zip:_____

Daytime Phone # _____ Fax # _____

E-mail: (optional)_____

☐ (Check here to verify the statements below.)

I authorize Ortonville Area Health Services to check these references that I have provided as required as part of the interview process. I understand my electronic signature is accepted as a handwritten signature for the purpose of this application.

_____ _____

Applicant's Signature Date

Submit