



Ortonville Area Health Services

Monitoring our Communities Health

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

Employment Application

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 <input type="checkbox"/> No <input type="checkbox"/>			IS YOUR AGE UNDER 18	
		IF NO, VISA TYPE AND #			Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> No <input type="checkbox"/>		
				IF YES, PLEASE SPECIFY:		
HAVE YOU PREVIOUSLY BEEN EMPLOYED AT ANY DIVISION OF OAHs? Yes <input type="checkbox"/> No <input type="checkbox"/>						
IF YES, WHAT DEPT? _____ WHEN? _____						
DO YOU HAVE A FRIEND OR RELATIVE WORKING HERE? Yes <input type="checkbox"/> No <input type="checkbox"/>						
NAME		DEPT.		RELATIONSHIP		

EMPLOYMENT HISTORY (attach additional page if needed)

Please list ***MOST RECENT*** position first

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

EDUCATION

SCHOOL	NAME OF SCHOOL LOCATION	# of YEARS COM- PLETED	COURSE OF STUDY	DID YOU GRADUATE?	DIPLOMA or DEGREE?	TYPE OF DIPLOMA/ DEGREE
ELEMENTARY				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
HIGH SCHOOL				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
TRADE				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
COLLEGE				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
GRADUATE				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
PROFESSIONAL				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
BUSINESS				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
OTHER				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

LANGUAGE SKILLS (where related to the position sought)

LANGUAGE	Do you SPEAK <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	Do you READ <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	Do you WRITE <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT
LANGUAGE	Do you SPEAK <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	Do you READ <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	Do you WRITE <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT

Professional Licenses, Registrations, and/or Certifications

* DO NOT INCLUDE DRIVER'S LICENSE

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 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) _____

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

Applicant's Signature

Date