CLOUD COUNTY HEALTH CENTER
1100 Highland Drive
Concordia, Kansas 66901
(785) 243-1234
FAX (785) 243-8411

FOR OFFICE USE ONLY: Date Received ____________
Routed To ______ ______ ______ Date ____________
Employment Date ____________ FTE ______
Department ____________ Rate ______
Position ____________

NAME: ______________________________ Social Security Number: ____________ Date: ____________
Last First Middle

ADDRESS: ______________________________ Telephone Number: ____________
Number Street City State Zip

POSITION DESIRED: ____________ Full Time ______ Part Time ______ Temporary ______ Date Available ______

SHIFT DESIRED: 7AM - 3PM ______ 8AM - 4PM ______ 3PM - 11PM ______ 11PM - 7AM ______ 12 Hour Shifts: AM ______ PM ______ Weekends ______

EDUCATION
Circle highest grade completed in Elementary or High School

1 2 3 4 5 6 7 8 9 10 11 12

College / University
Tech Schools

____________ Name ____________ Major / Course of Study ____________ Degree Received

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Professional Licenses. Registration, and/or certificate: Type ____________ Effective Date ____________ Number ____________

Have you ever been convicted of a felony? ______ Yes ______ No If yes, Explain ____________

In Case of Accident Notify: ____________ Name ____________ Address ____________ Telephone

Relatives Employed by the Health Center: ____________ Name ____________ Department ____________ Relationship

Have you ever been employed by Cloud County Health Center? ______ Yes ______ No If yes, Explain ____________

Employment History: May we check with your present employer? _____ Yes _____ No

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EMPLOYER ____________________ ADDRESS ____________________ PHONE ____________

POSITION ____________________ EMPLOYMENT PERIODS: FROM ____________________ TO ____________________

Month Day Year Month Day Year

SUPERVISOR ____________________ PRINCIPLE DUTIES: ____________________

REASON FOR LEAVING: ____________________

EMPLOYER ____________________ ADDRESS ____________________ PHONE ____________

POSITION ____________________ EMPLOYMENT PERIODS: FROM ____________________ TO ____________________

Month Day Year Month Day Year

SUPERVISOR ____________________ PRINCIPLE DUTIES: ____________________

REASON FOR LEAVING: ____________________

EMPLOYER ____________________ ADDRESS ____________________ PHONE ____________

POSITION ____________________ EMPLOYMENT PERIODS: FROM ____________________ TO ____________________

Month Day Year Month Day Year

SUPERVISOR ____________________ PRINCIPLE DUTIES: ____________________

REASON FOR LEAVING: ____________________

PROFESSIONAL REFERENCES

NAME ____________________ ADDRESS ____________________ TELEPHONE ____________

NAME ____________________ ADDRESS ____________________ TELEPHONE ____________

NAME ____________________ ADDRESS ____________________ TELEPHONE ____________

Please read before signing the application:

Cloud County Health Center is an equal opportunity employer. Cloud County Health Center does not discriminate because of race, color, religion, sex, national origin, ancestry, disability, marital status or age in employment.

I authorize any educational institution and my former employers to provide any information they may have regarding me in their records. I hereby release them, their employees and Cloud County Health Center from all liabilities for any damage whatsoever for providing or obtaining same.

I certify that the information in the application is complete and current to the best of my knowledge and I understand that Cloud County Health Center shall not be liable in any respect if my employment is terminated because of false statements, answers or omissions made by me on this application.

I agree if employed by Cloud County Health Center to be paid in accordance with the Fair Labor Standards Act adopted by my department. The law allows hospitals two options: (1) the payment of time and one-half after 40 hours of work in a work week and (2) the payment of overtime for all hours worked in excess of 80 hours in a 14-day work period or any hours in excess of 8 hours a day, not on both. The law provides that an employee may be paid every two weeks.

I hereby agree if employed by Cloud County Health Center to abide by the rules and policies of Cloud County Health Center.

I understand that my application will remain in the active file for a period of six months from the date of application and must be updated every six months to remain in the active file.

The employee and Cloud County Health Center have a right to freely enter into the employment relationship and sever this relationship at any time for any reason.

The Immigration Reform and Control Act of 1986 requires all employers to verify IDENTITY and EMPLOYMENT AUTHORIZATION for all employees.

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(SIGNATURE OF APPLICANT)