

**COMMUNITY MEMORIAL HOSPITAL DISTRICT  
APPLICATION FOR EMPLOYMENT**

1579 MIDLAND STREET – SYRACUSE, NE 68446

PHONE (402) 269-7611 FAX (402) 269-7617

Community Memorial Hospital provides equal employment opportunity to all applicants without regard to political affiliation, race, color, religion, national origin, gender, age, marital or veteran status, or mental or physical disability.

APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date Available	Social Security No.	Desired Salary	
Position Applied for			
How did you learn about this job?			
Are you a citizen of the United States?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you ever worked for our organization?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?
Have you ever been convicted of a felony?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain

EDUCATION			
High School		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	
College		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree
Other		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree

REFERENCES	
<i>Please list three professional references.</i>	
Full Name	Relationship
Company	Phone (     )
Address	
Full Name	Relationship
Company	Phone (     )
Address	
Full Name	Relationship
Company	Phone (     )
Address	

**PREVIOUS EMPLOYMENT**

A RESUME DOES NOT REPLACE THE INFORMATION REQUIRED TO BE COMPLETED IN THIS SECTION OF THE APPLICATION.  
BEGIN WITH YOUR MOST RECENT EMPLOYER.

Company		Phone ( )	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Company		Phone ( )	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Company		Phone ( )	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Company		Phone ( )	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>			

**ADDITIONAL INFORMATION**

List all job-related skills and qualifications acquired from previous employment or other experience.

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**DISCLAIMER AND SIGNATURE**

I certify that my answers are true and complete to the best of my knowledge. I understand that any material omission of facts or misrepresentation may result in my discharge, if hired, regardless of when discovered. I understand that unless otherwise defined by applicable law, any employment relationship with this company is of an "at will" nature, which means that the employee may resign at any time and the employer may discharge the employee at any time with or without cause. I grant permission to Community Memorial Hospital to investigate my work references and release them and any former employer from any and all liability resulting from such investigation. Upon my termination, I authorize the release of reference information on my work. I agree to submit to a post-offer physical, including drug and/or alcohol screening and recognize employment is contingent upon successfully meeting those requirements. I further agree that if I've been convicted of a crime, Community Memorial Hospital may obtain the details of my conviction to determine its relationship to the position I'm applying for as a condition of my employment. I grant permission to Community Memorial Hospital to verify my employment record, educational record, criminal record, and other records to verify the information I have provided on this application and/or any additional information I have provided and release Community Memorial Hospital from any liability resulting from such investigation.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**APPLICATIONS NOT SIGNED WILL NOT BE CONSIDERED**

**DO NOT WRITE IN THIS BOX**

FINAL INTERVIEW BY \_\_\_\_\_ DEPT. \_\_\_\_\_ DATE \_\_\_\_\_

STARTING DATE \_\_\_\_\_ STARTING RATE \_\_\_\_\_ SALARY \_\_\_\_\_ HOURLY \_\_\_\_\_

JOB TITLE \_\_\_\_\_ FULL TIME \_\_\_\_\_ PART TIME \_\_\_\_\_ LESS THAN PT \_\_\_\_\_

ANY ADDITIONAL NOTES \_\_\_\_\_

\_\_\_\_\_



**NOTICE/AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT**

I understand that Company may now, or at any time while employed, verify information within the application, resume or contract for employment. The verifications and/or checks may include but not limited to: driving record, workers compensation records, credit bureau files, employment references, personal references, any educational and licensing institution and to receive any criminal record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any State. A photocopy or telephonic facsimile (Fax) of this Disclosure and Consent authorization for Release of Information shall be valid as the original. The results of this verification process will be used to determine employment eligibility. All results will be kept CONFIDENTIAL. The information obtained will not be provided to any parties other than to the designated Company personnel.

I have carefully read and understand this disclosure and consent form and by my signature consent to the release of consumer or investigative consumer reports, as defined above in conjunction with my application for employment. I further understand this consent will apply during the course of my employment, should I obtain such employment, and that such consent will remain effect until revoked in a written document signed by me. In the event that I wish to refuse or revoke my consent at any time, I understand that I may do so. I further understand that any and all information contained in my job application, or otherwise disclosed to this company by me may be utilized for the purpose of obtaining the consumer reports or investigative consumer reports requested by Company and confirm that all such information is true and correct. I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as a cause for possible dismissal.

I authorize Hirease, Inc. and any of its Agents, to disclose orally and in writing the results of this verification process and/or interview to authorized representatives. I do hereby agree to forever release and discharge our agent, Hirease, Inc. and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint arising from the retrieving and reporting of information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IDENTIFYING INFORMATION FOR CONSUMER REPORTING AGENCY  
(PLEASE PRINT OR TYPE)**

Applicant Name: (First Middle Last)	Current Address: (street address)
Other Name(s) Used: (like Maiden)	City: State: Zip:
Social Security Number:	Former Address: (1)
Sex: Race:	City: State: Zip:
Driver's License No.: State of Issue:	Former Address: (2)
Month, Day and Year of Birth*:	City: State: Zip:
Educational Institution Location (City, State)	Professional License State Issued
Name Attended Under Degree Awarded Dates of Attendance/Graduation	License Number Issue Date Expiration Date

**FOR CA, MN, OK: PLEASE PROVIDE ME WITH A COPY OF MY BACKGROUND INVESTIGATION REPORT.  YES  NO**

**IF YOU RESIDE IN CT, PLEASE LIST YOUR CONTACT INFORMATION FOR REPORT NOTIFICATION:**

**EMAIL: \_\_\_\_\_**

**Have you ever been sanctioned, disciplined, debarred, and/or excluded by a duly authorized regulatory agency or are there any current restrictions or limits on your license (s) or certification (s)?  Yes  No If yes, please attach a complete explanation.**

**Have you ever been convicted of any criminal violation of the law other than a minor traffic violation or are you now under pending investigation or charges?  Yes  No If yes, please attach a complete explanation.**

*\*Without this information, we will be unable to properly identify you in the event we find adverse information during the course of our background investigation.*



# Division of Children and Family Services

State of Nebraska  
Dave Heineman, Governor

## AGENCY REQUEST FOR INFORMATION FROM THE NEBRASKA ADULT AND CHILD ABUSE AND NEGLECT REGISTER/REGISTRY

**The State of Nebraska approved this form, any alteration will invalidate it.**

I hereby request information from the Nebraska Adult and Child Abuse and Neglect Registry. I agree to use the requested information to determine whether to hire or retain the individual to provide care, custody, treatment, transportation or supervision of children or vulnerable adults.

**Agency Name/ Fax:** \_\_\_\_\_  
**Please do not use abbreviations**

**Address and Phone Number:** \_\_\_\_\_

I hereby authorize the Division of Children and Family Services to disclose whether I have an Adult and/or Child Abuse and Neglect Register/Registry record to the above-named agency.

**Print Full Legal Name: (applicant)** \_\_\_\_\_

\_\_\_\_\_  
**Signature (applicant)** **Date**

**Current Address:** \_\_\_\_\_  
**(Street/City/State/Zip)**

\_\_\_\_\_  
**Applicant Date of Birth** **Applicant Social Security Number**

**Other names previously used such as former married names, maiden name and nick names. Please Print.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Names and birth dates of your children and children who have lived with you. Please Print.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Any Address at which you have resided during the past 20 years. Please Print.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## VOLUNTARY SELF-IDENTIFICATION FORM

The following statistical information is used by Community Memorial Hospital District only for compliance with federal laws. Completion of this data is voluntary and will not be utilized for any employment decisions or conditions of employment, if hired.

*Please mark all that apply:*

### Sex

Female

Male

### Race

White

Black or African American

Hispanic or Latino

American Indian or Alaska Native

Asian

Native Hawaiian or Other Pacific Islander

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Name (please print)

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Date

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Signature