APPLICATION FOR EMPLOYMENT

The Sleepy Eye Medical Center is an Equal Opportunity Employer and does not discriminate in hiring or any other decisions on the basis of race, color, creed, religion, national origin, sex, marital status, familial status, sexual orientation age or disability. Applicants requiring reasonable accommodations in the application and/or interview process should notify a representative of the organization.

Please complete all applicable areas. **DO NOT mark your application "SEE RESUME."**
An incomplete application may reduce your opportunity for employment.

SEMC
Sleepy Eye Medical Center

PERSONAL INFORMATION

NAME	LAST	FIRST	MIDDLE INITIAL	
PRESENT ADDRESS	STREET	CITY	STATE ZIP	PHONE
PERMANENT ADDRESS	STREET	CITY	STATE ZIP	PHONE
CELL PHONE	EMAIL			

Are you legally eligible for employment in this country? Yes ☐ No ☐
(Proof of U.S. citizenship or immigration status will be required upon employment.)

EMPLOYMENT DESIRED

POSITION(S) DESIRED:

EMPLOYMENT DESIRED:
FULL-TIME CASUAL PART-TIME

DAYS AVAILABLE:
☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

SALARY DESIRED _____

DATE AVAILABLE (CHECK ONE):
☐ IMMEDIATELY ☐ UPON_____WEEKS NOTICE
☐ OTHER

Have you submitted an application for employment here before? Yes ☐ No ☐

If yes, give date(s) and position(s) _____

Have you ever been employed here before? Yes ☐ No ☐
If yes, give dates & name if different from above_____From_____To _____

EDUCATION & TRAINING

SCHOOL	NAME & ADDRESS OF SCHOOL	COURSE OF STUDY	CIRCLE LAST YEAR COMPLETED	DID YOU GRADUATE?	DIPLOMA, DEGREE OR CERTIFICATE RECEIVED
HIGH SCHOOL/GED			9 10 11 12		
POST-SECONDARY EDUCATION/ COLLEGE			1 2 3 4		
GRADUATE OR OTHER SPECIAL TRAINING			1 2 3 4		

SKILLS

List any correspondence courses, special courses, seminars, workshops, training and skills acquired that might relate to this position:

List computer training and experience:

ADDITIONAL INFORMATION

Do you speak, write or understand any foreign languages? Yes ☐ No ☐

If yes, describe which language(s) and how fluent of a speaker you consider yourself to be.

_____

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS

TYPE	ISSUING STATE OR ORGANIZATION	DATE ISSUED	NUMBER	EXPIRATION DATE

MILITARY EXPERIENCE

BRANCH	RANK	YEARS OF SERVICE	SKILLS/DUTIES

EMPLOYMENT HISTORY

Please account for all periods of unemployment in the comment section below. Even if you have attached a resume, this section MUST be completed. Please indicate below all work experience beginning with your **CURRENT or MOST RECENT** position. May we inquire of your present employer? ☐ Yes ☐ No

DATES OF EMPLOYMENT FROM MONTH_____YEAR_____TO MONTH_____YEAR ________	EMPLOYER (COMPANY NAME)	TELEPHONE NUMBER	
FULL NAME & TITLE OF SUPERVISOR	STREET ADDRESS	REASON FOR LEAVING	
TITLE OF POSITION YOU HELD	CITY	STATE	ZIP CODE
SUMMARIZE YOUR JOB DUTIES: ____________________ ____________________ ____________________		☐ FULL-TIME ☐ PART-TIME ☐ CASUAL	HOURLY RATE/ SALARY: START: END:

DATES OF EMPLOYMENT FROM MONTH_____YEAR_____TO MONTH_____YEAR ________	EMPLOYER (COMPANY NAME)	TELEPHONE NUMBER	
FULL NAME & TITLE OF SUPERVISOR	STREET ADDRESS	REASON FOR LEAVING	
TITLE OF POSITION YOU HELD	CITY	STATE	ZIP CODE
SUMMARIZE YOUR JOB DUTIES: ____________________ ____________________ ____________________		☐ FULL-TIME ☐ PART-TIME ☐ CASUAL	HOURLY RATE/ SALARY: START: END:

DATES OF EMPLOYMENT FROM MONTH_____YEAR_____TO MONTH_____YEAR ________	EMPLOYER (COMPANY NAME)	TELEPHONE NUMBER	
FULL NAME & TITLE OF SUPERVISOR	STREET ADDRESS	REASON FOR LEAVING	
TITLE OF POSITION YOU HELD	CITY	STATE	ZIP CODE
SUMMARIZE YOUR JOB DUTIES: ____________________ ____________________ ____________________		☐ FULL-TIME ☐ PART-TIME ☐ CASUAL	HOURLY RATE/ SALARY: START: END:

DATES OF EMPLOYMENT FROM MONTH_____YEAR_____TO MONTH_____YEAR _____	EMPLOYER (COMPANY NAME)	TELEPHONE NUMBER
FULL NAME & TITLE OF SUPERVISOR	STREET ADDRESS	REASON FOR LEAVING
TITLE OF POSITION YOU HELD	CITY	STATE ZIP CODE
SUMMARIZE YOUR JOB DUTIES: _____ _____ _____		☐ FULL-TIME HOURLY RATE/ SALARY: ☐ PART-TIME START: ☐ CASUAL END:

COMMENTS INCLUDING EXPLANATION OF ANY GAPS IN EMPLOYMENT

_____

_____

_____

_____

IF WORK OR EDUCATIONAL EXPERIENCE WAS OBTAINED UNDER ANOTHER NAME, PLEASE INDICATE:

_____

REFERENCES

PLEASE LIST THREE INDIVIDUALS WHO HAVE KNOWLEDGE OF YOUR WORK PERFORMANCE. PLEASE **DO NOT** INCLUDE RELATIVES OR PERSONAL REFERENCES. THE SLEEPY EYE MEDICAL CENTER RESERVES THE RIGHT TO CONTACT ALL PRIOR EMPLOYERS AND EDUCATIONAL INSTITUTIONS IN ADDITION TO THE REFERENCES LISTED BELOW.

NAME & TITLE	RELATIONSHIP & YEARS AQUAINTED	CURRENT ADDRESS-STREET, CITY,ZIP	CONTACT TELEPHONE
NAME & TITLE	RELATIONSHIP & YEARS AQUAINTED	CURRENT ADDRESS-STREET, CITY,ZIP	CONTACT TELEPHONE
NAME & TITLE	RELATIONSHIP & YEARS AQUAINTED	CURRENT ADDRESS-STREET, CITY,ZIP	CONTACT TELEPHONE

Please Read the following, and then sign below.
I certify that all information I have provided on this application is true, complete and correct to the best of my ability. I understand that any false, misleading or omission of information in connection with my application and or interview will disqualify me from consideration of employment and should I be employed will constitute immediate dismissal, whenever it is discovered.

I understand that nothing in this employment application or in the granting of an interview or in any policies, procedures or handbooks I might receive, is intended to create an employment contract between Sleepy Eye Medical Center and myself for employment.

I understand that upon making a contingent job offer that the employer will conduct a criminal background check and post-offer physical exam based on the demands of the position for which I am applying. I hereby consent to the physical and background check. Also my future employment is also contingent upon satisfactory verification of any applicable licenses and or education qualification requirements for this position.

I understand that if employed, I will be required to complete an Employment Verification Form (I-9) and within three days must show satisfactory evidence of my identity and eligibility for employment in the United States.

I understand that if I establish an employment relationship my position duties and responsibilities, hours of work and working conditions are subject to change at the discretion of management.

I authorize the references I have listed to disclose any information related to my work record and my professional experiences with them, without giving me prior notice of such disclosure. In addition, I release all persons from any and all claims, demands or liabilities for providing the information requested.

This application of employment is current for 60 days. At the conclusion of that time, if I have not heard from the employer and I still wish to be considered for employment, it will be necessary to complete a new application. Employment applications may be printed by going online to www.semedicalcenter.org and mailing in your application.

Signature of Applicant_____ Date _____

Please return the completed application for employment form to:

Sleepy Eye Medical Center
Attn: Human Resources
PO Box 323
400 Fourth Avenue NW
Sleepy Eye MN 56085

TO BE COMPLETED AT THE TIME OF THE INTERVIEW

I acknowledge I have read and understand the essential job duties for the position for which I have applied.

Signature of Applicant_____Date_____

WORK EXPERIENCE VERIFICATION

NAME OF APPLICANT	POSITION APPLIED FOR

SEMC
Sleepy Eye Medical Center

Please return this form along with your application for employment by signing and dating the authorization, in which we will use to verify employment information on your application. The work experience verification section should be left blank as it is generally completed by our facility following the interview process.

I hereby authorize the facility to which this form is addressed to furnish the requested information and release them from any and all liability for damage as a result of providing this information. I understand that without the benefit of employment and reference information, the Sleepy Eye Medical Center may be unable to evaluate if I am suitable for employment.

If your records are under a different name, please indicate that name below:

_____

Signature of Applicant_____ Date _____

WORK EXPERIENCE VERIFICATION
TO: _____

The above individual has applied for a position with the Sleepy Eye Medical Center. We would appreciate your assistance by providing us with any information you believe would be helpful to us in our decision making process. Your opinions are greatly appreciated.
Enclosed is a self-addressed stamped envelope for your convenience.

EMPLOYER NAME	WAS THE APPLICANT EMPLOYED BY YOUR ORGANIZATION? ☐ YES ☐ NO	
POSITION TITLE	JOB DUTIES	
DATES OF EMPLOYMENT FROM____/___/____TO____/____/_____	SALARY STARTING: ENDING:	
REASON FOR LEAVING	WOULD YOU REHIRE? ☐ YES ☐ NO	WERE ABSENCES FREQUENT OR OF CONCERN TO SUPERVISORS? ☐ YES ☐ NO

DID THE APPLICANT WORK WELL WITH:

SUPERVISORS ☐ YES ☐ NO COWORKERS ☐ YES ☐ NO CUSTOMERS ☐ YES ☐ NO

WHAT COMMENTS WOULD YOU LIKE TO SHARE WITH US THAT YOU FEEL MAY BE HELPFUL IN OUR DECISION MAKING PROCESS?

_____
_____
_____
_____
_____
_____

SIGNATURE:	TITLE:	DATE:

AN EQUAL OPPORTUNITY EMPLOYER

Position Applied For_____Date _____

This information will be used in analysis, reporting on Equal Employment Opportunity and Affirmative Action. Completing this information is voluntary. It will be separated from your application before consideration by the Sleepy Eye Medical Center. The information will in no way affect you as an individual applicant. This information will not be kept in personnel files and will not be made available to any person involved in decisions affecting an individual's employment or advancement to a position.

Gender:_____Female ____Male

Race/Ethnic Group

___ White, not of Hispanic origin - persons having origins in any of the original peoples of Europe, North Africa, or the Middle East

___ Black or African American, not of Hispanic origin - persons having origins in any of the Black racial groups of Africa.

___ Hispanic - persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin regardless of race.

___ Asian or Pacific Islander – person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Sub-Continent or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine islands and Samoa.

___ American Indian or Alaskan Native – persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

HOW DID YOU LEARN ABOUT THIS JOB OPENING

___ Newspaper Ad - Name of publication

_____

___ MN Job Service

___ Phone Inquiry

___ Internal Job Posting

___ Walk-In

___ Medical Center Website

___ Employee Referral

I do not wish to give any information _____