



Memorial Hospital

1900 State Street
618-826-4581 ext 1294

Chester, IL 62233
Fax: 618-826-5732

Chester Clinic
2319 Old Plank Rd
Chester, IL 62233
618-826-2388
Fax: 618-826-5139

Steeleville Family Practice
602 W Shawneetown Trail
Steeleville, IL 62288
618-965-3382
Fax: 618-965-2062

Employment Application

Memorial Hospital is committed to our policy of providing equal employment opportunity to employees and job applicants in a manner consistent with applicable laws and regulations.

APPLICANT INFORMATION					
Last Name		First		M.I.	Date
Street Address				Apartment/Unit #	
City		State		ZIP	
Phone		E-mail Address			
Date Available	Social Security No.		Are you 16 years of age or older? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Position Applied for			Desired Salary		
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 this company?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?	
EDUCATION					
High School		Address			
		Did you graduate?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Degree
College		Address			
		Did you graduate?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Degree
Other		Address			
		Did you graduate?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Degree

PROFESSIONAL LICENSES, REGISTRATIONS OR CERTIFICATIONS

Currently Licensed, Registered, or Certified? Type: _____ NO: _____ State: _____ Date: _____

License, Registration, or Certification EVER suspended, revoked or on probation? Yes No If Yes explain below:

MILITARY SERVICE

Branch _____ From _____ To _____

Rank at Discharge _____ Type of Discharge _____

If other than Honorable, explain _____

REFERENCES

Please list three professional references.

Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship
Company	Phone ()
Address	

PREVIOUS EMPLOYMENT Beginning with the 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"/>		

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release. I understand that employment is conditioned upon successfully passing a medical examination and drug screening. I hereby authorize and release any and all persons, schools, current and/or previous employers, etc. from any and all liability related to the release of information provided to this facility. I also understand that my employment is at-will which means I may terminate the employment relationship at any time and for any reason with or without notice, and this facility has the same right. I understand only a written agreement signed by an administrative representative of this facility and notarized, will supersede the preceding sentence.

Signature	Date
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We would like to have the following information for reference purposes. The applicant has consented to our making this inquiry. (See authorization below.)

Memorial Hospital Representative Signature _____

Title _____

EMPLOYMENT REFERENCE CHECK

Employed as _____ From _____ To _____

Reason for leaving _____

Would you re-employ applicant? YES NO

Please check below the rating that most accurately describes the applicant:

	Excellent	Good	Average	Below Average
Quality of Work				
Knowledge of Job				
Quantity of Work				
Judgment & Decision Making				
Relationship With Others				
Attendance				
Professional Conduct				

Remarks _____

Signature _____

Title _____

Date _____

APPLICANT AUTHORIZATION (FILL OUT THIS SECTION ONLY)

I understand and authorize Memorial Hospital to conduct a routine investigation based upon official records only, of my past employment, character information, work and attendance record, abilities and reason for terminating employment.

I agree to cooperate with Memorial Hospital in conducting this inquiry and release the individual who responds to this inquiry from any and all liability and responsibility resulting from this investigation.

Applicant Name: _____ Social Security Number: _____

Applicant Signature: _____ Date: _____