

CRAWFORD COUNTY HOME HEALTH, HOSPICE & PUBLIC HEALTH
105 N. Main Street, Courthouse Annex
Denison, IA 51442
712-263-3303

APPLICATION

NAME (Last, first & middle initial)		POSITION APPLYING FOR:	
ADDRESS: (Include Street, City, State & Zip Code)		ARE YOU A MILITARY VETERAN? Yes _____ No _____	
PHONE NUMBER:	SOCIAL SECURITY NUMBER:	ARE YOU LEGALLY ABLE TO WORK IN THE UNITED STATES? Yes _____ No _____	
CELL PHONE:	E-MAIL ADDRESS:	PREFERRED METHOD OF CONTACT (please check) ____ Home Phone ____ Cell Phone ____ E-Mail	
HOW DID YOU LEARN ABOUT THIS POSITION:			

EDUCATION

Type of School	Name of School	City and State	Circle Number of Years Completed	Degree Earned
High School			9 10 11 12	
College			1 2 3 4	
Other			1 2 3 4	

EMPLOYMENT HISTORY

BEGIN WITH MOST RECENT JOB. PLEASE FILL OUT THIS SECTION CAREFULLY AND COMPLETELY

COMPANY NAME	Date Started	Date Left	Rate of Pay	Job Title
COMPANY ADDRESS (CITY, STATE & ZIP CODE)	DESCRIBE JOB DUTIES: _____ _____ _____			
REASON FOR LEAVING:	_____ _____ _____			

COMPANY NAME	Date Started	Date Left	Rate of Pay	Job Title
COMPANY ADDRESS (CITY, STATE & ZIP CODE)	DESCRIBE JOB DUTIES: _____ _____ _____			
REASON FOR LEAVING:	_____ _____ _____			

EMPLOYMENT APPLICATION CONTINUED

Have you ever been fired or asked to resign from a job? Yes No If yes, please explain:

Is there any other work experience or information about yourself you want to share?

BE SURE TO READ THIS STATEMENT BEFORE SIGNING

I HEREBY CERTIFY, that this application is complete to the best of my knowledge for the periods of employment listed and all information given is true and contains no misrepresentations.

FURTHERMORE:

- 1. I am aware that all statements submitted on this application are subject to investigation and verification.
- 2. I authorize the persons, schools law enforcement agencies and other organizations or employers named in application to provide information requested by the Employer in its processing of this application.
- 3. I understand that, if the Agency employs me, either the agency or I can terminate my employment with or without cause at any time and for any or no reason.
- 4. I understand that any withholding of information or misrepresentation on application or on Employer medical forms could result in rejection for employment, or if employed, termination from the Employer.

SIGN HERE IN INK: _____

DATE: _____

CRAWFORD COUNTY HOME HEALTH, HOSPICE & PUBLIC HEALTH IS AN EQUAL OPPORTUNITY EMPLOYER

Prospective employees will receive consideration without discrimination because of race, creed, color, religion, political affiliation, national origin, sex, age, physical or mental disability, testing positive for human immune deficiency virus, sexual orientation or veteran status.

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REFERENCES

Please submit the name, position, address, and telephone number of three (3) individuals who know you in a professional capacity, such as recent past employers.

(1) _____
(Name) (Position)

(Street Address, City, State & Zip Code) (Telephone Number)

(2) _____
(Name) (Position)

(Street Address, City, State & Zip Code) (Telephone Number)

(3) _____
(Name) (Position)

(Street Address, City, State & Zip Code) (Telephone Number)

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

(Read carefully before signing)

I hereby authorize the above-named individuals to furnish to the Crawford County Home Health, Hospice & Public Health representatives/local Board of Health/Agency Administrator with information concerning my education and experience, my reasons for leaving employment, together with any and all information concerning me whether on record or not. I agree to release and hold harmless the above-named individuals from liability for any damages whatsoever for issuing such information.

I acknowledge and authorize the usage of xerox copies of this release to be the same as original when submitted to the above-named individuals.

Dated _____ Signature _____

Maiden Name _____

Crawford County Home Health, Hospice & Public Health is dedicated to equal employment. Prospective employees will receive consideration without discrimination because of race, creed, color, religion, political affiliation, national origin, sex, age, physical or mental disability, testing positive for human immune deficiency virus, sexual orientation or veteran status.

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AFFIRMATIVE ACTION
EQUAL OPPORTUNITY SURVEY

Crawford County Home Health, Hospice & Public Health is an Affirmative Action/Equal Opportunity Employer. We consider all applicants without regard to race, color, religion, sex, national origin, age, marital or veteran status, the presence of non-job related medical condition or impairment, or any other legally protected status.

Completion of the following information is voluntary. This page will be separated from the remainder of the applications and used only for affirmative action data collection purposes. It will in no way influence employment decisions.

POSITION APPLIED FOR _____

DATE OF APPLICATION _____

Race: Black White Hispanic Asian American Indian Other

Sex: Male Female

Age: Below 20 20-29 30-39 40 and above

Do you have a physical or mental impairment which substantially limits one or more major life activity which might in any way hinder your being able to perform the position for which you have applied? Yes No

If yes, does it affect speech hearing mobility other