

HARRISBURG
Medical Center

*100 Dr. Warren Tuttle Dr.
P.O. Box 428
Harrisburg, Illinois 62946
618-253-7671
Fax 618-252-2077*

Dear Applicant:

Thank you for your interest in employment with Harrisburg Medical Center, Inc.!

Your application will be given to an individual in the Human Resources Department who will route the application to the department for which you have applied. If an interview is to be scheduled you will be contacted by the Director/Supervisor of that department. Please be aware that if you are not selected to be interviewed at this time, your application will remain active for a three month period. Your application will need to be updated after this three month period. If there are any changes you would like to make to your current application, please feel free to notify us in writing.

Applications may be completed in the Human Resources Department, Monday through Friday, during the hours of 8:00a.m. - 4:30p.m.

There is no need to follow up by telephone to check on the status of your application unless specified by Human Resources Staff.

You may call Harrisburg Medical Center's JOB HOTLINE at (618) 253-7671 ext. 300 for a listing of current job openings. Contact the Employment Coordinator at ext. 249 if there is a position you qualify for.

Again, we appreciate your interest in Harrisburg Medical Center.

Sincerely,

HARRISBURG MEDICAL CENTER, INC.

The Employment Staff

NAME / Last, First, Middle _____

POSITION _____

DATE _____



Employment Application

An Equal Opportunity Employer. We comply with all applicable local, state and federal civil rights and equal employment laws and regulations.

Briefly describe duties and skills acquired through military or volunteer service: (include dates)

PROVIDE INFORMATION REGARDING PREVIOUS EMPLOYMENT BEGINNING WITH MOST RECENT EMPLOYER.

	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY: (Hr/ Mo/Yr)
JOB TITLE: _____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
EMPLOYER NAME: _____	PHONE: _____			
ADDRESS: _____				
DUTIES: _____				
REASON FOR LEAVING: _____				
MAY WE CONTACT YOUR CURRENT EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>				

	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY: (Hr/ Mo/Yr)
JOB TITLE: _____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
EMPLOYER NAME: _____	PHONE: _____			
ADDRESS: _____				
DUTIES: _____				
REASON FOR LEAVING: _____				

	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY: (Hr/ Mo/Yr)
JOB TITLE: _____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
EMPLOYER NAME: _____	PHONE: _____			
ADDRESS: _____				
DUTIES: _____				
REASON FOR LEAVING: _____				

	FROM: (MO/YR)	TO: (MO/YR)	SUPERVISOR'S NAME:	SALARY: (Hr/ Mo/Yr)
JOB TITLE: _____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
EMPLOYER NAME: _____	PHONE: _____			
ADDRESS: _____				
DUTIES: _____				
REASON FOR LEAVING: _____				

PLEASE IDENTIFY AND EXPLAIN ANY GAPS IN EMPLOYMENT LONGER THAN THREE (3) MONTHS:

PREVIOUS EXPERIENCE

LANGUAGE

REFERENCES

SIGNATURE

FOR OFFICE USE ONLY

LANGUAGE SKILLS - DO NOT COMPLETE UNLESS REQUESTED

LANGUAGE	DO YOU?	<input type="checkbox"/> SPEAK	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> READ	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> WRITE	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT
LANGUAGE	DO YOU?	<input type="checkbox"/> SPEAK	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> READ	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT	<input type="checkbox"/> WRITE	<input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> FLUENT

LIST AT LEAST THREE (3) PROFESSIONAL / WORK / SCHOOL REFERENCES WHO ARE NOT RELATIVES OR PERSONAL ACQUAINTANCES:

NAME AND RELATIONSHIP	TITLE	COMPANY NAME AND ADDRESS	TELEPHONE

CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW

I hereby affirm that the information provided on this application (and accompanying resume, if any) is true and complete. I understand that any false or misleading representations or omissions made on the application or during the hiring process may disqualify me from further consideration for employment and may result in discharge even if discovered at a later date.

I understand that employment may be conditioned upon successfully passing a medical examination and that I may be required to satisfactorily complete a drug screening as a condition of employment.

I hereby authorize persons, schools, my current employer (if applicable) and previous employers and other organizations to provide this facility and its affiliates with any requested information regarding my application or suitability for employment, and I completely release all such persons or entities from any and all liability related to the providing or use of such information.

I understand that my employment is at-will which means that I may terminate the employment relationship at any time and for any reason with or without notice, and that the facility has the same right. I understand that no one has the authority to enter into any agreement contrary to the preceding sentence, except for a written agreement signed by an administrative representative of this facility and notarized.

Date _____ Signature _____

HIRED? YES NO SEE COMMENTS BELOW

REFERENCES CHECKED AND BY WHOM:	REFERENCE #1	DATE	REFERENCE #2	DATE	REFERENCE #3	DATE

PERSONNEL NOTES (Please keep all information factual) _____

IF APPLICANT IS 18 YRS. OLD OR LESS, IS PROOF OF AGE ON FILE? YES <input type="checkbox"/> NO <input type="checkbox"/>	INTERVIEWER'S SIGNATURE
STARTING DATE <input type="checkbox"/> EXEMPT <input type="checkbox"/> NON-EXEMPT	COMPLETION OF EVALUATION PERIOD DATE APPROVED BY
DEPARTMENT COST CENTER	SIGNATURE
POSITION/JOB SITE	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> ON CALL STATUS <input type="checkbox"/> ROTATION
STARTING SALARY/GRADE DIFFERENTIAL	SHIFT EMPLOYEE NUMBER
NOTIFY IN CASE OF EMERGENCY NAME RELATIONSHIP ADDRESS TELEPHONE	

HARRISBURG MEDICAL CENTER
Equal Opportunity Certification

Harrisburg Medical Center, Inc., requests your cooperation in completing this form so we may comply with government record keeping requirements.

The information provided will only be used for statistical reporting purposes and will in no way affect your employment eligibility.

All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, age or national origin.

DO NOT PUT YOUR NAME ON THIS PAGE

Position for which you are applying: _____

Today's date: _____

Age: Under 40 Male

Over 40 Female

Disabled: 1) A person with a physical or mental impairment that substantially limits one or more major life activities; such as, walking, talking, hearing, seeing, breathing, learning, caring for oneself or working, 2) An individual with a record of such impairment; or 3) Someone who is regarded as having such an impairment.

Considering the definition, are you disabled? Yes No

Race: White (Caucasian)
 Black (African-American)
 Hispanic
 Asian/Pacific Islander
 American Indian/Alaskan

It is the policy of Harrisburg Medical Center that we will not knowingly employ or enter into a business relationship with an individual or entity, with or without pay, that is identified by a federal or state agency as excluded, suspended or otherwise ineligible for participation in federally funded health care programs, including but not limited to Medicare and Medicaid.

Please answer the following questions:

1. **Have you ever been convicted of or pled guilty or no contest to a felony or misdemeanor?**
_____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

2. **Are any felony or misdemeanor charges now pending against you?** _____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

3. **Have you ever participated in a first offender, deferred adjudication, or other program or arrangement where judgment or conviction has been withheld?** _____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

4. **Has any action been taken against you that excludes or has excluded you from participating for any length of time in any federally funded government health care program, including but not limited to Medicare and/or Medicaid?** _____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

5. **Are you the subject of any investigation or proceedings by any state or federal governmental bodies or their designated representatives that could result in your exclusion from participating for any length of time in any state or federally funded government health care program, including but not limited to Medicare and/or Medicaid?** _____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

6. **Have you ever had any professional registration, license, or certification suspended or revoked?** _____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

7. **Have you ever informally resolved any recommended or potential adverse action involving your professional registration, license, or certification?** _____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

8. **Are any professional registration, licensure, or certification actions now pending against you?**
_____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

9. **Have you ever been named as a defendant in any civil legal action involving your professional competence?** _____ yes _____ no
If yes, please explain in detail (use the back of this sheet or a separate sheet if necessary):

Current exclusion from participation in any federally funded health care program, including but not limited to Medicare and Medicaid, will prohibit your employment. Past exclusion from participation in any such federally funded program, conviction of a crime, being named as a defendant in a civil legal action, or adverse action involving your professional registration, license, or certification will not necessarily disqualify you from consideration for employment, however, failure to fully disclose will result in immediate denial or termination of employment.

I hereby certify that all statements made by me on this questionnaire are true and complete to the best of my knowledge, and I have withheld nothing that would affect this questionnaire unfavorably. I understand that false, misleading or incomplete information given on this questionnaire or in any subsequent interview(s) will likely result in immediate denial or termination of employment.

Printed Name _____

Signature _____ Date _____

Notice to Applicant

Under Illinois state law, we have an obligation to inform you that it is a civil rights violation for any Illinois employer to inquire about or to use arrest information or criminal history record information that has been ordered expunged, sealed or impounded.

Therefore, you do not have to answer YES when asked on this application if you have been convicted of or plead guilty to, a crime other than misdemeanor traffic violations IF AND ONLY IF your record has been sealed or expunged.

Please sign below indicating you have read and understand the above notice:

Name

Date