Hegg Memorial Health Center

Hegg Memorial Hospital • Hegg Medical Clinic
• Whispering Heights • Hegg Home Health
• Hegg Occupational Health • Four Seasons Retirement Community
• Hegg Rehab Agency • Generations Daycare

Today's Date: _____

To Applicant; We appreciate your interest in our organization and assure you that we are sincerely interested in your qualifications. A clear understanding of your background and work history will aid us in placing you in the position that best meets your qualifications and may assist us in possible future upgrading.

This facility is an equal opportunity employer. Employment, educational opportunities, and promotions in all job classifications are without regard to race, color, creed, sex, age, national origin, religion, disability or military status.

Hegg Memorial Health Center is committed to providing access and reasonable accommodation in its services, programs, activities and employment for individuals with disabilities. To request disability accommodation in the application process, contact the Human Resources Office in advance at: 712-476-8000 or 712-476-8024 (fax)

PERSONAL

Name: First	Middle	Last		Social Security Number
Address: Street	City	State	Zip Code	Telephone Number
Position Applied For 1. 2.			Rate of Pay Expected	Email Address Cell Phone
Type of Employment Interested In ❑ Full Time ❑ Part Time ❑ Temporary		Specify Days and Hours (if Part Time)		Date Available for Employment

PROFESSIONAL

Current License (Type)	Year	State	Number

List Areas of Experience in Your Profession.

EDUCATIONAL DATA

TYPE	NAME OF SCHOOL	ADDRESS	DID YOU GRADUATE	TYPE OF DEGREE	FIELD OF STUDY
High School					
Business Schools Vocational					
College or University					

This application is good for one year.

EMPLOYMENT HISTORY

Present or Last Employer	Your Title	Last Salary	Reason for Leaving
Address: Street City State Zip	Duties	Date Began	
Supervisor Phone No.		Date Left Mo. Yr.	May We Contact? ❑ Yes ❑ No

Present or Last Employer	Your Title	Last Salary	Reason for Leaving
Address: Street City State Zip	Duties	Date Began	
Supervisor Phone No.		Date Left Mo. Yr.	May We Contact? ❑ Yes ❑ No

Present or Last Employer	Your Title	Last Salary	Reason for Leaving
Address: Street City State Zip	Duties	Date Began	
Supervisor Phone No.		Date Left Mo. Yr.	May We Contact? ❑ Yes ❑ No

REFERENCES

SCHOOL OR PERSONAL REFERENCES WHICH WE MAY CONTACT (do not list relatives)

Name	Address Phone	Occupation
Name	Address Phone	Occupation
Name	Address Phone	Occupation

For Reference Purposes: Is your educational or employment history listed under another name? ❑ Yes ❑ No

If so, what?

Explain any unemployment periods of two months or more.

An application blank may make it difficult for you to adequately summarize your background. To assist us in finding the proper position for you with this facility, use the space below to summarize any additional information neccessary to describe your full qualification for employment or future promotion. You may also include a copy of your resume.

GENERAL INFORMATION

Who referred you to this facility?

❑ Employee (name) ❑ School Counselor ❑ Friend or Relative ❑ Walk In ❑ Advertisement, Newspaper, or Journal

Are you at least 16 years of age? ❑ Yes ❑ No

Have you ever been convicted of a felony? ❑ Yes ❑ No (A conviction does not necessarily bar you from employment)

If yes, please explain? _____

Have you ever been employed at HMHC? ❑ Yes ❑ No If so, when? _____

APPLICANT'S STATEMENT

I hereby give Hegg Memorial Health Center the right to investigate my past employment, education and activities. I release from all liability all persons, companies and corporations who supply such information. I indemnify Hegg Memorial Health Center against liability that might result from such an investigation. I understand that any false answer or statements or implications I make in this application or in any other required document shall be considered sufficient cause to deny employment or discharge if already employed.

I also understand that nothing contained in this application or in the granting of an interview is intended to create an employment contract between Hegg Memorial Health Center and myself for employment or for any benefit. I have received no promise regarding employment, and I understand that no such guarantee is binding on Hegg Memorial Health Center unless made in writing. If an employment relationship is established, I understand that I have the right to terminate my employment at any time and that Hegg Memorial Health Center has a similar right.

I consent to take a post-offer, pre-employment physical examination, including lab work and such future physical examinations/lab work as may be required by this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

If hired at Hegg Memorial Health Center, prior to my first day, I will verify that I am either a U.S. citizen or a legal resident foreign national.

Date _____ Applicant's Signature _____

Parental Consent for Minors _____

Date _____ Position(s) Applied For _____

EMPLOYEE SELF IDENTIFICATION FOR AFFIRMATIVE ACTION PROGRAMS:

Applicants are considered for all positions, and employees are treated during employment without regard to race, color, religion, sex, national origin, age, marital or veteran status or disability.

We comply with government regulations and affirmative action responsibilities. To help us comply with government record keeping and reporting requirements, please fill out the appropriate information. We appreciate your cooperation. Completion of this form is voluntary and the information provided will not be used or reviewed as part of your employment application.

Please Print

Name _____ Phone _____
First Middle Last

Address _____
Street City State Zip

Government agencies require periodic reports on the sex, ethnicity, disability and veteran status of applicants. This data is for analysis and affirmative action only. Submission of any information is voluntary.

Check One: ❑ Male ❑ Female

Check One: Race/Ethnic Group ❑ White ❑ Black ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian/Pacific Islander

Check if any of the following apply:

❑ Veteran of the Vietnam Era (served on active duty for a period of more than 180 days between August 5, 1964 and May 7, 1975; and discharged with other than dishonorable discharge).

❑ Disabled Veteran Active duty service from _____ to _____
Type of disability _____
Disability rating _____%

❑ Qualified Handicapped Individual
Type of disability _____

Hegg Memorial
Health Center
Avera Health

ACCOUNT NUMBER: 8329-C

IOWA HEALTH CARE FACILITY (135C) RECORD CHECK
Form C

TO: Iowa Division of Criminal Investigation
Bureau of Identification
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-5138 (voice - days)
(515) 281-4776 (voice - evenings)

FROM: Hegg Memorial Health Center
1202 21 st Ave.
Rock Valley, IA 51247
(712) 476-8000
(712) 476-8024 (fax)

(TYPE OR PRINT LEGIBLY)

REQUEST

Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)

Provide all other names or aliases you have ever previously been known by, including but not limited to nicknames, maiden names and other married names:

_____ _____

_____ _____

_____ _____

Date of Birth (mandatory)	Sex (mandatory)	Social Security Number (mandatory)
____/____/____		____-____-____

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history and dependent adult abuse check with the Division of Criminal Investigation.

Signature	Date