MEMORIAL HOSPITAL

1900 State Street Chester, IL 62233
618-826-4581 ext 1294 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

Submit application to hrdept@mhchester.com

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. (last 4 digits)	Are you 16 years of age or older? YES ☐ NO ☐
Position Applied for		Desired Salary

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If so, when?

EDUCATION

High School		Address	
	Did you graduate? YES ☐ NO ☐		Degree
College		Address	
	Did you graduate? YES ☐ NO ☐		Degree
Other		Address	
	Did you graduate? YES ☐ NO ☐		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 ☐ NO ☐		
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 ☐ NO ☐		
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 ☐ NO ☐		

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, alcohol/drug screening and background check. 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: _____