

WORK HISTORY Account for the past 3 employers. If you do not have 3 employers, list personal references and their relationship to you.

CURRENT EMPLOYER & ADDRESS	PHONE	POSITION & STARTING PAY	SUPERVISOR'S NAME & TITLE	DATES OF EMPLOYMENT
		Circle:Part-time / full-time		From: To: Final Wage: \$
Describe the work that you did:		Reason for leaving:		
May we contact? If not, why not?				

EMPLOYER NAME & ADDRESS	PHONE	POSITION & STARTING PAY	SUPERVISOR'S NAME & TITLE	DATES OF EMPLOYMENT
		Circle Part-time / full-time		From: To: Final Wage: \$
Describe the work that you did:		Reason for leaving:		

EMPLOYER NAME & ADDRESS	PHONE	POSITION & STARTING PAY	SUPERVISOR'S NAME & TITLE	DATES OF EMPLOYMENT
		Circle Part-time / full-time		From: To: Final Wage: \$
Describe the work that you did:		Reason for leaving:		

References: May we contact your present and previous supervisors for a reference? NO YES if no, please explain.

Have you ever been discharged by an employer? Yes No If yes, please explain all such terminations:

If you are employed and your background check determines you cannot work in Health Care we will be required to terminate your employment.

PLEASE READ AND SIGN:

I certify that I have given true, accurate and complete information (application, work history, skills inventory, resumes, curriculum vitae, etc.). I authorize employers, educational institutions, associations, registration and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigation of all statements made in this application and understand that false information, or a failure to disclose information may be grounds for rejection of my application, disciplinary action or dismissal if I am employed. I expressly waive any right I may have to review material or information received from a previous employer or educational institution under a promise of confidentiality.

Signature (unsigned applications will not be processed)

_____ Date: _____

An Equal Opportunity/Affirmative Action Employer



RED WING HEALTH CENTER

**TO HELP US IDENTIFY
WHICH JOB PLACEMENT ADS
ARE REACHING JOB CANDIDATES
WE WOULD APPRECIATE IT IF YOU WOULD TAKE A MINUTE
TO FILL OUT THIS FORM.**

Position Applied for: _____ **Date:** _____

WHERE DID YOU HEAR ABOUT THE POSITION OPENING YOU ARE APPLYING FOR?

_____ **SHOPPER** _____
(Name of Shopper)

_____ **NEWSPAPER** _____
(Name of Newspaper)

_____ **JOB SERVICE**

_____ **FRIEND**

_____ **FAMILY MEMBER**

_____ **OTHER** _____
(Explain)

THANK YOU FOR HELPING US ASSESS OUR JOB PLACEMENT ADS!

Red Wing Health Center

Invitation to all Red Wing Health Center Applicants and/or Employees for Voluntary Inclusion in the Red Wing Health Center's Equal Employment Opportunity Initiative

Red Wing Health Center is committed to a policy of equal opportunity in accordance with all applicable Equal Employment Opportunity laws and regulations at the federal, state, and local levels. As part of this commitment and as a matter of law, we must collect gender, disability, race/ethnic, and veteran status of applicants and employees for equal employment opportunity and reporting purposes.

Please help us fulfill these commitments by providing the information requested below. Providing this information is *voluntary*. Refusal to provide this information will not result in any adverse treatment. The information provided will be kept separate from the "Employment Application" or your "Personnel File" and in strict confidence except that government officials investigating Equal Employment Opportunity program compliance may have access to reported information.

To be included in Red Wing Health Center's Equal Employment Opportunity initiative, please check the appropriate boxes.
Thank you for your cooperation in this important initiative.

POSITION: _____

GENDER: (check one box only)

Female

Male

ARE YOU HISPANIC OR LATINO?

Yes

No

WHAT RACE OR RACES DO YOU CONSIDER YOURSELF TO BE? (check one box only)

White

Black or African American

Native Hawaiian or Other Pacific Islander

Asian

American Indian or Alaska Native

Two or More Races

VETERAN STATUS:

- Special Disabled Veteran** (i) A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Department of Veterans' Affairs for a disability(A) rated at 30 percent or more, or (B) rated at 10 or 20 percent in the case of a veteran who has been determined under Section 38 U.S.C. 3106 to have a serious employment handicap or (ii) a person who was discharged or released from active duty because of a service-connected disability.
- Vietnam Era Veteran** A person who: (i) served on active duty in the U.S. military, ground, naval or air service for a period of more than 180 days, and who was discharged or released there from with other than a dishonorable discharge, if any part of such active duty was performed:(A) in the Republic of Vietnam between February 28, 1961, and May 7, 1975; or (B) between August 5, 1964, and May 7, 1975, in all other cases; or (ii) was discharged or released from active duty in the U.S. military, ground, naval or air service for a service-connected disability if any part of such active duty was performed(A) in the Republic of Vietnam between February 28, 1961, and May 7, 1975; or (B) between August 5, 1964, and May 7, 1975, in any other location.
- Newly Separated Veteran** A veteran who served on active duty in the U.S. military, ground, naval or air service during the one-year period beginning on the date of such veteran's discharge or release from active duty.
- Other Protected Veteran** A veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized. For those with Internet access, the information required to make this determination is available at <http://www.opm.gov/veterans/html/vgmedal2.htm> A copy of the list also may be obtained by calling(301) 306-6752 and requesting that a copy of the list be mailed to you.

REFERENCE REQUEST

Red Wing Health Center

I hereby authorize the Red Wing Health Center to verify my current/former employment and to supply the information requested. I release the Red Wing Health Center and my current/former employer from any liability connected with the submission of the requested information.

My Name _____
Position applied for _____
Signature _____

*APPLICANT: **DO NOT** complete from this point on, this in for your former employer to complete.

WORK REFERENCE – COMPANYNAME: _____ PH: _____

Name while employed _____ Position _____

Employment dates: From _____ to _____

Reason for leaving _____

Would you rehire? ()Yes ()No Explanation _____

Comments _____

	Above Average	Average	Below Average		Above Average	Average	Below Average
Dependability	()	()	()	Initiative	()	()	()
Quality of Work	()	()	()	Attendance	()	()	()
Judgment	()	()	()				
Signature:			Title:				Date:

() Telephone Interview

Completed by: _____ Date: _____

PERSONAL REFERENCE

How well do you know the applicant? () Slightly () Well () Very Well

Years known _____ Relationship to applicant _____

Have you had any knowledge of applicant in last 12 months? () Yes () No

	Above Average	Average	Below Average
Personality	()	()	()
How do they relate with people	()	()	()
Dependability	()	()	()
Initiative	()	()	()
Signature:			Date:

() Telephone Interview Completed by: _____ Date: _____

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Initiative	()	()	()
Signature:			Date:

() Telephone Interview Completed by: _____ Date: _____