

Guthrie County Public Health Nursing Service
2002 State St., Suite 1 - Guthrie Center, IA 50115

Application for Employment

Application Date _____

Please Print or Type

_____/_____/_____
Social Security Number Last Name First Name Middle Name or Initial

Address (Number & Street) City State Zip Code

(_____) _____ (_____) _____
Phone (area code) number - daytime Phone (area code) number - evenings

CITIZENSHIP

If not a U.S. Citizen, do you intend to remain Permanently in the U.S.? _____

Can you, after employment, submit a Birth Certificate or other proof of U.S. citizenship? _____

If not a U.S. Citizen, what type of Visa do you possess? ___ Student ___ Permanent Entry U.S.A. ___ Other

Explain: _____ Visa # _____

U.S. MILITARY SERVICE

SERVICE BRANCH _____ FINAL RANK OR RATE _____

SPECIALTY _____

DATE ENTERED _____ DATE SEPARATED _____

RESERVE ORGANIZATION _____

Please list job related skills or experience _____

STATEMENT OF HEALTH

Is there any reason why you would be unable to perform or to safely perform any of the duties of the position for which you are applying? If yes, please explain: _____

Will you take a physical examination? ___ Yes ___ No

PERSONAL

HAVE YOU EVER BEEN CONVICTED OF A FELONY: ___ Yes ___ No

If yes, explain and give dates: _____

HAVE YOU EVER BEEN DISCHARGED FROM A JOB? ___ Yes ___ No

If yes, explain: _____

DO YOU HAVE A RECORD OF FOUNDED CHILD OR DEPENDENT ADULT ABUSE: ___ Yes ___ No

HAVE YOU EVER BEEN CONVICTED OF A CRIME IN THIS STATE OR ANY OTHER STATE? ___ Yes ___ No

PROFESSIONAL ORGANIZATIONS, SPECIAL INTERESTS, HOBBIES (Omit any which might indicate Race, Religion, Color, National Origin or Ancestry): _____

REFERENCES: NAMES OF PERSONS WE MAY CONTACT TO VERIFY YOUR QUALIFICATIONS FOR THE POSITION

Name _____ Occupation _____ Phone _____

Organization address: _____

Name _____ Occupation _____ Phone _____

Organization address: _____

Name _____ Occupation _____ Phone _____

Organization address: _____

IMPORTANT: Give Name and Address of Person to Notify in Case of Emergency

Name _____ Phone Number _____

Address (number, city, state, zip) _____

PREVIOUS WORK EXPERIENCE

ORGANIZATION: _____

KIND OF WORK _____

ADDRESS (Street/box number, city, state, zip) _____

EMPLOYMENT DATE: From _____ To _____

YOUR TITLE: _____ SUPERVISOR'S TITLE _____

AVERAGE NUMBER OF HOURS WORKED PER WEEK: _____

JOB DUTIES: _____

ORGANIZATION: _____

KIND OF WORK _____

ADDRESS (Street/box number, city, state, zip) _____

EMPLOYMENT DATE: From _____ To _____

YOUR TITLE: _____ SUPERVISOR'S TITLE _____

AVERAGE NUMBER OF HOURS WORKED PER WEEK: _____

JOB DUTIES: _____

ORGANIZATION: _____

KIND OF WORK _____

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KIND OF WORK _____

ADDRESS (Street/box number, city, state, zip) _____

EMPLOYMENT DATE: From _____ To _____

YOUR TITLE: _____ SUPERVISOR'S TITLE _____

AVERAGE NUMBER OF HOURS WORKED PER WEEK: _____

JOB DUTIES: _____

EDUCATION RECORD

Circle Highest Grade Completed

1 2 3 4 5 6 7 8 9 10 11 12

High School Graduate
or Equivalent (GED)? ____ Yes ____ No

Name and Location of Schools
Attended Beyond High School

Dates Attended
mo/yr mo/yr

Credit Received
Quarter
Semester
Hours
Hours
Hours

Field of Study or Area
of Concentration
Major Hours Minor
Hours

Type of Degree
Obtained

If you are working toward a degree, please give the anticipated completion date: _____

WHAT OFFICE MACHINES CAN YOU USE?

PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS

Type	State Issued	Date	No.
Type	State Issued	Date	No.
Type	State Issued	Date	No.
Type	State Issued	Date	No.

AREA OF SPECIALIZATION OR MAJOR
INTEREST: _____

PLEASE LIST ANY OTHER INFORMATION YOU FEEL PERTINENT TO YOUR APPLICATION: _____

READ BEFORE SIGNING

I certify that this application contains no willful misrepresentations and that the information is true and complete to the best of my knowledge. I also understand that if any of the information is found to be fake, it is grounds for disqualification or immediate dismissal. I understand that the agency will be performing a criminal history check as well as child abuse and dependent adult abuse record check in the State of Iowa.

I understand that any offer of employment with Guthrie County Public Health Nursing Service is contingent upon satisfactory passing of the required physical examination and background checks.

I hereby give permission to Guthrie County PHNS to consult with my previous employers, acquaintances and with other sources to verify the information contained herein and to learn of my ability and integrity (except where specifically requested not to under employment history section) for the purpose of securing any other information Guthrie County PHNS may deem necessary with my actual or possible employment by them. I hereby release them and their organization from all liability for any damage whatsoever resulting from issuing information concerning me.

Applicant's Signature in Ink

Date

An Equal Employment Opportunity/Affirmative Action Agency: Qualified applicants are eligible to compete for all positions without regard to race, color, national origin, sex, creed, religion, age, physical or mental disability, or marital status.

RERERENCES FOR APPLICANTS

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

(1) _____
(Name) (Position)

(Street Address) (City) (State) (Zip) (Telephone number)

(2) _____
(Name) (Position)

(Street Address) (City) (State) (Zip) (Telephone number)

(3) _____
(Name) (Position)

(Street Address) (City) (State) (Zip) (Telephone number)

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

(Read carefully before signing)

I hereby authorize the above-named individuals/institutions to furnish Guthrie County Public Health Nursing Service representatives/local Board of Health/local Nurse 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/institutions from liability for any damages whatsoever for issuing such information.

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

Dated _____ Signature _____

Witnessed _____
(Maiden Name)