

EMPLOYMENT APPLICATION

Marias Medical Center

640 Park Drive
 P.O. Box 915
 Shelby, MT 59474
 (406) 434-3202

FOR OFFICIAL USE ONLY

Date Received _____	Referenced _____
Cert Exp _____	AR Checked _____
Person Spoke to _____	Out of State _____
Person Spoke to _____	Ref by _____

We are an equal opportunity employer. We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status

PERSONAL

Name _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip Code)

Telephone _____ Social Security Number _____
(Area Code)

Driver's License Number _____ State _____ Expiration Date _____

Have you ever been convicted of a crime other than a traffic violation? Yes No EXPLAIN _____
 If so, have any of the convictions related to crimes of violence, fraud, deceit, theft, other deception, or the disclosure of confidential records, or the non-disclosure of reports required by the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act? Yes No _____
 If so, are you under supervision for such crimes? Yes No _____

JOB INTERESTS/SKILLS

Position(s) applied for _____

Are you 18 years of age or older? Can you provide required proof of your eligibility to work? Yes No If under 18 what is your birth date? _____

Type of employment requested Full Time Part Time Temporary Summer

Date you could begin working _____ Are you a citizen of the United States? Yes No
 If not can you provide proof of eligibility to work in the United States? Yes No

Summarize any special skills or qualifications _____

EDUCATION

TYPE OF SCHOOL	NAME AND LOCATION	COURSE OF STUDY	# OF YEARS	GRADE AVERAGE	MAXIMUM GRADE	DEGREE, DIPLOMA, CERTIFICATE AND HONORS RECEIVED
HIGH SCHOOL						
COLLEGE OR UNIVERSITY						
OTHER EDUCATION						
PROFESSIONAL LICENSE OR CERTIFICATION	Expiration Date: _____		Endorsement/Restriction: _____			

EMPLOYMENT HISTORY (LIST MOST RECENT FIRST)

1. Name of Employer _____

Address _____
(Street) (City) (State) (Zip Code) (Phone)

Supervisor and Title _____ Your Title _____

Employed From _____ To _____ Starting Salary _____ Ending Salary _____

Work Performed _____

Reason for leaving _____

2. Name of Employer _____

Address _____
(Street) (City) (State) (Zip Code) (Phone)

Supervisor and Title _____ Your Title _____

Employed From _____ To _____ Starting Salary _____ Ending Salary _____

Work Performed _____

Reason for leaving _____

3. Name of Employer _____

Address _____
(Street) (City) (State) (Zip Code) (Phone)

Supervisor and Title _____ Your Title _____

Employed From _____ To _____ Starting Salary _____ Ending Salary _____

Work Performed _____

Reason for leaving _____

REFERENCES

Name	Relationship	Home Phone	Daytime Phone

ACKNOWLEDGEMENT

I certify that the answers given by me in this application are correct to the best of my knowledge. I understand that any falsification of this application, whether willingly or accidental, is grounds for disqualification of employment consideration, or dismissal from employment if I am hired. I authorize Marias Medical Center to contact any and all of the references I have listed above and to obtain previous employment information or any other pertinent information that they may have. Further, I release the above mentioned references from any and all liability for any damages that may result from information collected by this company. Verification of eligibility to work in the United States must be satisfied for an offer to be made.

Applicant's Signature _____ Date _____