

*Hillstop Health Care Center
Garden View At Hillstop*

Premier Health Care Management Services LLC

Application for Employment

**410 Luella St
Watkins, MN 55389**

Telephone (320) 764-2300
Fax (320) 764-2665

Application for employment

Premier Health Care Management Services LLC

Applicants will receive consideration without discrimination because of race, creed, color, sex, age, national origin, disability, religion, marital status, sexual orientation, status with regard to public assistance, military/veterans status or any other protected classes as defined by law.

Name (Last, First, MI) _____ Social Security Number _____

Address (Street Number/PO Box, City, State, Zip) _____

Telephone Number _____ Emergency Contact/Number _____

Position Applying For _____ Date of Application _____

Best time to contact you at home? _____/_____ a.m./ p.m.

Do any friends/relatives work here (Circle One) Yes No

If Yes, state name, and location _____

Are you currently employed? (Circle One) Yes No

May we contact your present employer? (Circle One) Yes No

Are you legally eligible for employment in the United States? (Circle One) Yes No
Proof of Citizenship or Immigration Status will be Required upon Request

Date available for work _____

What is your desired pay range _____

Are You Available To Work

Full Time (Indicate Shift) First Second Third

Part Time (Indicate Shift) First Second Third

Temporary (Indicate dates available) _____

Are You Currently On "Lay-Off" Status And Subject To Recall? (Circle One) Yes No

Have You Been Convicted Of A Criminal Offense In The Past 15 Years?

(Circle One) Yes No

If Yes, What Was The Date And Nature Of Conviction? _____

Have You Ever Been Convicted or Has There Been Substantiated Abuse Or Neglect Of A Child Or An Adult Involving

Yourself? (Circle One) Yes No

EDUCATION:

Highest Grade Completed (Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Describe Any Specialized Training, Apprenticeship, and Skills _____

ADDITIONAL INFORMATION Other qualifications (Summarize Special Job-Related Skills and Qualifications Acquired From

Employment Or Other Experience) _____

PERSONAL REFERENCES: (NON RELATED)

NAME	ADDRESS	PHONE	RELATIONSHIP	YEARS KNOWN
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1. _____

2. _____

WORK RELATED REFERENCES:

NAME	ADDRESS	PHONE	RELATIONSHIP	YEARS KNOWN
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

COMPANY NAME

Telephone _____

Address (Street, City, State, Zip) _____

Employed (MM/DD/YY) to (MM/DD/YY) _____

Name of Supervisor _____

Hourly Rate/Salary _____

May we contact this employer? _____

Reason for Leaving _____

Person to Contact for Reference _____

Describe Work Performed _____

COMPANY NAME

Telephone _____

Address (Street, City, State, Zip) _____

Employed (MM/DD/YY) to (MM/DD/YY) _____

Name of Supervisor _____

Hourly Rate/Salary _____

May we contact this employer? _____

Reason for Leaving _____

Person to Contact for Reference _____

Describe Work Performed _____

COMPANY NAME

Telephone _____

Address (Street, City, State, Zip) _____

Employed (MM/DD/YY) to (MM/DD/YY) _____

Name of Supervisor _____

Hourly Rate/Salary _____

May we contact this employer? _____

Reason for Leaving _____

Person to Contact for Reference _____

Describe Work Performed _____

Applicant's Statement

I certify that the answers provided in this application are true and complete. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the facility retains the same right. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization. I understand that this application is not a contract of employment; that if hired, regardless of any oral representations to the contrary.

In signing this application, I state that I have received a copy of the Job Description and Essential Functions for all jobs for which I have applied. I understand that failure to fulfill any aspect of the job may be grounds for termination. I also understand I may be required to pass an agility test. I also understand that I may be required to take a physical examination conducted by a physician of the employer's choosing after I am given a qualified offer of employment.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

Name

Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Dear Health Care Employer:

Under Minnesota Statute, effective 07/01/02, health care providers may disclose the following requested information upon a written authorization from the employee with immunity from prosecution. Please fill out the form and return it to us. Thank you.

I, _____ authorize any current and former employers
(name of applicant)
to release to Hilltop Health Care Center the following information:

Dates of employment: _____ to _____
(date) (date)

Compensation and wage history:

Any acts of violence, theft, harassment, or illegal conduct that is documented in the personnel record and any response from the employee:

Any disciplinary warnings or actions taken against the employee within the last five years:

The reason for separation:

Signature of Applicant Date

Person completing this form: _____
Facility: _____
Address: _____
Telephone: _____