Fowler Health Care
221 2nd St.
Fowler, CO 81039
Ph: 719-263-4234 Fax: 719-263-5604

APPLICATION FOR EMPLOYMENT

Date: _____

Name: _____ _____ _____ _____
Last First Middle Maiden (if applicable)

Present Address: _____
Number Street City State Zip

SS#: _____ - _____ - _____ **Telephone:** _____

Position of Interest: _____ **Wage/Salary desired:** _____

_____ **Full Time** _____ **Part Time** **Able to work:** ____ Days ____Evenings ____ Nights
____ Weekends ____ Overtime

Date able to start work: _____

EDUCATION BACKGROUND

	Name of School	Location	Dates	Major & Degree
High School				
Trade Classes				
College/University				

WORK EXPERIENCE

Start with most recent employment

Employer Name: _____ Supervisor: _____
Address: _____ Employment Dates: From _____ To _____
_____ Hourly Wage/Salary: _____
Phone #: _____ Job Title: _____

List the jobs you held, duties performed, skills you used or learned, advancements or promotions while you worked at this company:

_____
_____

Reason for leaving - please be specific: _____
_____

May we contact your current employer? ____ Yes ____ No

WORK EXPERIENCE (Continued)

Employer Name: _____ Supervisor: _____

Address: _____ Employment Dates: From _____ To _____

_____ Hourly Wage/Salary: _____

Phone #: _____ Job Title: _____

List the jobs you held, duties performed, skills you used or learned, advancements or promotions while you worked at this company:

_____

_____

Reason for leaving - please be specific: _____

_____

Employer Name: _____ Supervisor: _____

Address: _____ Employment Dates: From _____ To _____

_____ Hourly Wage/Salary: _____

Phone #: _____ Job Title: _____

List the jobs you held, duties performed, skills you used or learned, advancements or promotions while you worked at this company:

_____

_____

Reason for leaving - please be specific: _____

_____

REFERENCES **List three (3) reference (not co-workers or relatives)**

Office Use Only

Name: _____ Date Called:_____ Completed By:_____

Position: _____ Person talked with: _____

Company: _____ Employment Dates: _____

Address: _____ Comments:_____

_____

Phone # _____

Supervisors Name _____ Eligible for Rehire Yes No

Office Use Only

Name: _____ Date Called:_____ Completed By_____

Position _____ Person talked with: _____

Company _____ Employment Dates: _____

Address: _____ Comments:_____

_____

Phone #: _____

Supervisors Name _____ Eligible for Rehire: Yes No

_____

Office Use Only

Name: _____ Date Called_____ Completed By:_____

Position _____ Person talked with: _____

Company _____ Employment Dates: _____

Address: _____	Comments: _____
_____	
Phone #: _____	
Supervisors Name _____	Eligible for Rehire: Yes No

CRIMINAL BACKGROUND

Have you ever been convicted of a felony? ____ YES ____ NO

If Yes please explain: _____

IDENTIFICATION VERIFICATION

You will need to bring to you interview:

- Drivers License
- Social Security Card
- Photo ID (if Drivers License not available)

Nursing Department Applicants will also need:

- Professional License
- CNA Class Certificate (if not licensed)
- CPR Certification Card

MILITARY SERVICE

Have you ever served in the Armed Forces? _____ Are you a member of the National Guard? _____

BACKGROUND CHECK INFORMATION

Nationcheck is authorized to do a background check on me in the course of consideration for possible employment. I voluntarily and knowingly authorize any law enforcement agency, state, county or federal agency, present employer, past employer or supervisor, administrator, finance/office, credit bureau, collection agency, college, university or other institution of learning or certification, private business, military branch or the National Personal Records Center, personal reference, and/or persons to release records or information they may have concerning my workers compensation claim history, or any other information requested. I voluntarily and knowingly unconditionallyy release any named or unnamed informant from any oand all liability resulting from the furnishing of this information. A photographic or faxed copy of the authorization shall be as valid as the original. My signature at the bottome of this page authorizes Fowler Health Care to release this information to NationCheck. (NationCheck is only an information provider and does not make hiring decisions.)

Applicants Signature _____ Date of Birth _____ Date_____

STATEMENT OF UNDERSTANDING

I understand that neither the acceptance of this application nor the subsequent entry into any type of employment relationship with Fowler Health Care creates an actual or implied contract of employment.

I understand that, if I accept employment with Fowler Health Care, it will be on an at-will basis. This means that either Fowler Health Care of I have the right to terminate the employment relationship at any time, for any reason, with or without cause.

I understand that Fowler Health Care is a drug free work environment. This means my pre-employment drug test must be negative. I release Fowler Health Care, and its employees from any and all liability arising out of or related in any way to such testing. I understand that I will be required to **pay a $20 fee** for pre-employment drug screening. This fee will be refunded if my test is negative.

I authorize Fowler Health Care to investigate information concerning my education, employment experiences and other aspects of my background relevant to my proposed employment. I release Fowler Health Care and its employees from all liability arising form such investigation.

Applicant Signature _____ Date _____

Fowler Health Care is an equal opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability.