



Sheyenne Care Center

Sisters of Mary of the Presentation Health System

EMPLOYMENT APPLICATION

Sheyenne Care Center, in union with the Sisters of Mary of the Presentation, works for the glory of God by bringing the Word and Healing of Jesus Christ to all, with a special concern for the poor. Sheyenne Care Center through a shared ministry with the laity participate, through the health care mission in the work of healing which is, ultimately, the work of God. Our individual inspiration is Jesus and His Gospel message. Permeated with the Charism of the Sisters of Mary of the Presentation, we minister to one another and to all who come to us for care: those who suffer from physical, psychological and social woundedness.

POSITION APPLYING FOR: _____ **DATE OF APPLICATION:** _____
 If no position is listed, the application may not be considered for employment

PERSONAL

Last Name		First Name		Mid.Int.	
Home Address		Apt. #	City		State Zip
(Area Code) Telephone #		U.S. Citizen <input type="checkbox"/> yes <input type="checkbox"/> no		Social Security #	Is your age Under 18 <input type="checkbox"/> yes <input type="checkbox"/> No
List any reason known to you why you might not be able to perform consistently and promptly any of the duties of position applied for: (Please review job description before answering this question)					
Date Available	Starting Salary needed		Will you accept another position? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Please specify		
Will you accept shift work <input type="checkbox"/> yes <input type="checkbox"/> no		Will you accept weekend work <input type="checkbox"/> yes <input type="checkbox"/> no		Your desire <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary	
Were you previously employed at a Sisters of Mary of the Presentation facility <input type="checkbox"/> yes <input type="checkbox"/> no If yes: Where _____ When _____ In what capacity _____					
Have you been convicted of a crime: <input type="checkbox"/> yes <input type="checkbox"/> no If Yes, give date(s), Offense(s), and disposition:			Do you have a friend or relative working here? <input type="checkbox"/> yes <input type="checkbox"/> no Name _____ Dept. _____ Relationship _____		
Have you ever been excluded from participation in any federal or state Medicare, Medicaid or any other third party payor or have such pending action? <input type="checkbox"/> yes <input type="checkbox"/> no If yes. A letter showing reinstatement is required for further consideration for employment.					

EMPLOYMENT HISTORY

List Most Recent position first		List other Names used while employed with these employers.			
From Mo. Yr.	Name of Employer	Name/Title Last Supervisor		Telephone #	
To Mo. Yr.	Address:	Position Held		Ending Salary Per	
Briefly describe the work you performed:					
Reason for Leaving:				May we contact this employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Most Recent position first		List other Names used while employed with these employers.			
From Mo. Yr.	Name of Employer	Name/Title Last Supervisor		Telephone #	
To Mo. Yr.	Address:	Position Held		Ending Salary Per	
Briefly describe the work you performed:					
Reason for Leaving:				May we contact this employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Most Recent position first		List other Names used while employed with these employers.			
From Mo. Yr.	Name of Employer	Name/Title Last Supervisor		Telephone #	
To Mo. Yr.	Address:	Position Held		Ending Salary Per	

Briefly describe the work you performed:

Reason for Leaving: May we contact this employer
 Yes No

EDUCATION

School	Name of School	Location	Years Completed	Date From	To	Course of Study	Did you Graduate	Diploma Degree
Elem.								
High School							<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trade							<input type="checkbox"/> Yes <input type="checkbox"/> No	
College							<input type="checkbox"/> Yes <input type="checkbox"/> No	

REFERENES (NAMES OF PERSONS NOT RELATED TO YOU)

Name	Address	Phone

**PROFESSIONAL LICENSES, REGISTRATION AND/OR CERIFICATIONS – DO NOT INCLUDE
DRIVERS LICENSE**

Type	State Issued	Date Issued	Expires	Number	Eligible
Type	State Issued	Date Issued	Expires	Number	Eligible
Type	State Issued	Date Issued	Expires	Number	Eligible
Type	State Issued	Date Issued	Expires	Number	Eligible

APPLICANT'S CERTIFICATION

I certify that all matters contained in this application are true, and that any misleading or false statements would render this application void and would be sufficient cause for immediate dismissal in the event of employment.

I understand that this is an application for employment and that no employment contract is being offered.

I further understand that as a condition for employment I may be required to submit to a drug test according to Sheyenne Care Center standards and if my drug test results are unsatisfactory, I will not be employed by Sheyenne Care Center.

I hereby authorize Sheyenne Care Center to investigate all matters contained in this application and to contact prior employment to obtain any and all information related to my past work performance.

I agree, if employed to abide by all Sheyenne Care Center rules and regulations. I understand that such employment is for an indefinite period of time and that the company can change wages, benefits and conditions of employment at any time.

I understand that I am required to immediately notify Sheyenne Care Center if any action is proposed to exclude me from participation in any federal or state Medicare, Medicaid or other third party payor program.

I have read and understand the above.

Date: _____ Signature: _____

I certify that all matters contained in this application are true, and that any misleading or false statements would render this application void and would be sufficient cause for immediate dismissal in the event of employment.

1. Have you ever had any convictions for mistreatment, neglect or abuse of an elderly person or someone within your care, or misappropriation of another person's property?

YES NO

2. If an offer of employment is made, I agree to give a release to Sheyenne Care Center allowing them to have a criminal background check conducted.

YES NO

SIGNATURE: _____

DATE: _____

IMPORTANT NOTICE TO ALL APPLICANTS

If you are selected for employment you must be prepared to verify your eligibility to work as required under the Immigration Reform and Control Act of 1986. This requirement applies to all new employees including U.S. citizens, permanent residents and nonimmigrant. You will have to provide documents within 3 days of your hire date to verify your identity and eligibility to work.

AN EQUAL OPPORTUNITY EMPLOYER