



WMS
Willmar**Medical**Services

A joint venture of ACMC and Rice Memorial Hospital

Employment Application

Please return application form to the
Human Resources Department.

101 Willmar Avenue SW • Willmar, MN 56201-359
320-231-5000 • 1-888-225-6580 • www.acmc.com

Date of Application: _____

LAST NAME		FIRST NAME	MIDDLE NAME	SOCIAL SECURITY #	
OTHER NAMES YOU HAVE USED TO IDENTIFY YOURSELF (FOR REFERENCE PURPOSE ONLY)					
CURRENT MAILING ADDRESS	STREET		CITY	STATE	ZIP CODE
PERMANENT ADDRESS (IF DIFFERENT FROM ABOVE)					
PHONE NUMBER			OTHER NUMBERS WHERE YOU MAY BE CONTACTED		
BEST TIME TO CONTACT YOU AT HOME _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.			MAY WE CONTACT YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WORK NUMBER AND BEST TIME TO CALL (____) _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		

HOW WERE YOU REFERRED TO OUR ORGANIZATION?	HAVE YOU BEEN EMPLOYED HERE BEFORE? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, give dates: from _____ to _____
DATE AVAILABLE TO START WORK	ARE YOU LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES? <input type="checkbox"/> No <input type="checkbox"/> Yes
WILL YOU NOW OR IN THE FUTURE REQUIRE SPONSORSHIP BY WILLMAR MEDICAL SERVICES, LLP FOR EMPLOYMENT AUTHORIZATION IN THE UNITED STATES? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>Explain</i>)	
HAVE YOU EVER BEEN CONVICTED OF, OR ENTERED A PLEA OF GUILTY OR NO-CONTEST TO, A FELONY? ** <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>Explain</i>)	

****THIS INFORMATION MAY BE CONSIDERED IN HIRING OR JOB PLACEMENT, BUT WILL NOT AUTOMATICALLY DISQUALIFY YOU FOR EMPLOYMENT.**

WORK PREFERENCE

POSITION APPLYING FOR OR TYPE OF WORK YOU ARE INTERESTED IN	SALARY EXPECTED
EMPLOYMENT INTEREST IS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PART TIME <input type="checkbox"/> SUMMER	DATE AVAILABLE TO START WORK
GEOGRAPHIC REQUIREMENTS-Circle the affiliate location(s) you are interested in working. ACMC Imaging Willmar Surgery Center Rice Hospital Imaging Cancer Treatment Center Diabetes Center	

All applicants are encouraged to submit a resume for previous employment listing.

EDUCATIONAL RECORD

SCHOOL	NAME & LOCATION	COURSE OF STUDY	CHECK YEAR COMPLETED				DID YOU GRADUATE?		CERTIFICATE/ DEGREE RECEIVED
			1	2	3	4	YES	NO	
HIGH									
TECHNICAL									
COLLEGE									
COLLEGE									
HONORS RECEIVED INCLUDING SCHOLASTIC AND HONORARY ORGANIZATIONS TO WHICH YOU WERE ELECTED OR APPOINTED									
EXTRACURRICULAR ACTIVITIES IN WHICH YOU ACTIVELY PARTICIPATED PLEASE INDICATE ANY OFFICES HELD**									

**Applicant need not disclose any activities which might reveal them as a member of a protected class.

LICENSES AND/OR CERTIFICATIONS

NURSES, MEDICAL TECH, X-RAY TECH, ETC.

<p>CURRENT NUMBER: _____</p> <p><input type="checkbox"/> LICENSE</p> <p><input type="checkbox"/> CERTIFICATE</p> <p><input type="checkbox"/> REGISTRATION</p>	<p>OCCUPATION _____</p> <p>STATUS OF LICENSE _____</p> <p>EXPIRATION DATE _____</p> <p>STATE ISSUED: _____ DATE: _____</p>
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OTHER QUALIFICATIONS

SUPERVISORY EXPERIENCE

EXPLAIN NATURE OF SUPERVISION

OTHER TRAINING AND EXPERIENCE

DESCRIBE ANY TRAINING, EXPERIENCE OR QUALIFICATIONS (NOT PREVIOUSLY COVERED) THAT MIGHT BE OF INTEREST

EMPLOYMENT HISTORY

LIST MOST RECENT FIRST

COMPANY NAME		FROM		TO		STARTING SALARY
		MO.	YEAR	MO.	YEAR	
						ENDING OR CURRENT SALARY
JOB TITLE	CITY STATE					
SUPERVISOR'S NAME	TELEPHONE NUMBER () -	REASON FOR LEAVING				MAY WE CONTACT THIS EMPLOYER
BRIEF JOB DESCRIPTION					<input type="checkbox"/> Yes, Immediately <input type="checkbox"/> Yes, At a Later Date <input type="checkbox"/> No, Do Not Contact	

COMPANY NAME		FROM		TO		STARTING SALARY
		MO.	YEAR	MO.	YEAR	
						ENDING OR CURRENT SALARY
JOB TITLE	CITY STATE					
SUPERVISOR'S NAME	TELEPHONE NUMBER () -	REASON FOR LEAVING				MAY WE CONTACT THIS EMPLOYER
BRIEF JOB DESCRIPTION					<input type="checkbox"/> Yes, Immediately <input type="checkbox"/> Yes, At a Later Date <input type="checkbox"/> No, Do Not Contact	

COMPANY NAME		FROM		TO		STARTING SALARY
		MO.	YEAR	MO.	YEAR	
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		MO.	YEAR	MO.	YEAR	
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BRIEF JOB DESCRIPTION					<input type="checkbox"/> Yes, Immediately <input type="checkbox"/> Yes, At a Later Date <input type="checkbox"/> No, Do Not Contact	

REFERENCES

LIST AT LEAST 3 REFERENCES WHO ARE NOT RELATIVES OR EMPLOYERS:

NAME	RELATIONSHIP/TITLE	MAILING ADDRESS	TELEPHONE

APPLICANT'S STATEMENT

I certify that all information I have provided is true, complete and correct.

I understand that any information provided by me that is found to be false, incomplete or misrepresented, will be cause to (i) cancel further consideration of this application, or (ii) immediately discharge me from the employer's service, whenever it is discovered.

I expressly authorize, without reservation, the employer, its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume or job interview. I hereby waive any and all rights and claims I may have regarding the employer, its agents, employees or representative, for seeking, gathering and using such information in the employment process and all other persons, corporations or organizations for furnishing such information about me.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and the employer reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute contract for employment for any specified period or definite duration. I understand that no representative of the employer is authorized to make any assurances to the contrary and that no implied oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the employer's president.

I further understand that an offer of employment is conditional based on proper employment authorization, favorable background verification, ability to perform the essential functions of the job (with or without reasonable accommodations) and passing a pre-employment drug screen.

Minnesota law prohibits smoking in medical facilities, therefore the applicant agrees to refrain from tobacco products within the facility, surrounding grounds, or company owned vehicles.

I also understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete an I-9 Form.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANT STATEMENT.

I certify that I have read, fully understand and accept all terms as stated above.

SIGNATURE OF APPLICANT _____ **DATE** _____

DISCLOSURE AND AUTHORIZATION REGARDING BACKGROUND CHECK

In considering your application for employment or in making other employment decisions, Willmar Medical Services may request that a consumer reporting agency prepare a consumer report or investigative consumer report (“investigative report”) regarding you. In addition, Willmar Medical Services may independently conduct background checks on you. The consumer report, investigative report and/or background check may include, but not be limited to, information regarding your credit history, criminal convictions, employment history, education, training, motor vehicle records, personal references, any data provided on this application and/or during the interview process.

1. By signing this disclosure, you consent to Willmar Medical Services’ obtaining a consumer report and/or investigative consumer report on you and further consent to Willmar Medical Services’ independently conducting a background check on you. Your failure or refusal to consent may be considered by Willmar Medical Services in evaluating your application for employment or in making other employment decisions.

2. By this disclosure, you are advised of your right to receive a copy of the consumer report and/or the investigative report obtained by Willmar Medical Services. By checking the box found on the bottom of this form, you may request at no expense a copy of either the consumer or investigative report, should one be prepared.

3. In accordance with the federal Fair Credit Reporting Act, if an investigative report is requested, (a) you have the right to request that Willmar Medical Services completely and accurately disclose to you the nature and scope of any requested report, (b) you are being provided a written summary of your rights under the Fair Credit Reporting Act together with this Authorization form, and (c) you have the right to obtain a copy of the report by providing proper identification and directing a written request to Verified Credentials, Inc. (20890 Kenbridge Court, Lakeville, MN 55044. 1-800-473-4934) or by checking the box below.

I hereby authorize the appropriate individuals, entities, institutions or agencies to release information, and I release them from any liability as a result of such inquiries or disclosures. I further understand and waive my right of privacy in this investigation. By signing the acknowledgement below, I hold harmless and release Willmar Medical Services and its agent Verified Credentials, Inc. from any and all liability relating to or arising from such consumer reports and/or consumer investigative reports and/or background checks.

I hereby certify that all the statements and answers I provided in connection with my application for employment with Willmar Medical Services (e.g., on my application, cover letter and/or resume) are true and complete to the best of my knowledge, and I understand that if any statements and/or answers are found to be false, misleading or information has been omitted, such statements or omissions may be cause for rejection of my application or termination of my employment if already employed.

Legal Last Name	Legal First Name	Legal Middle Name
<hr/>		
Street Address		
<hr/>		
City	State	Zip Code

Please list any additional cities and states you have lived in during the past 7 years:

Please list any other names used in the past 7 years:

Drivers License Number	State Issued	Expiration Date	Date of Birth (To be used for background information only)
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I authorize a photocopy of this release to be accepted with the same authority as the original and if employed by the above named company this release will remain in effect throughout such employment.

Signature	Social Security Number	Date
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I wish to receive a copy of any consumer and/or investigative report requested by Willmar Medical Services.

If currently employed: My current employer may be contacted YES NO