



# Community Memorial Hospital

SO MUCH. SO CLOSE TO HOME. **Cloquet**

**Community Memorial Hospital**  
 Human Resources  
 512 Skyline Boulevard  
 Cloquet, MN 55720  
 218.879.4641  
 www.cloquethospital.com

Community Memorial Hospital (CMH) welcomes you as an applicant for employment. Résumés are accepted but are not a substitute for this application. Applications must be **complete** for consideration. Acceptance of your application for employment by CMH does not imply that you will be hired and should not be construed as a contract or promise of employment. Your application for employment will be considered current for six months from the date it was received.

## Employment Application

An Equal Opportunity and Affirmative Action Employer.

Date of Application:
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**PLEASE PRINT IN INK OR TYPE; COMPLETE ENTIRE APPLICATION**

CONTACT INFORMATION				
Last Name		First Name		Middle Initial
Street Address		City		State      Zip
E-mail Address			Social Security #	
Home Phone (      )		Alternative Phone (      )		

JOB INTEREST	
Posting Number applying for	Job Title (limit one; employment applications remain active for 6 months from receipt)
Number of Hours <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> On call	Shifts Available <input type="checkbox"/> Days <input type="checkbox"/> Afternoons <input type="checkbox"/> Nights <input type="checkbox"/> Any
Salary requirements	Days of week available? <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday

EMPLOYMENT ELIGIBILITY		
Have you ever worked for Community Memorial Hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶	Are you eligible for rehire? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you understand that Community Memorial Hospital is a tobacco, drug and alcohol free campus? <input type="checkbox"/> No <input type="checkbox"/> Yes
Your name while working here	Hire date	Termination date
Job Title	Department	Supervisor
Are any of your relatives presently employed with Community Memorial Hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ Name, Relationship, Department: _____		
Are you 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ If no, what is your age: _____	Are you legally authorized to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ If hired, you will be required to show proof.	
NOTICE TO APPLICANT		
Should you be offered a position within Community Memorial Hospital you will be required to complete a background investigation. On a separate form, you will be asked to respond to questions related to any conviction or plea of guilty or nolo contendere to a petty misdemeanor, gross misdemeanor or felony. Conviction of a crime does not automatically disqualify you for employment, however it may impact the job that is appropriate for you within Community Memorial Hospital.		
Are you currently a temporary or contract employee working at Community Memorial Hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ Name of Agency: _____ Department: _____		

REFERRAL SOURCE (Check all that apply)		
<input type="checkbox"/> Employee referral _____	<input type="checkbox"/> CMH Posting Board	<input type="checkbox"/> School _____
<input type="checkbox"/> Job Fair _____	<input type="checkbox"/> CMH Web-site	<input type="checkbox"/> Radio _____
<input type="checkbox"/> Agency _____	<input type="checkbox"/> CMH Job Hotline	<input type="checkbox"/> Minnesota Job Bank
<input type="checkbox"/> Newspaper ad _____	<input type="checkbox"/> Telephone Inquiry/walk-in	<input type="checkbox"/> Other _____

FOR OFFICE USE ONLY	
Posting Number	Applicant Number
Interview dates	Code

**EMPLOYMENT RECORD**

Starting with your PRESENT or most RECENT Employer, please list all jobs you have had including experience in the military. Do not omit work experience just because it may be unrelated to the job for which you are applying. Attach an additional sheet if necessary  
**PLEASE COMPLETE THIS SECTION EVEN IF YOU ARE PROVIDING A RÉSUMÉ.**

Name of present or last employer

Employer's street address

City

State

Zip

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

 Part time  Full time

Avg. hours/week

Job title

Description of duties

Reason(s) for leaving

Are you eligible for rehire?

 Yes  No

May we contact?

 No ► If No, why? \_\_\_\_\_

Your name when working there (first, middle, last)

 Yes ► If Yes, Supervisor's name \_\_\_\_\_

Phone and extension

Final Pay \$ \_\_\_\_\_ Circle one  
hr wk yr

Name of last employer

Employer's street address

City

State

Zip

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

 Part time  Full time

Avg. hours/week

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Phone and extension

Final Pay \$ \_\_\_\_\_ Circle one  
hr wk yr

Name of last employer

Employer's street address

City

State

Zip

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

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Phone and extension

Final Pay \$ \_\_\_\_\_ Circle one  
hr wk yr

Name of last employer

Employer's street address

City

State

Zip

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

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 Yes ► If Yes, Supervisor's name \_\_\_\_\_

Phone and extension

Final Pay \$ \_\_\_\_\_ Circle one  
hr wk yr

EDUCATION					
SCHOOLS ATTENDED	NAME OF SCHOOL AND LOCATION	DID YOU GRADUATE?	CHECK ONE BOX	GRADE POINT AVERAGE	
HIGH SCHOOL	Name of School	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Currently Enrolled	<input type="checkbox"/> Diploma <input type="checkbox"/> GED		Major course of study
	City and State				Your name while attending
	Circle highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12				
TECHNICAL VOCATIONAL BUSINESS OR MILITARY TRAINING	Name of School	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Currently Enrolled	<input type="checkbox"/> Assoc. Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate		Degree/Major
	City and State				Your name while attending
COLLEGE OR UNIVERSITY	Name of School	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Currently Enrolled	<input type="checkbox"/> Degree <input type="checkbox"/> Certificate		Degree/Major
	City and State				Your name while attending
GRADUATE SCHOOL	Name of School	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Currently Enrolled	<input type="checkbox"/> Degree <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate		Degree/Major
	City and State				Your name while attending

To be completed by Registered/Licensed/Certified applicants – list all active and expired.			
License/Certification	State	License/Certification #	Expiration date
License/Certification	State	License/Certification #	Expiration date
License/Certification	State	License/Certification #	Expiration date
License/Certification	State	License/Certification #	Expiration date
Are there any restrictions to your license(s)?			
<input type="checkbox"/> No <input type="checkbox"/> Yes ► If Yes, explain: _____			
Is your license now or has it ever been under investigation or encumbered in Minnesota or any other state?			
<input type="checkbox"/> No <input type="checkbox"/> Yes ► If Yes, explain: _____			
Are you CPR Certified?		Are you ACLS Certified?	
<input type="checkbox"/> No <input type="checkbox"/> Yes ► Certification date ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Yes ► Certification date ____/____/____	
<b>Nursing Assistants – Are you on the Minnesota Registry?</b>			
<input type="checkbox"/> No <input type="checkbox"/> Yes ► If hired, you will be asked to provide proof of licensure.			

REFERENCES – To be completed by all applicants			
LIST WORK OR EDUCATION – RELATED REFERENCES. DO NOT LIST FRIENDS OR RELATIVES.			
NAME	ADDRESS	DAYTIME PHONE	RELATIONSHIP



**Agreement and Applicant Release**

I understand that the information on this application has been requested for the purpose of evaluating my qualifications for employment and that this document, or any item discussed regarding employment, does not constitute a contract or promise of employment. I affirm that the information provided in my application, résumé and interview is true and correct to the best of my knowledge.

I authorize Community Memorial Hospital to investigate my background including all the information contained in my application and information I provide in the interview.

I understand and agree that any offer of employment is dependent upon my satisfactory completion of Community Memorial Hospital's pre-employment investigation, which may include but is not limited to a pre-placement health assessment; verification of current work authorization in the United States; criminal history check; Office of the Inspector General check; work history verification; reference checks and any other investigations required by the position for which I am applying or mandated by local, state or federal laws. I waive and release any and all claims, including but not limited to claims of defamation, libel and slander, that I may have against any such individual or company as a result of their compliance with Community Memorial Hospital's request for information.

I authorize all educational institutions I have attended to provide Community Memorial Hospital with all information which it seeks related to the dates of my attendance, the degrees I have named, the courses I have taken, my grades and related matters. I waive and release any and all claims I may have against these institutions as a result of their compliance with Community Memorial Hospital's request for information.

I understand that Community Memorial Hospital is a Tobacco, Drug, and Alcohol Free Campus.

By signing below, I am affirming my understanding and acknowledgment of support in all items addressed in this document. I further understand that if I am hired by Community Memorial Hospital and I am not covered by a collective bargaining agreement containing a contrary provision, my employment will be "at will", which means that either Community Memorial Hospital or I may terminate the employment relationship at any time for any reason. I further understand that, if hired, my "at will" employment may only be changed in a written document signed by the CEO/Administrator of Community Memorial Hospital (or designee), and that no representative of Community Memorial Hospital has the authority to make any oral promise to me concerning my employment.

I hereby certify that all the statements and answers set forth on the application form and/or my résumé are true and complete to the best of my knowledge, and I understand that if any statements and/or answers are found false or that information has been omitted, such false statements or omissions may be cause for rejection of my application or termination of my employment.

SIGNATURE: **X** \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
First Middle Initial Last



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## EQUAL OPPORTUNITY INFORMATION

The information requested is being used in accordance with the Minnesota and Federal Human Rights Act and rules and regulation adopted pursuant to these acts.

The equal employment opportunity record will be kept separate from your personnel file and the answers to the questions will **NOT** be used in the hiring or promotion process. **Providing this information is voluntary and will be treated with confidentiality.** If you refuse to provide this information you will not be subject to adverse treatment.

I understand what I have read and  wish  do not wish to supply the information below

Date: \_\_\_\_\_

Position applying for: \_\_\_\_\_

Sex:  Male  Female

Race/Ethnic group: (check one)

**AFRICAN AMERICAN**

Persons having origins in any Black racial groups of African (not of Hispanic) origin.

**ASIAN OR PACIFIC ISLANDER**

Persons having origins in any of the Far East, Southeast Asia, Indian Subcontinent (India, Pakistan, Bangladesh, Sri Lanka, Nepal, Sikkam and Bhutan), or Pacific Islands (China, Japan, Korea, Philippine Islands and Samoa).

**INDIAN OR ALASKAN NATIVE AMERICAN**

Persons having origins in any of the original people of North America, who maintain cultural identification through tribal affiliation or community recognition.

**HISPANIC**

Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture, regardless of race.

**CAUCASIAN**

Persons having origins in any of the original peoples of Europe, North Africa or the Middle East, (not of Hispanic origin).

Veteran:  No  Yes

Disability:  No  Yes

Hearing impairment

Mental illness

Disability impairment

Learning disability

Visual impairment

Other: \_\_\_\_\_

If yes, please describe:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**EVEN IF YOU HAVE FILLED OUT THE ABOVE INFORMATION GIVING YOUR IDENTITY IS OPTIONAL**

\_\_\_\_\_  
 Last Name

\_\_\_\_\_  
 First Name

\_\_\_\_\_  
 Middle