

EMPLOYMENT APPLICATION

Please Print. Read Carefully. Complete all sections.

POSITION APPLYING FOR: _____ Mercy Defiance Hospital
 _____ Mercy Defiance Clinic
 ALTERNATE POSITION OF CHOICE: _____ Mercy Napoleon Clinic

Name: (Last) _____ (First) _____ (Middle) _____ Today's Date _____

Address: _____ Street _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Number _____ Social Security#: _____ Date of Birth: (if under 18): _____
 () () -- --

In emergency notify: Name: _____ Phone#: () _____

How were you referred to this organization? Walk In Web Site Advertisement _____
 Employee _____ Other _____

Employment status preference:
 Full Time _____ Part Time _____ Supplemental _____ Contingent _____ Temporary _____ Per Diem _____

Shift Preference: First _____ Second _____ Third _____ Variable _____ Weekends _____

When would you be available to begin employment? _____

EDUCATIONAL BACKGROUND

School	Name and address of School	Circle Last Year Completed	Did You Graduate?	List, Diploma, Degree, or Certificate
High School/GED		1 2 3 4	____ Yes ____ No	
College or University (Undergraduate)		1 2 3 4	____ Yes ____ No	
College or University (Graduate)		1 2 3 4	____ Yes ____ No	
Other		1 2 3 4 5	____ Yes ____ No	

PROFESSIONAL REGISTRATION/LICENSURE/CERTIFICATION

License Name	Number	State(s)	Current?	Expiration Date
			____ Yes ____ No	
			____ Yes ____ No	
			____ Yes ____ No	

Have you ever had any professional license or certification suspended, revoked, or put on probation?
 No _____ Yes _____ Please explain: _____

Is your license or certification currently under investigation?
 No _____ Yes _____ Please explain: _____

Have you ever been denied a license or certification?
 No _____ Yes _____ Please explain: _____

No _____ Yes _____ Please explain: _____

EMPLOYMENT (PLEASE PRINT) (Start with your present or last job) "See resume" is not acceptable.

Employer: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
From _____ / _____ **To** _____ / _____
Hourly Rate of Pay: \$ _____
Reason for Leaving: _____
May we contact this employer at this time? Yes ___ **No** ___

Position: _____
Duties: _____

Supervisor: _____
Supervisor's Phone # :(_____) _____ - _____

Employer: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
From _____ / _____ **To** _____ / _____
Hourly Rate of Pay: \$ _____
Reason for Leaving: _____
May we contact this employer at this time? Yes ___ **No** ___

Position: _____
Duties: _____

Supervisor: _____
Supervisor's Phone # :(_____) _____ - _____

Employer: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
From _____ / _____ **To** _____ / _____
Hourly Rate of Pay: \$ _____
Reason for Leaving: _____
May we contact this employer at this time? Yes ___ **No** ___

Position: _____
Duties: _____

Supervisor: _____
Supervisor's Phone # :(_____) _____ - _____

OTHER KNOWLEDGE, SKILLS, AND ABILITIES: _____

Do you have the legal right to work in the United States? Yes ___ **No** ___

Have you ever been employed by Mercy Defiance Clinic, Mercy Health Partners or Catholic Health Partners?
Yes ___ **No** ___ **If yes, indicate the location worked: Mercy Defiance Hospital** ___ **Mercy Defiance Clinic** ___
Mercy St. Vincent Medical Center ___ **Mercy Children's Hospital** ___ **Mercy St. Charles Hospital** ___
Mercy St. Anne Hospital ___ **Mercy Tiffin Hospital** ___ **Mercy Willard Hospital** ___ **Other** _____

Last Year employed? _____ **Under name of:** _____

Do you have any relatives employed by the Mercy Health Partners Metro Division or Mercy Defiance Clinic:
Yes ___ **No** ___

If yes, please give Name, Department and Relationship.
Name: _____ **Dept.** _____ **Relationship** _____

Were you in the U.S. Armed Forces: Yes ___ **No** ___ **If yes, What branch:** _____

Special Training: _____

Are you now a member of the National Guard or Reserve Unit? Yes ___ **No** ___

Have you ever been convicted of a felony? A "yes" answer does not automatically disqualify you. Yes ___ **No** ___
If yes, state nature of conviction & dates: _____

Have you ever been excluded or suspended from taking part in any federal or state-funded health care program, including but not limited to Medicare or Medicaid? Yes ___ **No** ___ **If yes, Explain:** _____

Are you, or is an employer of yours within the past year, currently under investigation for healthcare fraud, abuse or misconduct from participation in any Federal or State healthcare program, including Medicare and/or Medicaid? Yes ____ No ____ If yes, please explain _____

Are you currently on "layoff" status and subject to recall? Yes ____ No ____
Have you ever been discharged by an employer or resigned in lieu of discharge? Yes ____ No ____
If yes, please explain: _____

PROFESSIONAL REFERENCES

Name	Title/Relationship	Company	Telephone

AUTHORIZATION AND UNDERSTANDING

I certify all statements made by me on this application are true and complete to the best of my knowledge and without consequential omissions of any kind. I also certify that I have not knowingly withheld any information that would affect this application unfavorably. I understand and agree that any false statement or omissions as discussed above with respect to the information required on this application is grounds for refusal to hire me or for withdrawal of any offer of employment made to me or for the termination of my employment by Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic.

I authorize Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic to investigate all matters covered by this application as well as all statements made by me on this application. I also authorize my previous employers, schools, or other persons named as references or former supervisors to disclose information they may have regarding my suitability for employment and the matters addressed in my application and release them from any liability arising out of their disclosure of information. I further release Mercy Defiance Hospital, Mercy Defiance Clinic, Mercy Napoleon Clinic and its employees and agents from all liability for damages whatsoever if an employment offer is not tendered to me, or is withdrawn, or if my employment is terminated because of the results of the investigation of this application.

I understand that if I am offered employment with Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic, I may terminate my employment at any time with or without cause, and Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic may terminate or modify the relationship at any time with or without cause.

In consideration of my employment, I agree to conform to policies and procedures of Mercy Defiance Hospital, Mercy Defiance Clinic, and Mercy Napoleon Clinic, and I understand that no representative of Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic has the authority to enter into an agreement that changes or is contrary to the above.

I understand that if I am offered employment by Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic, the offer is contingent upon my passing a physical examination, which includes drug screening. This is to determine if I can perform safely and satisfactorily, with reasonable accommodation to any handicap, the essential elements of the position for which I am applying. I consent to take future examinations that may be required by Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic. I understand that I may be required to be tested for drug or alcohol use according to applicable policies.

I understand that if I am offered employment by Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic, the offer is contingent on my passing a background check.

I understand that if I am employed, the needs of Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic may make the following conditions mandatory: overtime, shift change, a rotating work schedule, or a work schedule other than Monday through Friday.

I hereby certify that I am genuinely interested in employment with Mercy Defiance Hospital, Mercy Defiance Clinic, or Mercy Napoleon Clinic, and acknowledge that I have read and understood the above statements and had the opportunity to ask questions.

Print Name

Signature

_____/_____/_____
Date

