MEMORIAL COMMUNITY HEALTH, INC.
1423 7th Street
Aurora, NE 68818
402-694-3171

APPLICATION FOR EMPLOYMENT

Thank you for applying for employment with Memorial Community Health, Inc. MCHI has adopted six Standards of Behaviors. These Behavior Standards are about improving patient, resident and employee satisfaction and to focus our job around the hub of Purpose, Worthwhile Work and Making a Difference. Memorial Community Health, Inc. isn't just a good place to work, it's a GREAT place to work.

STANDARDS OF BEHAVIOR

From Beginning to End, Improving Lives through Community Health Services

POSITIVE ATTITUDE

- I will be helpful and courteous by offering assistance and walking customers to their destination and going the extra mile for anyone in my path.
- I will make eye contact and offer a greeting to everyone I meet.
- I will practice the 3 E's, encouragement, empathy and enthusiasm. I will choose not to use the three B's, belly aching, back biting and bickering.

TEAMPLAYER

- I will work to resolve conflicts and achieve balance by setting aside differences when working together.
- I will be an organized team player and offer to assist my co-workers as time permits.

COMMUNICATION

- I will inform coworkers of my whereabouts if leaving the department.
- I will make sure customer information is kept confidential.
- I will identify myself, the facility or department when answering the telephone.

KNOWLEDGE/CONFIDENCE

- I will be familiar with the policies and procedures of my department and the facility.
- I will attend departmental and informational meetings.
- I will introduce myself when entering a patient/resident room and explain my purpose and any procedure(s) to be done.
- I will answer questions truthfully and obtain necessary information if answer unknown.
- I will be familiar with equipment use, storage and maintenance.

INTEGRITY

- I will take responsibility for my actions and be truthful.
- I will ensure that personal conversations, demeanor and behaviors are appropriate for the situation.
- I will treat all others with dignity and respect.

APPEARANCE

- I will follow my departmental dress code and wear my name tag clearly visible.
- I will have good personal hygiene (clean hair, teeth, nails, clothing), and be fragrance free (perfume, smoke). Use of Febreeze and breath mints encouraged.
- I will keep gum chewing to a minimum (no snapping or popping).
- I will keep the facility clean and neat. If I see trash/spills I will take appropriate actions.
- I will keep my work area clean and organized.

Effective: 1/1/2006

APPLICATION FOR EMPLOYMENT

MEMORIAL COMMUNITY HEALTH, INC.
1423 Seventh Street
Aurora NE 68818-1197
(402) 694-3171

Federal and State laws prohibit discrimination in employment because of sex, age, race, color, religion, creed, marital status, national origin, ancestry, disability or handicap.

Pre-Employment Drug Screens are required. Policy available upon request.

PERSONAL INFORMATION: DATE: ______________

NAME ____
Last First Middle Initial

PRESENT ADDRESS ____
Street City State Zip Code

TELEPHONE ___________________________ SOCIAL SECURITY NUMBER ______________________________

If you cannot be reached at above phone number, where may we contact you?
Name ____ Phone Number ____

If under 18 years of age, do you have parental permission? Yes _____ No _____ Name ________________________________

Telephone Number ______________________________ Relationship ____

If not a U.S. citizen, do you have the legal right to remain permanently and work in the United States? Yes _____ No _____

Have you ever been convicted of a felony? Yes _____ No _____

Have you ever been treated for chemical dependency? Yes _____ No _____

Have you ever been sanctioned or an excluded provider for a federal or state health care program or have any such actions under investigation at this time?
Yes _____ No _____

EMPLOYMENT DESIRED

Position/Type of work applied for ____

Shift you can work: Day _____ Evening ____ Night ____ Rotation ____ Date you can start: ____________________________

Professional Licenses/Certifications: Has your license ever been revoked or placed on probation? Yes _____ No _____

Type ____ Number ___________________ Expiration Date _____________

Type ____ Number ___________________ Expiration Date _____________

Have you ever worked for any department of this facility before? Yes _____ No _____ When? ______________________________

Name at that time ___________________________________ Supervisor ____________________________________

Reason for leaving ____

EDUCATION:

Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 Masters Doctorate
(circle grade completed) Grade School High School College

	Name and Address of School	Course/Type of Study	Degree/Diploma/Certificate	Year Obtained
College				
Vocational/ Trade School				

REFERENCES: Please list three people not related to you.

	NAME	ADDRESS (Street, City, State, Zip)	PHONE #:	YEARS ACQUAINTED
1.		____	_________________	__________
2.		____	_________________	__________
3.		____	_________________	__________

FORMER EMPLOYERS:

List below your work experience starting with your present or last place of employment.

DATE	Name and Address of Employer	Name of Supervisor	Position/Duties	Reason for Leaving
From To	Name: ___________________________ Address: _________________________ ________________________________	 Phone:		
From To	Name: ___________________________ Address: _________________________ ________________________________	 Phone:		
From To	Name: ___________________________ Address: _________________________ ________________________________	 Phone:		

May we contact your present employer at this time? Yes ___ No ___
Please attach any resume or additional information you wish to submit with this application.

In case of emergency
Notify: ____
Name Address

Home: _____________________
Work: _____________________
Phone Numbers

APPLICANT'S STATEMENT

If employed by Memorial Community Health, Inc., I agree to abide by compliance plans and its rules and regulations. The above information is complete and true to the best of my knowledge. I understand that discovery of misrepresentation or omission of facts herein will be cause for immediate dismissal. I authorize this facility to contact any and/or all of my references and/or previous employers for full information. I agree to take a physical examination, including a drug screen, at any time, at the request of this facility, and agree that the examining physician may disclose the findings to this facility or an authorized agent of this facility as it relates to the essential functions of my job only. I further understand that this is an application for employment and that no contract is being offered. I understand that MCHI is an "at-will" employer. This means that except as protected by federal or state statute, my employment may be terminated by myself or by MCHI at any time. I understand that if I am employed, such employment is an indefinite period of time and that the company can change wage, benefits, and conditions at any time. Incomplete applications will not be accepted or processed.

I understand that a set of Standards of Behavior has been developed by the employees of MCHI to establish specific behaviors that all employees are expected to practice while on duty.

By incorporating these standards as a measure of overall work performance, MCHI makes it clear that employees are expected to adhere to and practice the standards of behavior outlined in the Personnel Manual and as stated on this application.

I have read and understand the Standards of Behavior and, if offered employment by MCHI, I agree to comply with and practice the standards as outlined.

I certify that I have not been convicted of an offense that would preclude employment in a health care facility (hospital, nursing facility, clinic or other positions hired by Memorial Community Health, Inc.) and that I am not excluded from participation in a federal or state health care program.

____
Applicant's Signature

(Do not write below this line)

Interviewed by: ____ Date: ___________________________

Remarks: ____

Hired: ________ If yes, position ________________________________ If no, consider for another position __________________________

Scheduled # of Hours/Days: ______________________ Start Date ____________________ Wages______________________

Approved by Department Head: ____

Approved by Administration: ____

MEMORIAL COMMUNITY HEALTH, INC.
dba Memorial Hospital, Memorial Community Care,
Memorial Health Clinics and East Park Villa
1423 Seventh Street
Aurora NE 68818-1197

AUTHORIZATION TO RELEASE INFORMATION

The individual named below has applied for employment with our facility. His/her signature represents agreement for information to be released by you. Please complete this form and return as soon as possible. Thank you.

I, ____, authorize previous employers and references to furnish any information which may be requested by Memorial Community Health, Inc. and pertinent to my employment/position. I release such persons from claims or liabilities, as a result of disclosure, whether favorable or unfavorable. It is agreeable to me that a photocopy of this release is acceptable.

Signature: ____ Date ________________________

Name at the time of Employment ____

Social security number ____________________________________

Date(s) of employment:

________ to ________	EXCELLENT	GOOD	FAIR	POOR	NO OPPORTUNITY TO OBSERVE
Quality of Work					
Conduct					
Attendance/Tardiness					
Attitude About Work					
Relationships with Others					
Initiative					
Potential					
Health					

What are his/her outstanding strengths? ____

____

What are his/her weaknesses?

____

____

Would you re-employ? Yes ___ No ___ If no, why? ____

Comments:

____

____

____

Signature _______________________________________ Title ____

Facility ____ Date ____

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This form is not required to be completed until an employment opportunity has been offered.

I understand that as a condition of my employment, my name will be checked against the following as indicated by the position for which I am applying. My signature authorizes the following agencies to release information to Memorial Community Health, Inc., dba Memorial Hospital, Memorial Health Clinics, Memorial Community Care and East Park Villa, regarding me which may be listed on their respective registries. A check of these registers may be necessary to ensure that I meet provider standards.

1. Nebraska State Patrol
2. Nebraska Sex Offender Registry
3. Licensure Verification
4. Nurse Aide Registry
5. Office of the Inspector General's list of Sanctioned and Excluded Individuals
6. Social Security Number Verification
7. Specially Designated Nationals

To the best of my knowledge, I do not have a conviction or prior history of adult or child abuse/neglect or maltreatment nor the misappropriation of funds or property. Neither have I been convicted of a crime involving moral turpitude.

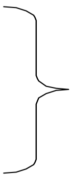
I understand that the information provided may be used to reach an adverse decision regarding my employment, up to and including, not being hired or termination if my work for Memorial has already begun. The following information has been provided by me in order to complete the required background checks as listed above. A copy of this consent may be used.

PLEASE PRINT. The back of the form may be used for additional information.

______________________________ ____________________
(Signature of Applicant/Employee) (Date Signed)

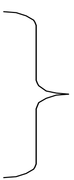
______________________________ ____________________
(Printed or Typed Name of Applicant/Employee) (Social Security Number)

____
____
____



Other Names Used
(Please Print or Type)

____
____
____



Other Addresses in Past Twenty (20) Years
(Please Print or Type)

____
____

Names of Children Who Have Lived
With You

_________________________ ____
(Applicants Date of Birth) (Current Street Address/City/State/Zip-**Do Not** use a PO Box #)

______________________________ ____________________
(Witness Signature) (Date Witnessed)

This release becomes void ninety (90) days after signature by Applicant/Employee.

Additional Information for the Release of Information Consent

Additional Names not listed on the front:

____

Additional Addresses not listed on the front:

Additional name of children not listed on the front:

Other information to make the check more complete:

Division of Children and Family Services

State of Nebraska

Dave Heineman, Governor

AGENCY REQUEST FOR INFORMATION FROM THE NEBRASKA ADULT AND CHILD ABUSE AND NEGLECT REGISTER/REGISTRY

The State of Nebraska approved this form, any alteration will invalidate it.

I hereby request information from the Nebraska Adult and Child Abuse and Neglect Registry. I agree to use the requested information to determine whether to hire or retain the individual to provide care, custody, treatment, transportation or supervision of children or vulnerable adults.

Agency Name/ Fax: Memorial Community Health, Inc. 402.694.5024
Please do not use abbreviations

Address and Phone Number: 1423 7th Street Aurora, NE 68818 402.694.3171

I hereby authorize the Division of Children and Family Services to disclose whether I have an Adult and/or Child Abuse and Neglect Register/Registry record to the above-named agency.

Print Full Legal Name: (applicant)____

____ ________________________
Signature (applicant) **Date**

Current Address: ____
(Street/City/State/Zip)

_______________________________________ ____________________________________
Applicant Date of Birth **Applicant Social Security Number**

Other names previously used such as former married names, maiden name and nick names. Please Print.

____
____
____

Names and birth dates of your children and children who have lived with you. Please Print.

____
____
____
____

Any Address at which you have resided during the past 20 years. Please Print.

____
____
____