

EDUCATION:					
Name & Location of Schools or Colleges	Major Subject	Did you Graduate?	College Degree	Years of Attendance	
				From	To

FORMER EMPLOYERS AND EXPERIENCE				
Name, Address and Telephone Number	Nature of Experience	Period		Reason for Leaving
		From	To	

PERSONAL REFERENCES (NOT RELATIVE)		
Name	Address	Phone

LIST ANY OTHER INFORMATION YOU WOULD LIKE US TO CONSIDER FOR THE TYPE OF EMPLOYMENT YOU ARE SEEKING: _____

I understand that after being made a conditional job offer, I will be given a post-offer medical examination. I hereby consent to such examinations and recognize that employment is contingent upon receipt of a satisfactory medical evaluation. I further understand and agree that after I am employed, I will be required to submit to medical examinations and I agree to the release of any test results to appropriate Hospital personnel.

I understand that this application is not an offer of employment. I agree that if I am employed by Schoolcraft Memorial Hospital that my employment is at will and may be terminated at any time, with or without notice and with or without cause, at the option of either the Hospital or myself.

I understand that I will be subject to the policies and rules and regulations established by the Board of Trustees and the Administrator and that these policies, benefits, rules and regulations are subject to change by the Board of Trustees and the Administrator at any time.

I understand that any misstatements in, or omissions from this application constitute cause for denial of employment or cause for dismissal. All information submitted by me in this application is true to the best of my knowledge and belief.

I authorize the references listed in this application for employment and any prior employer, educational institution, or any other persons or organizations to give Schoolcraft Memorial Hospital any and all information concerning my previous employment/educational accomplishments, disciplinary information, or any other pertinent information they may have. I understand that such information may contain my social security number. I release all parties from all liability for any damage that may result from furnishing that information to this hospital. In addition, I hereby waive written notice that employment information is being provided by any person or organization.

This application is current for a period of six months. At the conclusion of this time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary to fill out a new application.

Signature of Applicant: _____ DATE: _____

Please Print Name: _____

If you have any questions, or would like to update your application at any time in the future, please contact Gina Lindquist, Human Resources Director, at 341-3211.

Thank you.