



# Central Michigan District Health Department

*Promoting Healthy Families, Healthy Communities*

## APPLICATION FOR EMPLOYMENT CONFIDENTIAL

This is an application for employment with the Central Michigan District Health Department which serves Arenac, Clare, Gladwin, Isabella, Osceola and Roscommon Counties. Positions in this agency are filled on the basis of competitive evaluations and this application does become a part of the evaluation process. CMDHD is an Equal Opportunity Employer. Please type or print clearly and complete all items on both sides of the application.

### PERSONAL DATA

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  

LAST
FIRST
MIDDLE

Have you ever worked under another name?     Yes     No    If yes, give name \_\_\_\_\_

Address \_\_\_\_\_ Phone No. (    ) \_\_\_\_\_  

NUMBER & STREET

\_\_\_\_\_ Daytime No. (    ) \_\_\_\_\_  

CITY
STATE
ZIP CODE

Position Desired \_\_\_\_\_ Annual Salary Desired \_\_\_\_\_

Check (✓) type of employment desired:     Full Time     Part Time     Substitute

Location Desired: \_\_\_\_\_

- Are you:
- Yes     No    a citizen of the U.S.? If no, please note VISA status \_\_\_\_\_
  - Yes     No    over the age of 18?
  - Yes     No    a previous applicant?
  - Yes     No    a previous employee?
  - Yes     No    legally able to work in the U.S.?
  - Yes     No    a licensed driver with a car available for work?
  - Yes     No    physically capable of performing the duties of the position(s) applied for? If no, please explain: \_\_\_\_\_

**Michigan law requires employers to make accommodations to handicapped applicants and employees where the accommodation does not impose an undue hardship on the employer.**

**Handicapped employees and applicants may request an accommodation of their handicap by notifying the agency in writing of the need for accommodation within 182 days of the date the handicapper knows or should know that an accommodation is needed. Failure to properly notify the agency will preclude any claim that the employer failed to accommodate th handicapper.**

School	Name and Address of School	Course of Study	Check Last Year Completed	Did You Graduate?	List Diploma or Degree
Elementary		X	5 6 7 8	X	X
High			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No Year _____	
College			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	
Other (Specify)			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	

**List below present and past employment, beginning with your most recent**

Name and Address of Comany and Type of Business	From		To		Weekly Starting Salary	Weekly Ending Salary	Reason for Leaving	Name of Supervisor
	Mo.	Yr.	Mo.	Yr.				
	Describe the work you did:							
Telephone								

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	Mo.	Yr.	Mo.	Yr.				
	Describe the work you did:							
Telephone								

I hereby give permission to contact the employers listed above concerning my prior work experience.

Signed \_\_\_\_\_

If there is a particular employer(s) you do not wish us to contact please indicate which one(s). \_\_\_\_\_

\_\_\_\_\_

**PERSONAL REFERENCES (Not Relatives or Former Employers)**

Name and Occupation	Address	Phone Number

PROFESSIONAL INFORMATION (if applicable)

Professional Licensure \_\_\_\_\_ License No. \_\_\_\_\_

Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Registry or Certification \_\_\_\_\_ Registration No. \_\_\_\_\_

Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Out-of-State Licenses \_\_\_\_\_ License No. \_\_\_\_\_

Is Michigan Registration Pending?  Yes  No

MILITARY SERVICE RECORD

Have you had any experience in the Armed Forces of the United States or in a State National Guard? Yes  No

If yes, what branch? \_\_\_\_\_ Rank at discharge \_\_\_\_\_ Date of Discharge \_\_\_\_\_

Are you in the reserves? Yes  No  If yes, date obligation ends \_\_\_\_\_

Special/technical training \_\_\_\_\_

ADDITIONAL INFORMATION

Have you been convicted of a crime? Yes  No

If so, where, when and nature of offense \_\_\_\_\_

Do you have a valid driver's license? Yes  No  License No. \_\_\_\_\_ State \_\_\_\_\_

List professional, trade, business or civic activities and offices held \_\_\_\_\_

State any additional information that you feel may be helpful to us in considering your application. \_\_\_\_\_

Name, address, and telephone number of the person to be notified in the event of accident or emergency \_\_\_\_\_

AUTHORIZATION AND UNDERSTANDING

Upon the signing of this application, I represent that all of the information now or hereafter given by me in support of my application is true and complete. I authorize you to verify any of the information concerning my employment, education, credit or medical history with the appropriate individuals, companies, institutions or agencies, and I authorize them to release such information as you require, including any possible prior disciplinary employment record, without any obligation to give me written notice of such disclosure. I hereby release you and them from any liability whatsoever as a result of any such inquiries and disclosures. I agree that any false information in support of my application may subject me to discharge at any time during the period of my employment.

I agree that either party may terminate the employment relationship, with or without cause, at any time, and I further agree that this arrangement may only be altered in writing directed to me personally and signed by the Board of Health. I agree that I shall be bound by the other rules, policies, regulations and terms and conditions of employment of the agency as they are from time to time changed, and no additional obligations can be imposed on the agency except those which have been acknowledged in writing, by the Board of Health. I hereby authorize the agency to deduct from each and every period of my pay any amounts necessary to offset any damages caused by me or the value of property or money entrusted to me by, or owed by me to the agency during the course of my employment.

I agree that any action or suit against the agency arising out of my employment or termination of employment, including, but not limited to, claims arising under State or Federal civil rights statutes, must be brought within 180 days of the event giving rise to the claims or be forever barred. I waive any limitation periods to the contrary. I further agree that if I should bring any action or claim arising out of my employment against the agency in which the agency prevails, I will pay to the agency any and all cost incurred by the agency in defense of said claims or actions, including attorney fees. I further agree that my employment is conditional until such time as the results of my pre-employment physical (if such physical is required) are known.

Signature

Date