



**Job Application**  
**Grover C. Dils Medical Center**  
 An Equal Opportunity Employer

If you believe you require an accommodation during the selection process, please contact us to make appropriate arrangements.

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

Address: PO Box & Physical Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Position Applied For: \_\_\_\_\_

How did you hear about this position?  Advertisement  Walk-In  Referral \_\_\_\_\_ (whom)  
 Other \_\_\_\_\_

If offered employment, when can you be available to begin? \_\_\_\_\_

What type of employment will you accept?  Full-Time  Part-Time  Temporary

Will you be available for shift work?  Yes  No

Will you be available to work weekends and/or holidays if necessary?  Yes  No

Can you perform the requirements of this job with or without reasonable accommodations?  Yes  No

To qualify for employment, applicants must be a minimum of 18 years, unless otherwise specified in the job announcement. If offered employment, can you furnish proof of age?  Yes  No

What is your minimum salary requirement? \_\_\_\_\_

After an offer of employment, can you submit verification of your legal right to work in the United States?  Yes  No

List other names, if any, you have used: \_\_\_\_\_

**Education Record**

Did you graduate from high school or receive a GED certificate?  Yes  No

School Name	Location	Year of completion/ Hours earned	Diploma, Degree or Certificate	Major Field of Study
Business/Technical/Vocational				
1				
2				
College/University(Undergraduate)				
1				
2				
Graduate School				

For positions which require a high school graduation/GED or a college degree, a copy of the high school diploma/GED certificate or college diploma may be required.



**Licenses:** (Optional, unless required for the position for which you are now applying.)

List current licenses, certifications, or registrations required for the position for which you are applying. Indicate types, state license numbers, and expiration dates:

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Answer only if position requires:

1. Do you possess a valid driver's license? Yes No  
If so, license expires \_\_\_\_\_ Class \_\_\_\_\_ Restrictions (If any) \_\_\_\_\_
2. For positions that require typing:  
I certify that I can type at a speed of \_\_\_\_\_ WPM.

List any special skills you possess and/or equipment or office machines you can operate:

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### Other Information

Have you ever been convicted of, plead guilty or nolo contendere to, or been granted deferred adjudication for a felony, misdemeanor, (excluding juvenile adjudication), or any lesser crime other than a minor traffic infraction? Yes No If yes, list all such offenses and provide date, name of court, and disposition. Omission of information may be considered cause for disqualification from the employment pre-screening process or result in termination of employment.

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Have you ever been disciplined in your employment related to workplace violence?  Yes No If yes, please explain: \_\_\_\_\_

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Do you presently use illegal drugs? Yes No

Have you ever been employed by Grover C. Dils Medical Center? Yes No If yes, please provide the following information: Position Title: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_  
Reason for Separation: \_\_\_\_\_

Are you related to anyone who is currently employed by Grover C. Dils Medical Center? Yes No  
If yes, please provide the following information:

Related person's name: \_\_\_\_\_ Department: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**Employment History:** Provide information regarding all paid, military, and volunteer work, which may be related to the position for which you are applying. Describe your most recent position first; then list other positions in order held, beginning with the most recent. Use a separate block for each position, even if with the same organization. Use additional sheets if necessary. **Do Not** use references such as "See Resume" in place of completing this section.

May we contact all employers listed? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach a list of any exceptions with an explanation.)
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**Include three references with one of the following: address, phone number or email:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

<b>Present Employer:</b> _____ Position: _____ Address: _____ From (Mo./Yr.) _____ To (Mo. /Yr.) _____ Full-Time (30 + hrs./wk.) _____ Part-Time (<30 hrs./wk) _____ Supervisor's Name/Title _____ Telephone: _____ Salary: _____ Related Duties: _____  Reason for Leaving: _____ _____
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<b>Employer:</b> _____ Position: _____ Address: _____ From (Mo./Yr.) _____ To (Mo. /Yr.) _____ Full-Time (30 + hrs./wk.) _____ Part-Time (<30 hrs./wk) _____ Supervisor's Name/Title _____ Telephone: _____ Salary: _____ Related Duties: _____  Reason for Leaving: _____ _____
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<b>Employer:</b> _____ Position: _____ Address: _____ From (Mo./Yr.) _____ To (Mo. /Yr.) _____ Full-Time (30 + hrs./wk.) _____ Part-Time (<30 hrs./wk) _____ Supervisor's Name/Title _____ Telephone: _____ Salary: _____ Related Duties: _____  Reason for Leaving: _____ _____
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Please state below any other information that would be helpful in determining your qualifications for this position. You may include significant accomplishments, previous career highlights, or any other relevant information that is not requested in this employment application. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Criminal History Statement

### Please Read Carefully

**Statements 1-15 below refer to any criminal conviction which may be either a felony or misdemeanor.**

1. I have never been convicted of murder, voluntary manslaughter, or mayhem.
2. I have never been convicted of assault with intent to kill or to commit sexual assault or mayhem.
3. I have never been convicted of sexual assault, statutory sexual seduction, incest, lewdness or indecent exposure or any other sexually related crime that is punished as a felony (including felony prostitution).
4. I have never been convicted of prostitution, solicitation, lewdness, or indecent exposure, or any other sexually related crime that is punished as a misdemeanor, within the immediately preceding 7 years.
5. I have never been convicted of a crime involving domestic violence that is punished as a felony.
6. I have never been convicted of a crime involving domestic violence that is punished as a misdemeanor, within the immediately preceding 7 years.
7. I have never been convicted of abuse or neglect of a child or contributory delinquency.
8. Within the past seven years, I have not been convicted of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS within the immediately preceding 7 years.
9. I have never been convicted of abuse, neglect, exploitation or isolation of older persons or vulnerable persons, or any provision of NRS 200.5091 to 200.50995, inclusive, or a law of any other state or other jurisdiction that prohibits the same or similar conduct.
10. Within the past seven years, I have not been convicted of any provision of law relating to the State Plan for Medicaid of a law of any other state or other jurisdiction that prohibits the same or similar conduct.
11. I have never been convicted of a violation of any provision of NRS 422.450 to 422.590, inclusive, statutory provisions relating to Nevada's State Plan for Medicaid.
12. Within the past seven years, I have not been convicted of a criminal offense under the laws governing Medicaid or Medicare.
13. Within the past seven years, I have not been convicted of any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property.
14. I have never been convicted of any felony involving the use or threatened use of force or violence against the victim or the use of a firearm or other deadly weapon.
15. I have not been convicted of an attempt or conspiracy to commit any of the offenses listed in numbers 1 through 14 within the immediately preceding 7 years.

I affirm that the statements 1-15 above are true and correct; I authorize the submission of my fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its background check report.

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Signature

Date

Printed Name

Nevada Revised Statutes 449.123 requires that employees or independent contractors of an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing, a residential facility for groups or a home for individual residential care or, if residential services are provided to children, a medical facility or a facility for treatment of abuse of alcohol or drugs that provide services to children complete this type of statement. These statutes are available online at <http://leg.state.nv.us/NRS/NRS-449.html>.



## Acknowledgments

Please **READ ALL** of the following statements and **INITIAL EACH** of the boxes to indicate you have read and understand each of the statements. If you have any question, contact Grover C. Dils Medical Center (Human Resources Department.)

- Following an offer of employment, you will be required to submit verification of your legal right to work in the United States.
- All offers of employment and all information regarding compensation and other terms and conditions of employment will be made in writing. Verbal statements may not be relied upon.
- This application is the property of Grover C. Dils Medical Center and will become part of my personnel file if I am hired.
- I authorize Grover C. Dils Medical Center to contact any employer or individual that I have listed on my employment application and/or resume or mentioned during job interviews, to obtain from them any relevant information regarding my previous employment, military service, criminal history, characteristics or traits necessary for job performance, or other relevant qualifications for employment and/or continued employment with Grover C. Dils Medical Center. In addition, I authorize Grover C. Dils Medical Center to conduct a background search which includes criminal history and military history. In addition, if the position I am applying for requires driving an employer vehicle, I authorize employer to conduct a Department of Motor Vehicles (DMV) search. If the position to which I am applying involves contact with minors or with any persons having diminished capacity to care for themselves, a search of government sex offender registries may be conducted. I further authorize Grover C. Dils Medical Center to contact any institution and/or licensing authority to verify my possession of education, licenses, and/or certificates which may qualify me for employment.
- In exchange for Grover C. Dils Medical Center's consideration of my employment application, and/or my continued employment with Grover C. Dils Medical Center, if any, I authorize anyone possessing information to furnish it to Grover C. Dils Medical Center upon request, and I release the organizations and all individuals providing the information or acquiring the information, including Grover C. Dils Medical Center from all claims, liability, and damages whatsoever claimed to be related to furnishing, obtaining, or using said information. This release applies to, but is not limited to, claims for defamation, libel, slander, infliction of emotional distress, and interference with current or prospective economic relations.
- I further understand this consent will apply during the entire course of my employment with Grover C. Dils Medical Center should I obtain such employment. I understand and agree this consent shall remain in effect indefinitely.
- I hereby certify that all statements made in this application are true. I understand that any false statement of material facts herein may cause forfeiture on my part of all rights to any employment with Grover C. Dils Medical Center. I understand that any misrepresentation, falsification, or material omission of information may result in my failure to receive an offer, or if I have been hired, in my dismissal from employment regardless of length of employment. I understand that neither this document nor any offer of employment from Grover C. Dils Medical Center constitutes an employment contract unless a specific contract document to that effect is executed. I agree to undergo any job related physical examination and drug screening upon conditional offer of employment. I further understand and agree that this paragraph applies to any information supplied by me at a later date as part of this application.

Additionally, my signature below certifies that the information provided is true and correct to the best of my knowledge.

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Signature

Date

Printed Name



## Federal Welfare Reform

Federal Welfare Reform as implemented by the 1997 Legislative Session requires that professional and occupational licensing agencies add the following questions regarding child support to all applications for new licenses and renewals. Your license, issued by the Bureau, is subject to this new requirement mandated by the federal government of all states, including Nevada. Your license may be denied or restricted if back child support is owed by you. If you fail to answer the questions, provide social security information, and sign the area of the form, your application will not be processed. Please mark the appropriate response.

Failure to clearly mark one of the choices will result in denial of the application.

- I am not subject to a court order for the support of a child.
- I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.
- I am subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order. (You are required to contact your local District Attorney or the Welfare Division to arrange payment).

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Signature

Date

Printed Name

## Notice and Authorization Concerning Consumer and Investigative Consumer Reports

This form, which should be read carefully, has been provided to you because Grover C. Dils Medical Center may request consumer reports or investigative consumer reports in connection with your application for employment, or at any time during the course of your employment with Grover C. Dils Medical Center or for other employment-related purposes. Any information contained in such reports may be taken into consideration for purposes of evaluating your suitability for employment, promotion, reassignment, or retention as an employee. Additionally, in the event that claims or disputes between you and Grover C. Dils Medical Center are filed with any third parties, Grover C. Dils Medical Center may request investigative consumer reports for purposes of evaluation and response, regardless of whether you remain in the employment of Grover C. Dils Medical Center at the time such claims or disputes arise.

The types of reports that may be requested from consumer reporting agencies under the policy include, but are not limited to, credit reports, criminal records checks, court records checks, driving records, and/or summaries of educational and employment records and histories. The information contained in these reports may be obtained by a consumer reporting agency from public record sources or through personal interviews with your co-workers, neighbors, friends, associates, current or former employers, or other personal acquaintances.

I have carefully read and understand this notice and authorization form and by my signature below, consent to the release of consumer or investigative consumer reports, as defined above to Grover C. Dils Medical Center (1) in conjunctions with my application for employment, (2) during the entire course of my employment, should I obtain such employment, and (3) after any such employment ends. I further understand that any and all information contained in my job application or otherwise disclosed to Grover C. Dils Medical Center by me before, during or after my employment, if any, may be utilized for the purpose of obtaining the consumer report or investigative consumer reports requested by Grover C. Dils Medical Center and confirm that all such information provided in connection with my job application is true and correct. I understand and acknowledge that nothing in this notice and authorization is intended to be, or is an offer of employment or a promise of continued employment.



Signature

Date

Social Security Number

### Authorization for Disclosure of Information

I hereby authorize all of the following, without limitation, to disclose information about me to a consumer reporting agency such as Hire Right, Inc. and its agents in connection with its preparation of background reports on me for Grover C. Dils Medical Center (“The Company”): Law enforcement and all other federal, state and local agencies; Learning institutions (including public and private schools, colleges and universities); Testing agencies; Information service bureaus; Credit bureaus; Record/data repositories; Courts (federal, state and local); Motor vehicle records agencies; My past or present employers; military; and all other individuals and sources with any information about or concerning me.

The information that can be disclosed to the consumer reporting agency and its agents includes, but is not limited to, information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses.

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

Printed Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Other Names Used: \_\_\_\_\_ Year Used: \_\_\_\_\_

Current Address: \_\_\_\_\_

Former Address: \_\_\_\_\_

Former Address: \_\_\_\_\_

Former Address: \_\_\_\_\_

Former Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Driver’s License Number: \_\_\_\_\_ State of Issuance: \_\_\_\_\_

### Background Investigation Consent

I, \_\_\_\_\_, hereby authorize Grover C. Dils Medical Center and its agents to independently research my background, fingerprints, character, past employment and education. This includes contacting references and other persons, reviewing records maintained by any of these persons, and both public and private organizations. This may also include insurance and workers compensation information.

I release Grover C. Dils Medical Center and its agents from any and all liability, claims or lawsuits relating to Grover C. Dils Medical Center's research and/or the use of information obtained from any or all of the above referenced sources. I agree to defend, indemnify, and hold harmless Grover C. Dils Medical Center from any and all liability claims or lawsuits which may result, including those from Grover C. Dils Medical Center's research, or actions taken as a result of its research.

I understand that failure to reveal any prior employment I have had within the past ten (10) years or the providing of any false or misleading information, either on my employment application or this form, may be grounds for termination if Grover C. Dils Medical Center employs me.

I understand that the above data is for purpose of identification only.

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



State of Nevada



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

4150 Technology Way, Suite 300  
Carson City, Nevada 89706  
Telephone: (775) 684-4200 . Fax: (775) 684-4211  
[www.health.nv.gov](http://www.health.nv.gov)

**NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS, CONSENTS AND  
SELF DISCLOSURE OF CRIMINAL HISTORY  
FINGERPRINT BACKGROUND WAIVER - NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS**

As an applicant who is the subject of a Federal Bureau of Investigation (FBI) fingerprint-based criminal history record check for a noncriminal justice purpose you have certain rights which are discussed below.

1. You must be notified by Grover C. Dils Medical Center that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.
2. If you have a criminal history record, the officials making a determination of your suitability for the job, license or other benefit for which you are applying must provide you the opportunity to complete or challenge the accuracy of the information in the record. You may review and challenge the accuracy of any and all criminal history records which are returned to the submitting agency. The proper forms and procedures will be furnished to you by the Nevada Department of Public Safety, Records Bureau upon request. If you decide to challenge the accuracy or completeness of your FBI criminal history record, Title 28 of the Code of Federal Regulations, Section 16.34, provides for the proper procedure to do so:

**16.34- Procedure to obtain change, correction or updating of identification records.**

If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency.

3. Based on 28 CFR § 50.12 (b), officials making such determinations should not deny the license or employment based on information in the record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.
4. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.
5. I hereby authorize Grover C. Dils Medical Center to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me. In giving this authorization, I expressly understand that the records may include information pertaining to notations of arrest, detentions, indictments, information or other charges for which the final court disposition is pending or is unknown to the above referenced agency. For records containing final court disposition information, I understand that the release may include information pertaining to dismissals, acquittals, convictions, sentences, correctional supervision information and information concerning the status of my parole or probation when applicable.
6. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the





submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

**Consent to Check of Registries**

I consent to have a check of registries conducted, including, but not limited to, any government abuse registries such as the Nevada Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child, licensing registries, sexual abuse registries, the Office of Inspector General List of Excluded Individuals and Entities registry and any other registries that may be required by the Division of Public and Behavioral Health.

**Self-Disclosure Statement of Criminal History**

**I attest that I have never been convicted of any of the following crimes:**

- Murder, voluntary manslaughter or mayhem;
- Assault or battery with intent to kill or to commit sexual assault or mayhem;
- Sexual assault, statutory sexual seduction, incest, lewdness or indecent exposure, or any other sexually related crime that is punished as a felony (including felony prostitution);
- A crime involving domestic violence that is punished as a felony;
- Abuse or neglect of a child or contributory delinquency;
- Abuse, neglect, exploitation or isolation of older persons or vulnerable persons, including, without limitation, a violation of any provision of NRS 200.5091 to NRS 200.50995, inclusive, or a law of any other jurisdiction that prohibits the same or similar conduct;
- A violation of any provision of NRS 422.450 to NRS 422.590, inclusive; or
- Any other felony involving the use or threatened use of force or violence against the victim or the use of a firearm or other deadly weapon.

**I attest that I have not been convicted of any of the following crimes within the immediately preceding 7 years:**

- Prostitution, solicitation, lewdness or indecent exposure, or any other sexually related crime that is punished as a misdemeanor;
- A crime involving domestic violence that is punished as a misdemeanor;
- A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;
- A violation of any provision of law relating to the State Plan for Medicaid or a law of any other jurisdiction that prohibits the same or similar conduct;
- A criminal offense under the laws governing Medicaid or Medicare;
- Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property; or
- An attempt or conspiracy to commit any of the offenses listed in this Self Disclosure Statement of Criminal History section.

**Consent to be enrolled in a RAP (Record of Arrests and Prosecutions) Back System (optional- check only if you consent)**

I understand that if I check this box, the facility, hospital, agency, program or home I am under employment/contract/service with or the Division of Public and Behavioral Health may enroll me in a RAP (Record of Arrests and Prosecutions) back system which would allow the Central Repository for Nevada Records-of Criminal History to notify my employer and the Division of Public and Behavioral Health of any criminal offenses that I may be convicted of in the future.

**Authorization of Submission of Fingerprints**

I authorize the submission of my fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its background check report.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original.

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

I understand that a person who willfully provides a false statement or information connected with a background investigation that would disqualify the person from employment, including without limitation, a conviction of a crime listed in NRS 449.174, is guilty of a misdemeanor. I declare under penalty of perjury that the foregoing is true and correct.

Applicant's Printed Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Signature: \_\_\_\_\_

Submitting Agency: Grover C. Dils Medical Center P.O. Box 1010 Caliente, NV 89008 Date: \_\_\_\_\_



Agency Representative Printed Name: \_\_\_\_\_ Agency Representative Signature: \_\_\_\_\_

**In consideration of being employed, I understand and agree that:**

1. If I misrepresent or deliberately leave out a fact on my application, I may be refused employment or, if employed, I may be terminated.
2. The employer has my authorization to thoroughly investigate my work and personal history and I hereby consent to take any test, whenever the employer deems it necessary in any employer investigation. I will hold no person, corporation or organization liable for my giving or it's receiving information in such investigation.
3. If employed, I may terminate my employment at any time without notice or cause, and the employer may terminate or modify the employment relationship at any time without prior notice or cause. In consideration of my employment, I agree to conform to the rules and regulations of the employer, and I understand that no department head or representative of the employer, other than the Administrator, has any authority to enter into any agreement, oral or written, for employment for any specified period of time or to make any agreement or assurances contrary to this policy.
4. Any doctor, hospital or testing laboratory has my consent to conduct medical or drug tests on me, and I hereby give my consent to having all information released for the employer to determine my abilities to perform job duties now or in the future. I also give my consent to physical searches of myself and my tool box, lunch box, car, locker or any packages or purse I have while on the employer's premises, whether or not I have a lock on such items.
5. The needs of the employer may make the following conditions mandatory: overtime, shift work, rotating work schedule, or a work schedule other than Monday through Friday. I accept these conditions of employment.
6. The employer is an equal opportunity employer. The employer does not discriminate in employment and no question on my employment application is used for the purpose of limiting or excluding any applicant's consideration for employment on a basis prohibited by local, state or federal law.
7. If employed, I understand that my employment is for no definite period of time, and if terminated, the employer is liable only for wages or salary earned as of the date of termination.
8. I have read and agree to the above and hereby certify that the facts I have provided in my employment application are true and complete.
9. This application is current and active for only six months. At the conclusion of this time, if I have not had any contact from the employer and still wish to be considered for employment, it will be necessary for me to fill out a new application.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For Personnel Department Use Only</b>	
Arrange Interview: ___ Yes ___ No	
Remarks: _____	
Interview Date: _____	
Employed: ___ Yes ___ No	
Job Title: _____	Date of Employment: _____
Department: _____	Hourly Rate/Salary: _____
By: _____	Date: _____



Name/Title
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