Public Health
Prevent. Promote. Protect.

HEALTH SERVICES OF LYON COUNTY
315 FIRST AVENUE SUITE 208
ROCK RAPIDS IA 51246
Ph. (712) 472-8200 Email: hslc@co.lyon.ia.us Fax 712-472-4039

Please complete all sections below:

APPLICANT INFORMATION:

Applicant Name _____

Applicant Address _____

City, State, Zip Code _____

Primary contact number _____

Email address if applicable _____

EMPLOYMENT POSITION:

Position applying for: _____

How did you hear about this position? _____

On what date can you begin working if hired for this position? _____

Days/hours available: _____

JOB SKILLS/QUALIFCATIONS:

Please list the skills and qualifications you possess for the position in which you are applying:

_____
_____
_____
_____
_____
_____
_____
_____
_____

EDUCATION/TRAINING:

High School

NAME	LOCATION	YEAR GRADUATED	DEGREE EARNED

College/University

NAME	LOCATION	YEAR GRADUATED	DEGREE EARNED

Vocational School/Specialized Training

NAME	LOCATION	YEAR GRADUATED	DEGREE EARNED

PREVIOUS EMPLOYMENT:

Employer Name: _____
Job Title: _____
Supervisor: _____
Employer address: _____
Employer phone: _____/_____/_____
Dates employed from: _____ to _____
Reason for leaving: _____

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Job Title: _____
Supervisor: _____
Employer address: _____
Employer phone: _____/_____/_____
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Job Title: _____
Supervisor: _____
Employer address: _____
Employer phone: _____/_____/_____
Dates employed from: _____ to _____
Reason for leaving: _____

AUTHORIZATION:

The information contained in this application are true and complete to the best of my knowledge. I understand that falsified statements on this application may be grounds for not hiring me, or if I am hired it may be grounds for immediate termination of employment at any point in the future.

It is my understanding that no representative of Health Services of Lyon County has the authority to enter in any agreement for employment for any specific period, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized representative of the company. This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the American Disabilities Act and other relevant federal and state laws.

This authorization is for the verification of any or all information listed in the above application.

Applicant Signature _____

Date: _____/_____/_____