HEALTH SERVICES OF LYON COUNTY
315 First Ave, Suite 208
Rock Rapids, IA 51246
(712)472-8200

PERSONAL INFORMATION:

Name (First, Middle and Last): _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: Cell: _____ Home: _____

POSITION APPLYING FOR: _____

DAYS/HOURS AVAILABLE: Please indicate below:

Monday __ Tuesday__ Wednesday___ Thursday___ Friday___ Saturday___ Sunday ____

Hours available: From _____ To _____

EDUCATION: Please list name/address of school attended

1. _____ Diploma/Degree: Yes No

_____

2. _____ Diploma/Degree: Yes No

_____

3. _____ Diploma/Degree: Yes No

_____

4. _____ Diploma/Degree: Yes No

_____

Skills and Qualifications: Additional licenses, skills, training and awards received:

_____

_____

EMPLOYMENT HISTORY: Current/Past Employment

1. Employer: _____ Name of Supervisor: _____
   Address: _____
   Position Title: _____
   Dates Employed from _____ To: _____
   Responsibilities: _____
   Can we contact Your Supervisor? _____

   Salary: _____
   Reason for Leaving: _____

2. Employer: _____ Name of Supervisor: _____
   Address: _____
   Position Title: _____
   Dates Employed from _____ To: _____
   Responsibilities: _____

   Salary: _____
   Reason for Leaving: _____
   Can we Contact Your Supervisor? _____
3. Employer: _____ Name of Supervisor: _____
   Address: _____
   Position Title: _____
   Dates Employed from _____ To: _____
   Responsibilities: _____

   Salary: _____
   Reason for Leaving: _____
   Can we Contact Your Supervisor? _____

REFERENCES: Please list three references

Name/Title/Address/Phone: _____

Name/Title/Address/Phone: _____

Name/Title/Address/Phone: _____

Please use the space below (if needed) to provide additional information necessary to describe your full qualifications for the specific position for which you are applying.

_____

_____

_____

_____

_____

Authorization

The facts contained in this application are true and complete to the best of my knowledge and 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 has any authority to enter into any agreement for employment for any specified period, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.

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

Signature: _____ **Date:** _____