LMAS District Health Department

Application for Employment

An Equal Opportunity Employer

COUNTY: _____ **POSITION APPLYING FOR:** _____

PERSONAL INFORMATION	
Name:	Home Telephone No.: ( )
Address:	Work Telephone No.: ( )
City, State, Zip:	Cellular No.: ( )
Can you provide the documents required to prove that you are legally able to work in the U.S.? ☐ Yes ☐ No	Email Address: Do you have a valid driver's license? ☐Yes ☐ No
Are you at least 18 years of age? ☐ Yes ☐ No	Have you ever been convicted of a felony? ☐Yes ☐ No If Yes, please explain: _____

EMPLOYMENT DESIRED	
Have you applied here before? ☐ Yes ☐ No	If Yes, When: Location:
Have you ever been employed here? ☐ Yes ☐ No	If Yes, When: Location:
Are you employed now? ☐ Yes ☐ No	If so, may we contact your employer? ☐ Yes ☐ No
Are you currently on layoff or leave from another company? ☐ Yes ☐ No	Are you willing to travel? ☐ Yes ☐ No If so, what % of time?
Are you willing to relocate? ☐ Yes ☐ No	Are you available for full or part-time work?
Date you can start:	Starting Salary Desired: $

LIST APPLICABLE SKILLS	

EDUCATION				
Name of School	Address	Main Course Of Study	GPA	Degree
List any scholastic honors received and offices held while in school:				

Are you planning to pursue other studies? ☐ Yes ☐ No	If so, where and what course of study?

EMPLOYMENT HISTORY **(List employment for the past 10 years, starting with present job if applicable.)**	
(1) Company Name:	Address:
Supervisor: Phone:	City, State, Zip:
Job Title:	Reason for Leaving:
List Specific Duties:	
Dates Employed: From To	Salary: $
(2) Company Name:	Address:
Supervisor: Phone:	City, State, Zip:
Job Title:	Reason for Leaving:
List Specific Duties:	
Dates Employed: From To	Salary: $
(3) Company Name:	Address:
Supervisor: Phone:	City, State, Zip:
List Specific Duties:	
Job Title:	Reason for Leaving:
Dates Employed: From To	Salary: $
Company Name:	Address:
Supervisor: Phone:	City, State, Zip:
List Specific Duties:	
Job Title:	Reason for Leaving:
Dates Employed: From To	Salary: $

(If you need additional space please attach a separate sheet)

PLEASE LIST THREE PEOPLE (WHO ARE NOT RELATED TO YOU)
AND WHOM YOU HAVE KNOWN FOR AT LEAST ONE YEAR.

NAME	ADDRESS CITY, STATE, ZIP	TELEPHONE NUMBER	OCCUPATION	YEARS ACQUAINTED

LUCE-MACKINAC-ALGER-SCHOOLCRAFT
DISTRICT HEALTH DEPARTMENT
14150 Hamilton Lake Road, Newberry, MI 49868
Phone: (906) 293-5107
Fax: (906) 293-5453

Authorization and Understanding

(PLEASE READ BEFORE SIGNING)

I certify that all statements made by me on this application are true and complete to the best of my knowledge and that I have withheld nothing which, if disclosed, would affect this application unfavorably.

I authorize my previous employers, schools or persons named as references to give any information regarding employment or educational record. I agree that this company and my previous employers shall not be held liable in any respect if a job offer is not extended, is withdrawn or my employment is terminated because of false statements, omissions or answers made by me on this application. In the event of my employment with this company I will comply with all rules and regulations as set forth in any communication distributed to employees.

In compliance with the Immigration Reform and Control Act of 1986, I understand that I will be required to provide approved documentation that verifies my right to work in the United States on my first day of employment. I am in receipt of a list of approved documents, which have been supplied with this application. (See Page 5)

I further understand and agree that my employment is not for a definite period of time and may, regardless of the date of payment of wages or salary, be terminated for any reason and at any time without previous notice.

I hereby acknowledge that I have read and understood the above statements.

Signature:_____Date: _____

LUCE-MACKINAC-ALGER-SCHOOLCRAFT
DISTRICT HEALTH DEPARTMENT
14150 Hamilton Lake Road, Newberry, MI 49868
Phone: (906) 293-5107
Fax: (906) 293-5453

AUTHORIZATION TO RELEASE INFORMATION

As an applicant for a position with the LMAS District Health Department, I have been asked to furnish information for use in reviewing my background and qualifications. I hereby authorize the investigation of my past and present work, character, education, military, and police records to ascertain any and all information, which may be pertinent to my employment qualifications.

The release in any manner of any and all information by you is authorized whether such information is of record or not, and I do hereby release all persons, firms, agencies or companies, whomsoever, from any damages resulting from furnishing such information.

This authorization shall be valid for six months from the date of my signature below. You may retain this copy of my release for your files. Thank you for your assistance.

Signature:_____Date: _____

Type or print your name: _____

Witness: _____ Date: _____