



ST. GERARD'S  
 COMMUNITY OF CARE  
 613 1ST AVE SW—PO Box 448  
 HANKINSON ND 58041-0448  
 701-242-7891  
 Email: StGerard@rrt.net

EMPLOYMENT APPLICATION

Position applying for: \_\_\_\_\_

Date of application: \_\_\_\_\_

**PERSONAL**

LAST	FIRST	MI	PHONE
STREET	APT#	PO BOX	EMAIL:
CITY-ST-ZIP		SSN#	DOB (optional)
US CITIZEN?	YES	NO	--- IF NO, VISA TYPE & NUMBER: _____

List any reason you know of why you may not be able to perform consistently and promptly any of the duties of the position applied for: *(BE SURE TO REVIEW JOB DESCRIPTION BEFORE ANSWERING.)*

\_\_\_\_\_

Date available? \_\_\_\_\_

Will you accept another position? Yes No If yes, please specify: \_\_\_\_\_

Will you accept shift work? Yes No

Will you accept weekend work? Yes No

Are you willing to work \_\_\_ Full Time \_\_\_ Part Time \_\_\_ Temporary \_\_\_ PRN

Do you have a relative or friend working here? Yes No If yes, who: \_\_\_\_\_

Were you ever employed by St. Gerard's in the past? Yes No If yes, when and in what capacity:

\_\_\_\_\_

Have you ever been convicted of a crime? Yes No If yes, date(s), offense(s) and disposition:

\_\_\_\_\_

Have you ever been excluded from participation in any federal or state Medicare, Medicaid or other third party payor program, or now have such pending action? Yes No If yes, a letter of reinstatement is required for further consideration.

Have you ever been found guilty of abusing, neglecting, or mistreating residents by a court of law? Yes No

Have you had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property? Yes No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**EDUCATION**

Circle last year completed: High School 9 10 11 12 College 1 2 3 4

Were you ever certified as a Certified Nurse Assistant? Yes No

If yes, in which State are you licensed? \_\_\_\_\_ License # \_\_\_\_\_

If RN, LPN or ASPN in which State are you licensed? \_\_\_\_\_ License # \_\_\_\_\_

## EMPLOYMENT HISTORY ~ LIST MOST RECENT POSITION FIRST

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSITION HELD: \_\_\_\_\_ ENDING SALARY: \_\_\_\_\_ PER \_\_\_\_\_

BRIEFLY DESCRIBE YOUR DUTIES: \_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_ MAY WE CONTACT THIS EMPLOYER? YES NO

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSITION HELD: \_\_\_\_\_ ENDING SALARY: \_\_\_\_\_ PER \_\_\_\_\_

BRIEFLY DESCRIBE YOUR DUTIES: \_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_ MAY WE CONTACT THIS EMPLOYER? YES NO

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSITION HELD: \_\_\_\_\_ ENDING SALARY: \_\_\_\_\_ PER \_\_\_\_\_

BRIEFLY DESCRIBE YOUR DUTIES: \_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_ MAY WE CONTACT THIS EMPLOYER? YES NO

## REFERENCES (NAMES OF PERSONS NOT RELATED TO YOU)

NAME \_\_\_\_\_ CITY & STATE \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_

NAME \_\_\_\_\_ CITY & STATE \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_

NAME \_\_\_\_\_ CITY & STATE \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_

## PROFESSIONAL LICENSES, REGISTRATIONS AND/OR CERTIFICATIONS

**DO NOT INCLUDE DRIVER'S LICENSE**

TYPE \_\_\_\_\_ STATE ISSUED \_\_\_\_\_ DATE ISSUED \_\_\_\_\_ EXPIRES \_\_\_\_\_ NUMBER \_\_\_\_\_ ELIGIBLE \_\_\_\_\_

TYPE \_\_\_\_\_ STATE ISSUED \_\_\_\_\_ DATE ISSUED \_\_\_\_\_ EXPIRES \_\_\_\_\_ NUMBER \_\_\_\_\_ ELIGIBLE \_\_\_\_\_

*CONTINUED ON PAGE 3...*

## APPLICANT'S STATEMENT

I certify that all information contained in this application is true, and understand that any misleading or false information or willful omission will be sufficient cause for immediate dismissal or refusal of employment.

I understand that all information in this application is subject to verification and that St. Gerard's Community of Care may investigate my work and personal history and verify all data given on this application, on related papers and interviews.

By my signature below I consent to a criminal to a criminal history background check. I also authorize all individuals, schools, businesses, employers (past and present), and references herein, except my current employer IF SO NOTED, to provide any information requested about me, and I release them from all liability for damage in providing this information.

I further understand that employment is "at will" and that nothing contained in this employment application or statements made during the interview process (if an interview is granted) are intended to create an employment contract between St. Gerard's Community of Care and myself for either employment or for the provision of any benefit for myself.

I also understand that St. Gerard's Community of Care may require a pre-employment drug and alcohol testing. No prospective employee will be asked to submit to testing unless an offer of employment has been made. An offer of employment could be conditioned on the prospective employee testing negative for illegal drugs and alcohol. I understand and agree to submit to the required pre-employment testing, if an offer of employment is made to me.

I acknowledge and understand that I am required to immediately notify St. Gerard's Community of Care if any action is proposed to exclude me from participation in any federal or state Medicare, Medicaid or third party payor program.

I have read, understand and agree with all of the above statements.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## IMPORTANT NOTICE TO ALL APPLICANTS

If you are selected for employment you must be prepared to verify your eligibility to work as required under the Immigration Reform and Control Act of 1986. This requirement applies to all new employees, including U.S. citizens, permanent residents and non-immigrants. You will have to provide documents within 3 (three) days of your hire date to verify your identity and eligibility

## FOR OFFICE USE ~ DO NOT COMPLETE

Contacted North Dakota State CNA Registry:

By \_\_\_\_\_ Date \_\_\_\_\_

Findings: \_\_\_\_\_

Other State CNA Registry Contacted:

By \_\_\_\_\_ Date \_\_\_\_\_

Findings: \_\_\_\_\_

Other State CNA Registry Contacted:

By \_\_\_\_\_ Date \_\_\_\_\_

Findings: \_\_\_\_\_