ANTELOPE MEMORIAL HOSPITAL
102 WEST 9TH, BOX 229
NELIGH, NEBRASKA 68756-0229
PHONE: (402) 887-4151
FAX: (402) 887-6397
E-MAIL: hr@amhne.org

EMPLOYMENT APPLICATION

Antelope Memorial Hospital
Healing Body, Mind and Spirit

PERSONAL

LAST NAME	FIRST	MIDDLE	DATE
STREET ADDRESS			TELEPHONE #
CITY, STATE, ZIP			ALTERNATE PHONE #
E-mail Address (Optional)			
Position Desired			DESIRED RATE OF PAY

___Full-Time   ___Part-Time   ___As Needed   ___On Call   Desired number of hours per week_____   ___Days   ___Afternoon to Evening   ___Overnight   Are you legally authorized to work in the United States?   ___Yes   ___No

Have you every applied for employment with us? What position/s?

Have you ever worked for AMH previously? ___Yes ___No	If Yes, list job title/s:	When would you be available to start work?

EDUCATION

SCHOOL	NAME AND LOCATION OF SCHOOL	COURSE OF STUDY	NO. OF YEARS	Did You Graduate?	Degree or Diploma
Graduate				Yes ☐ No ☐	
College				Yes ☐ No ☐	
Business/ Trade/ Technical				Yes ☐ No ☐	
High School				Yes ☐ No ☐	
Elementary				Yes ☐ No ☐	

Other special training or skills (languages, machine operation, information systems, software applications, etc.)

PROFESSIONAL LICENSES, CERTIFICATIONS AND/OR REGISTRATIONS			
TYPE	STATE ISSUED	ISSUE AND EXPIRATION DATES	NUMBER

PREVIOUS EMPLOYMENT

Complete <u>ALL</u> information below for each employer. Use a separate page if needed to list additional employment.

1

Company Name	**Telephone**
Address **City** **State** **Zip**	**Employed - (Month and Year)**
Name of Supervisor	**From To**
Your Job Title	**Pay Rate Start Last**
Describe Your Work	**Reason for Leaving**

2

Company Name	**Telephone**
Address **City** **State** **Zip**	**Employed - (Month and Year)**
Name of Supervisor	**From To**
Your Job Title	**Pay Rate Start Last**
Describe Your Work	**Reason for Leaving**

3

Company Name	**Telephone**
Address **City** **State** **Zip**	**Employed - (Month and Year)**
Name of Supervisor	**From To**
Your Job Title	**Pay Rate Start Last**
Describe Your Work	**Reason for Leaving**

4

Company Name	**Telephone**
Address **City** **State** **Zip**	**Employed - (Month and Year)**
Name of Supervisor	**From To**
Your Job Title	**Pay Rate Start Last**
Describe Your Work	**Reason for Leaving**

Indicate reason/s for any gaps in employment:

We may contact the employers listed above unless you indicate those you do not want us to contact.

DO NOT CONTACT   **Employer Number (s) _____   Reason _____**

LIST THREE PERSONS WE MAY CONTACT WHO HAVE KNOWLEDGE OF YOUR SKILLS, EXPERIENCE AND CHARACTER AND ARE ABLE TO VERIFY YOUR QUALIFICIATIONS FOR THE POSITION FOR WHICH YOU ARE APPLYING *(OTHER THAN RELATIVES)*

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NAME ADDRESS	TITLE	COMPANY
	PHONE	E-MAIL
NAME ADDRESS	TITLE	COMPANY
	PHONE	E-MAIL
NAME ADDRESS	TITLE	COMPANY
	PHONE	E-MAIL

By signing below, I certify that the answers and information set out above are true, accurate and complete to the best of my knowledge. I acknowledge that if any answer or information is not true, accurate or complete, I may not be hired, or if hired, I may be discharged. I authorize Antelope Memorial Hospital to investigate all statements contained in this application for employment and to investigate my character and qualifications. I give permission to all current or previous employers and/or managers, unless otherwise noted above, to discuss my personal and employment history with Antelope Memorial Hospital, consent to the release of such information, and release them from all liability and all claims based upon any statements or information they provide.

I understand that this application is not a contract of employment. I also acknowledge that no oral representations have been made, and that no one within Antelope Memorial Hospital has the authority to make oral contracts of employment. If hired, my employment relationship with Antelope Memorial Hospital is terminable, at-will, with or without cause, by either myself or Antelope Memorial Hospital.

I also understand that any offer of employment may be conditional upon my passing a physical examination by a health care professional and background screen.

I understand and agree to all of the conditions and statements set forth above, and throughout this application.

Signature: Date:

Voluntary Self-Identification Form

The Equal Employment Opportunity Commission (EEOC) requires organizations with 100 or more employees to invite applicants to self-identify gender and race and complete an EEO-1 report each year. Completion of this data is voluntary and will not affect your opportunity for employment, or terms or conditions of employment.

This information provided on this form is *CONFIDENTIAL* and will be used for reporting purposes *only*.

DATE: _____ **POSITION APPLIED FOR**: _____

PRINTED NAME: _____ **SIGNATURE**: _____

___ **I do not wish to self identify.**

GENDER: (Please check one of the options below)

_____ Male   _____ Female

RACE/ETHNICITY:

Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.)

☐ Yes **If you answered "Yes" you have completed this form.**

☐ No **If you answered "No" please select one of the descriptions below corresponding to the ethnic group with which you identify.**

___ **White (Not Hispanic or Latino)**: A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

___ **Black or African American (Not Hispanic or Latino)**: A person having origins in any of the black racial groups of Africa.

___ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)**: A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.

___ **Asian (Not Hispanic or Latino)**: A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

___ **American Indian or Alaska Native (Not Hispanic or Latino)**: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

___ **Two or more races (Not Hispanic or Latino)**: All persons who identify with more than one of the above five races.