

Employment Application



Please complete each applicable section. Enter "N/A" if item does not apply to you.

Return completed application to:

PrairieStar Health Center, Human Resources Department, 2700 E. 30th Ave., Hutchinson, KS 67502

Phone: 620-663-8484 Fax: 620-802-0690 email: resumes@prairiestarhealth.org

| | | | | | |
|--|--|---|------------------------|--------------------------------------|---------------------------|
| POSITION APPLIED FOR | | | | APPLICATION DATE | |
| APPLICANT INFORMATION | | | | | |
| LAST NAME | | FIRST | | MIDDLE | |
| STREET ADDRESS | | | | SOC SEC # (LAST 4 DIGITS) XXX-XX- | |
| CITY | | STATE | ZIP CODE | PHONE # | |
| EMAIL ADDRESS | | | | DATE AVAILABLE TO WORK | |
| TYPE OF EMPLOYMENT DESIRED: Full-time Part-time On-call | | | | DESIRED SALARY | |
| Under what other name(s) have you been employed or attended school? | | | | | |
| Have you been previously employed by PSHC? Yes No Position/Dept.: | | | | From To | |
| Reason For Leaving: | | | | | |
| Are you related to any current PSHC employee or member of the Board of Directors? Yes No | | | | If yes, who | |
| Are you over the age of 18? Yes No | | Are you legally eligible for employment in the US? Yes No | | | |
| Have you ever been discharged from employment? | | Yes | No | If yes, explain | |
| Have you ever been found guilty, pled no contest, or had a conviction for any felony? | | Yes | No | If yes, explain | |
| Have you ever been convicted of a crime which excludes you from federal health care programs? | | Yes | No | If yes, explain | |
| Have you been sanctioned from Medicare or Medicaid for fraud or abuse? | | Yes | No | If yes, explain | |
| EDUCATION AND TRAINING | | | | | |
| HIGH SCHOOL/GRADUATE EQUIVALENCY DIPLOMA | | | | | |
| SCHOOL NAME | | CITY | STATE | ZIP CODE | GRADUATED? Yes No |
| COLLEGE/UNIVERSITY/PROFESSIONAL & TRADE SCHOOL - PLEASE START WITH THE MOST RECENT | | | | | |
| INSTITUTION NAME | | DEGREE EARNED | COURSE OF STUDY | YEARS COMPLETED | GRADUATED? Yes No |
| STREET ADDRESS | | CITY | STATE | ZIP CODE | |
| INSTITUTION NAME | | DEGREE EARNED | COURSE OF STUDY | YEARS COMPLETED | GRADUATED? Yes No |
| STREET ADDRESS | | CITY | STATE | ZIP CODE | |
| INSTITUTION NAME | | DEGREE EARNED | COURSE OF STUDY | YEARS COMPLETED | GRADUATED? Yes No |
| STREET ADDRESS | | CITY | STATE | ZIP CODE | |
| SPECIAL SKILLS/CERTIFICATION/LICENSURES | | | | | |
| Special knowledge, skills, and abilities to be considered - relevant to the position you are applying. | | | | | |
| 10-key Medical Terminology List Other Skills: | | | | | |
| Microsoft Office Suite: Word Excel Outlook PowerPoint Publisher Computer Programs: | | | | | |
| TYPE OF CERTIFICATE/LICENSE | | REGISTRATION NUMBER | EXPIRATION DATE | ISSUING STATE/AUTHORITY | |
| | | | | | |
| | | | | | |
| | | | | | |
| Are you licensed to practice in Kansas? Yes No | | | | | |

Employment Application



| REFERENCES | | | | | | | | | |
|---|-------|------|-----------------|----------|----|--------------------------|--|----------|--|
| PLEASE LIST THREE PROFESSIONAL REFERENCES WHO ARE NOT RELATED TO YOU | | | | | | | | | |
| NAME | | | PHONE | | | EMAIL | | | |
| NAME | | | PHONE | | | EMAIL | | | |
| NAME | | | PHONE | | | EMAIL | | | |
| EMPLOYMENT HISTORY (List current or most recent employer first) | | | | | | | | | |
| EMPLOYER | | | | | | STARTING/FINAL JOB TITLE | | | |
| EMPLOYER ADDRESS | | | | CITY | | STATE | | ZIP CODE | |
| FROM: | Month | Year | STARTING SALARY | | | SUPERVISOR'S NAME | | | |
| | | | Hourly | Annually | \$ | | | | |
| TO: | Month | Year | ENDING SALARY | | | PHONE # | | | |
| | | | Hourly | Annually | \$ | | | | |
| JOB DUTIES | | | | | | REASON FOR LEAVING | | | |
| EMPLOYER | | | | | | STARTING/FINAL JOB TITLE | | | |
| EMPLOYER ADDRESS | | | | CITY | | STATE | | ZIP CODE | |
| FROM: | Month | Year | STARTING SALARY | | | SUPERVISOR'S NAME | | | |
| | | | Hourly | Annually | \$ | | | | |
| TO: | Month | Year | ENDING SALARY | | | PHONE # | | | |
| | | | Hourly | Annually | \$ | | | | |
| JOB DUTIES | | | | | | REASON FOR LEAVING | | | |
| EMPLOYER | | | | | | STARTING/FINAL JOB TITLE | | | |
| EMPLOYER ADDRESS | | | | CITY | | STATE | | ZIP CODE | |
| FROM: | Month | Year | STARTING SALARY | | | SUPERVISOR'S NAME | | | |
| | | | Hourly | Annually | \$ | | | | |
| TO: | Month | Year | ENDING SALARY | | | PHONE # | | | |
| | | | Hourly | Annually | \$ | | | | |
| JOB DUTIES | | | | | | REASON FOR LEAVING | | | |
| May we contact your present employer? | | | | | | Yes | | No | |
| Please explain any gaps in work history: | | | | | | | | | |
| APPLICANT STATEMENT | | | | | | | | | |
| I _____ hereby apply for employment with PrairieStar Health Center. I agree to conform to the rules, expectations, and regulations of PrairieStar Health Center. Employment with PrairieStar Health Center is 'at will', and I understand that PrairieStar Health Center or I may terminate my employment at any time, with or without cause or notice. | | | | | | | | | |
| I hereby authorize PrairieStar Health Center, its representative, employees or agents to contact and obtain information from all references, employers, public agencies, licensing authorities, educational institutions, credit bureaus, consumer reporting agencies, and law enforcement agencies. I release them and PrairieStar Health Center from any and all liability and responsibility by reason of their doing so. | | | | | | | | | |
| PrairieStar Health Center is an Equal Opportunity Employer. Federal, state and/or local law prohibits unlawful discrimination in employment practices because of race, color, religion, age, sex, national origin, sexual orientation, veteran status, or disability. No question on the application is asked for the purpose of limiting or excluding any applicant's consideration for employment because of his or her race, color, religion, age, sex, national origin, sexual orientation, veteran status, or disability. | | | | | | | | | |
| I understand that any offer of employment will be contingent on the following: proof of eligibility for employment as required by the Immigration Reform and Control Act; satisfactory completion of a background and/or reference checks; satisfactory completion of a health assessment and drug and/or alcohol screening. | | | | | | | | | |
| I hereby acknowledge that the information provided on this Employment Application is true, complete and correct. I understand that if employed any false statements or any kind of omissions of facts called for on this Application will be considered sufficient cause for dismissal if discovered at a later date. I understand that a violation of fraud/abuse or misconduct in relation to Federal Healthcare Programs may disqualify me from further consideration for employment and will be considered justification for dismissal if discovered at a later date. | | | | | | | | | |
| Do not sign until you have read the above Applicant Statement. I certify that I have read, fully understand and accept all terms of the foregoing Applicant Statement. | | | | | | | | | |
| SIGNATURE | | | | | | DATE | | | |