

# Presentation Medical Center

PO BOX 759  
213 2nd AVE. N.E.  
ROLLA, ND 58367



PHONE: 701-477-3161  
FAX: 701-477-5564  
www.pmc-rolla.com

## Application for Employment

Human Resources  
213 2<sup>nd</sup> Ave NE  
PO Box 759 Rolla, ND 58367  
701/477-3161 (phone)  
701/477-5564 (fax)

*To Applicant: We appreciate your interest in our organization and assure you that we are sincerely interested in your qualifications. A clear understanding of your background and work history will aid in placing you in the position that best meets your qualifications and may assist us in considering future advancement.*

*Presentation Medical Center, in union with the Sisters of Mary of the Presentation, is a Catholic healthcare organization. Through the power and example of Jesus Christ and his gospel values, we are committed to joyfully provide wholistic care and healing with integrity, compassion and respect to all we serve.*

*Presentation Medical Center is an equal opportunity employer. Employment, educational opportunities and promotions in all job classifications are without regard to race, color, creed, sex, age, national origin, religion, disability, military status, marital status, status with regard to public assistance, sexual orientation, or any other classification protected by applicable state or federal laws.*

### PERSONAL

Name: First	Middle	Last	Social Security Number
Address: Street	City	State	Zip Code
Position Applied For (In order of Preference):			Date Available for Employment
1.	2.		
Type of Employment Interested In:		Are you under age 16?	Number of Hours Desired
<input type="checkbox"/> Full Time 32-40 hrs/wk	<input type="checkbox"/> Part Time 17 ½ - 31 ¾ hrs/wk	<input type="checkbox"/> Casual less than 17 ½ hrs/wk	<input type="checkbox"/> Temporary
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been previously employed at PMC? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, give job title, department and dates of employment _____			

### EDUCATIONAL DATA

TYPE	NAME OF SCHOOL	ADDRESS (City / State)	DID YOU GRADUATE	TYPE OF DEGREE	FIELD OF STUDY
High School or GED					
Business Schools Vocational Correspondence					
College or University					

The following section must be completed even if accompanied by a Resume'.

### EMPLOYMENT HISTORY (List Last or Present position first)

Name Address _ City/State/Zip _ Supervisor _ Phone No. _	Your Title	Last Salary	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Duties	Date Began Mo. Yr.	Reason for Leaving
Date Left Mo. Yr.			
Name Address _ City/State/Zip _ Supervisor _ Phone No. _	Your Title	Last Salary	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Duties	Date Began Mo. Yr.	Reason for Leaving
Date Left Mo. Yr.			
Name Address _ City/State/Zip _ Supervisor _ Phone No. _	Your Title	Last Salary	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Duties	Date Began Mo. Yr.	Reason for Leaving
Date Left Mo. Yr.			

If you need additional space to identify your entire employment history, please continue on a separate sheet of paper.

For Reference Purposes: Is your educational or employment history listed under another name?  Yes     No

If so, what? \_

Explain any unemployment periods of two months or more.

### PROFESSIONAL LICENSES AND/OR CERTIFICATIONS

Type	Organization or State Issued	Date Expired	Number
Type	Organization or State Issued	Date Expired	Number
Type	Organization or State Issued	Date Expired	Number

Has your professional license or certification ever been subject to suspension, revocation or cancellation?     Yes     No     N/A

If yes, when, where and disposition of case

## OTHER

Other Qualifications/ Volunteer Information / Specialized Training / Skills / Certifications

## PROFESSIONAL REFERENCES

We may contact: (Do not list relatives)

Name	Address_ City/State/Zip Phone No._	Occupation
Name	Address_ City/State/Zip Phone No._	Occupation
Name	Address_ City/State/Zip Phone No._	Occupation

## PERSONAL REFERENCES

We may contact: (Do not list relatives)

Name	Address_ City/State/Zip Phone No._	Relationship
Name	Address_ City/State/Zip Phone No._	Relationship
Name	Address_ City/State/Zip Phone No._	Relationship

## GENERAL INFORMATION

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status?  Yes  No

Have you ever been convicted of any crime?  Yes  No If yes, when, where and disposition of case \_

A criminal conviction record does not by itself constitute an absolute bar to employment. The nature of the conviction record will be considered in relation to the responsibilities of the position sought in making each employment decision.

Have you ever been found liable of abuse, neglect or mistreatment of persons, or misappropriation of property by a court of law or in an administrative proceeding?  Yes  No If yes, when, where and disposition of case \_

**SMOKING AND DRUG FREE WORKPLACE**

*Our policy is to promote and provide a safe and healthy environment for our patients, residents, employees, physicians, students, volunteers and visitors. Therefore, we do not allow smoking or the use of alcohol or illegal products within property of Presentation Medical Center.*

**APPLICANT'S STATEMENT**

I hereby give Presentation Medical Center the right to investigate my past employment, education and activities. I release from all liability all persons, companies and corporations who supply such information. I indemnify Presentation Medical Center against liability that might result from such an investigation. I understand that any false answer or statements or implications I might make in this application or in any other required document shall be considered sufficient cause to deny employment or for discharge if already employed.

I also understand that nothing contained in this application or in the granting of an interview is intended to create an employment contract between Presentation Medical Center and myself for employment or for any benefit. I have received no promise regarding employment and I understand that no such guarantee is binding on Presentation Medical Center. If an employment relationship is established, I understand that I have the right to terminate my employment at any time and that Presentation Medical Center has similar rights.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**FOR HUMAN RESOURCES USE ONLY**

Date Received in Human Resources \_\_\_\_\_ By Whom \_\_\_\_\_

No position available

Reviewed

Interviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Interviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

**EMPLOYMENT**

Starting Date and Time	Department	Job Title
Classification	Salary	By

**TRANSFER AGREEMENT**

Starting Date and Time	Department	Job Title
Classification	Salary	By

1. Have you ever been convicted of a crime which is listed as grounds for mandatory or permissive exclusion from any Federal or State healthcare program pursuant to 42 U.S.C. & 1320a-7(a)-(b)(3) (whether you were actually excluded or not? (For purposes of this questions, “convicted” has the meaning set forth in 42 U.S.C. & 1320 a-7(i) and includes any judgment of conviction that has been entered against you, even if there is an appeal pending or the judgment has been expunged; any finding of guilt by a federal, state or local court; any plea of guilty or nolo contendere; or any entry into a first offender, deferred adjudication or other program whereby a judgment of conviction has been withheld.)  Yes  
 No

Please explain:

2. Have you ever been excluded, suspended or debarred from; or otherwise sanctioned by the Medicare or Medicaid programs or any other federally-funded healthcare program?  Yes  No

Please explain:

3. Have you ever defaulted on a Health Education Assistance loan?  Yes  No

Please explain:

4. Do you, or any member of your immediate family or household have a direct or indirect ownership or controlling interest of 5% or more in any health care or related business? (For purposes of this question, “immediate family member” has the meaning given in 42 U.S.C. & 1320a-7(j) and includes your: (1) Spouse; (2) natural or adoptive parent, child or sibling; (3) stepparent, stepchild, stepbrother or stepsister; (4) father, mother, daughter, son, brother or sister-in-law; (5) grandparent or grandchild; or (6) spouse of a grandparent or grandchild. (Include provider numbers for each.)  
 Yes  No

Please explain:

5. Have any of the entities in question #4 above been excluded, suspended or debarred from or otherwise sanctioned by Medicare, Medicaid or any other federally-funded healthcare program?  Yes  No

Please explain:

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Applicant Signature

Date