Memorial Medical Center
Right here in the place we love.

EMPLOYMENT APPLICATION

Memorial Medical Center
Human Resources
1615 Maple Lane Ashland, WI 54806
Ph: 715-685-5520 Fax: 715-685-5109
Email: employment@ashlandmmc.com

SAVE

POSITION(S) APPLIED FOR:		**Date of application**:	

PERSONAL

Last Name	First Name	Middle Initial	
Home Address	City	State	Zip
Telephone number	Date Available / Full time / Part time	E-mail address	
Days & hours available for work			
Were you previously employed at Memorial Medical Center? ☐ NO ☐ YES When?	Have you ever been **convicted** of a crime? ☐ NO ☐ YES Explain:		
Do you have a relative working here? ☐ NO ☐ YES Give Name			
Emergency Contact: (Name and Phone number)	Date of birth if under 18 (Note: You must be 16 or older to work at MMC)		

EMPLOYMENT HISTORY

LIST MOST RECENT POSITION FIRST

Dates Employed	Name of employer	Position held	Name/Title last supervisor
Address	Phone	E-mail	Ending salary
Briefly describe the work you performed:			Full Time ☐ Part Time ☐
Reason for leaving:		May we contact this employer? YES ☐ NO ☐	
Dates Employed	Name of employer	Position held	Name/Title last supervisor
Address	Phone	E-mail	Ending salary
Briefly describe the work you performed:			Full Time ☐ Part Time ☐
Reason for leaving:		May we contact this employer? YES ☐ NO ☐	
Dates Employed	Name of employer	Position held	Name/Title last supervisor
Address	Phone	E-mail	Ending salary
Briefly describe the work you performed:			Full Time ☐ Part Time ☐
Reason for leaving:		May we contact this employer? YES ☐ NO ☐	

List Additional Employment History on a Separate Sheet

EDUCATION

School	Name of school	Location	Years completed	Dates From Mo	Dates From Yr	Dates To Mo	Dates To Yr	Course of Study	Did you graduate?	Diploma / Degree
High School										
Vocational										
College										
Graduate										

REFERENCES
(At least 2 should be employers, supervisors or teachers.)

NAME	MAILING ADDRESS (Include Street, City, State and Zip code)	PHONE / E-MAIL	RELATIONSHIP

LIST HEALTH CARE, BUSINESS, OR INDUSTRIAL EQUIPMENT THAT YOU OPERATE PROFICIENTLY.

LIST PROFESSIONAL LICENSES, REGISTRATION AND/OR CERTIFICATION WITH EXPIRATION DATES (DO NOT INCLUDE DRIVERS LICENSE)

HAS YOUR PROFESSIONAL LICENSE OR REGISTRATION EVERY BEEN TERMINATED, STIPULATED, RESTRICTED, LIMITED, CONDITIONED, SUSPENDED, REVOKED, REFUSED, VOLUNTARILY RELINQUISHED OR NOT RENEWED BY ANY LICENSING BOARD OR ANY HEALTH-RELATED AGENCY ORGANIZATION, OR IS THERE SUCH ACTION OR REVIEW PENDING? YES ☐ NO ☐
If YES, please give details on a separate sheet.

AUTHORIZATION AND RELEASE

I hereby authorize investigation of all statements contained in this application and agree that if any misrepresentation has been made by me herein or the results of an investigation are not satisfactory for any reason, any offer of employment made to me by the hospital may be terminated immediately without any obligation or liability to me other than for payment, at the rate agreed upon, for services actually rendered if I have been employed.

In connection with my application for employment, I authorize the hospital and any agent acting on its behalf, to conduct an inquiry as to my personal history including and or all of my former employers, references, any agency and any or all educational institutions. I hereby release this hospital, and any agent acting on its behalf, from any and all liability of whatsoever nature by reason of requesting such information from any person.

If offered employment, I consent to a pre-employment physical examination and other health requirements including a drug test. If hired at MMC, I agree to future examinations as the hospital may require. I understand that an offer of employment and continued employment is contingent upon the satisfactory completion of employee health requirements.

Further, I also understand that any offer of employment is contingent upon the satisfactory completion of a criminal background check.

I hereby acknowledge that I have read and understand the foregoing.

DATE_____ SIGNATURE _____

SUBMIT BY EMAIL

Or you may submit by fax, mail, or scan/email a printed copy