



PERSONAL INFORMATION

Name:

Date:

Address:

City:

State:

Zip Code:

Phone:

JOB-RELATED INFORMATION

Position Desired:

Can you perform the essential functions of the position for which you are applying?

YES

NO

If no, please explain. (If you have any questions as to what functions are applicable to the position for which you are applying, please ask the interviewer before you answer this question.)

When are you available to begin work?

Hourly rate/Salary desired

Are you legally eligible to be employed in the United States? YES NO

(Proof of identity and eligibility will be required upon employment)

Are you over the age of 18? YES NO

(If no, you may be required to provide authorization to work.)

Have you ever worked for this Department before? YES NO

If yes, when? (Give dates)

Job Title:

Do you have any relatives or friends who work for the Department? YES NO

If yes, who?

Are you available to work: FULL-TIME

PART-TIME

TEMPORARY

Are you presently employed? YES NO

If yes, may we contact your employer? YES NO

Have you completed any special courses, seminars, and/or training directly related to the position for which you are applying? YES NO

If yes, please describe:

REFERENCES

Give the names of three persons not related to you, whom you have known for at least three (3) years.

Name	Address, Phone, Email	Company	Years Known
1.			
2.			
3.			

Southeast District Health Department is an equal opportunity employer, and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity or expression, pregnancy, age, national origin, disability status, genetic information, protected veteran status, or any other characteristic protected by law.

IMPORTANT, PLEASE READ AND SIGN

I understand that neither the completion of this application nor any other part of my consideration for employment establishes any obligation for Southeast District Health Department to hire me. If I am hired, I understand that either Southeast District Health Department or I can terminate my employment at any time and for any reason, with or without cause and without prior notice. I understand that no representative of Southeast District Health Department has the authority to make any assurance to the contrary.

I attest with my signature below that I have given to Southeast District Health Department true and complete information on this application. No requested information has been concealed. I authorize Southeast District Health Department to contact references provided for employment reference checks. If any information I have provided is untrue, or if I have concealed material information, I understand that this will constitute cause for the denial of employment or immediate release.

Signed:

Date: