



PONDERA MEDICAL CENTER

Employment Application

✓ Please complete this application by typing or printing in ink. *INCOMPLETE or UNSIGNED applications will not be considered.*

✓ *PONDERA MEDICAL CENTER is an equal employment opportunity employer. All applicants are considered for employment based on their qualification without regard to race, color, religion, national origin, sex, age, marital status, disability or any other factor prohibited by law or regulation.*

✓ Do you need any accommodations to participate in the application or interview process? Yes No

NOTE: all applications are reviewed and only the most qualified candidates are contacted for further consideration and interview.

Position(s) Applied For: _____ **Desired Hourly Rate:** _____

PLEASE TYPE OR PRINT CLEARLY AND COMPLETE APPLICATION **EVEN IF YOU ATTACH A RESUME.**

Personal Data

Full Name: _____

List all last names used within the last 7 years: _____

Present Address _____ **City** _____ **State** _____ **Zip** _____

Phone () _____ **Cell Phone** () _____ **E-Mail** _____

Education

High School Diploma or GED? Yes No **Name of High School** _____

Name of school beyond High School: _____

Major: _____ **Minor:** _____ **Degree:** _____ **Date of Degree:** _____

Major: _____ **Minor:** _____ **Degree:** _____ **Date of Degree** _____

License and/or Certifications (For positions requiring licensure or certification, please complete the following:

License/Certification(s)	State	Registration #	Expiration Date

Special Skills: List skills such as equipment, tools, machinery or office equipment operated, training programs, or any other qualifications that have a direct reflection on the job(s) applied for.

Work Experience (List most recent work experience first) All information requested is required (not optional).

Company Name:			Immediate Supervisor:		
Address:		City	State	Zip	Phone:
Job Title:			Start Date:		End Date:
Job Duties:			* (required) Hourly Rate:		
Reason For Leaving:					

Company Name:			Immediate Supervisor:		
Address:		Phone:			
Job Title:			Start Date:		End Date:
Job Duties:			Hourly Rate:		
Reason For Leaving:					

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Address:		Phone:			
Job Title:			Start Date:		End Date:
Job Duties:			Hourly Rate:		
Reason For Leaving:					

General Information – Answer all questions

Do you have relatives or friends working here? YES NO **If Yes**, please indicate names and relationship:

Have you worked for PMC before? YES NO **If YES**, please list dates and positions:

Have you ever had a professional license disciplinary action, or has your license ever been revoked, suspended, restricted, or modified in any State and / or Have you been listed as excluded from working in a Medicaid or Medicare facility by the OIG?

YES NO **If Yes to either question**, attached full details.

Have you been convicted of, pled guilty to, or been confined for any criminal offense within the past seven (7) years?

YES NO **If Yes**, please attach full details.

AVAILABILITY: Full-Time Part-Time Work When you are needed/PRN Temporary (how many months: _____)

Indicate shift preference (1, 2, 3rd priority) _____ Days _____ Evenings _____ Nights _____ No Preference

Days available to work: (please circle) Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Shift preference: __ 4 hours __ 8 hours __ 10 hours __ 12 hours **Rotate shifts** Yes No / **Weekends** Yes No

References (At least two business references – do not list relatives as references)

Name	Address	Phone

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

AUTHORIZATION, VERIFICATION, RELEASE, AND SIGNATURE:

1. I authorize the investigation of all matters, including criminal background check, which PMC deems relevant to my qualifications for employment, including all statements made in this application, in any attachments or supporting documents, and in any interviews. I authorized PMC to request and receive such information regarding me and my former employment, education, and training, and I release from all liability any persons (such as former supervisors, employers, or co-workers) supplying it. I also release PMC from all liability, which might result from making the investigation.
2. I certify that the facts and information in this application, in any attachments or supporting documents, and in any interviews are (or will be) true and complete to the best of my knowledge. I understand that any falsification, misrepresentation or omission, as well as any misleading statements or omissions, generally will result in denial of employment or immediate termination, regardless of when and how discovered.
3. **Pondera Medical Center is a Drug and Alcohol Free Work Place.** I understand and I agree that I may be required to submit to drug and alcohol testing, if I am offered a job, but before I become an employee. I authorize the release of the results of the tests described above to use to evaluate my qualifications of employment. I also hereby release PMC from all liability arising out of or connected with any drug and alcohol testing.
4. **I understand this application is not intended to be a contract of employment. I further understand that any employment the facility may offer me may be terminated at any time before the 6 month probationary period ends.**
5. I have read each of these statements. I have also reviewed all of the information provided in this application and any attachments or supporting documents.

YES NO

Signature of Applicant

Date

**THANK YOU FOR YOUR INTEREST IN PMC.
PLEASE FEEL FREE TO ATTACH YOUR RESUME OR ANY ADDITIONAL INFORMATION WHICH MAY BE HELPFUL
IN EVALUATING YOUR QUALIFICATIONS AND RETURN YOUR APPLICATION TO:**

**PMC
ATTN: HUMAN RESOURCES**

Deliver In-person to the: Front Desk at : 805 SUNSET BLVD., CONRAD, MT or:

By mail: P.O. Box 668 Conrad, MT 59425 or:

**By Scan & email: pmcig@yahoo.com (must have written signature – no electronic signatures)
or:**

By Fax: (406) 271-3917

PONDERA MEDICAL CENTER

REQUIRED

PLEASE FILL-OUT AND SIGN – THIS INFORMATION IS CONFIDENTIAL

REFERENCE RELEASE & BACKGROUND INFORMATION AUTHORIZATION

I hereby authorize Pondera Medical Center (PMC) to make inquiries of educational institutions attended and previous employers regarding my past school/employment record, including employment dates, salary, employment evaluations, and any other information necessary to assess my qualifications. In addition, I acknowledge that in accordance with Medicaid and Medicare laws, an inquiry about my record of criminal convictions may be made through the State of Montana or other States that I have worked in, or other agencies as required upon hire and during employment. I also authorize PMC to check the list of excluded individuals and entities on the Office of Inspector General for any Medicare fraud prior to hiring. I release all parties connected with such requests from all claims, liabilities and damages for whatever reason arising out of furnishing this information.

NAME: _____

OTHER LAST NAMES USED IN LAST 7 YEARS: _____

Birth Date: Month _____ Day _____ Year _____

Social Security Number: _____

States lived in during the past 7 years: _____

Date: _____ **Signature of Applicant:** _____

PONDERA MEDICAL CENTER Employment Application Supplement

AFFIRMATIVE ACTION INFORMATION

Applicant Name: _____ **Date:** _____

The name of the position(s) you are applying for: _____

Voluntary Affirmative Action Information (completion of information below is voluntary).

In an effort to comply with requirements regarding government record keeping, reporting and other legal obligations, we ask that you complete this data survey. Your cooperation is appreciated.

Please be advised that your survey is not part of your official application for employment. It is considered confidential information that will not be used in any hiring decision.

Check One: Male Female

Check One/ or if multiple ethnicity check two or more:

American Indian/Alaskan Native Asian/Pacific Islander

Black Hispanic/Latino White (not of Hispanic/ Latino origin)

Check if applicable: Vietnam Era Veteran Disabled Veteran

Disabled

Age Category: 16-17 18 – 39 40 or over

How did you first learn about this opening? (*Check one*)

Job Service Friend (*Non Employee*) Internet (*Specify*) _____

Newspaper (*Specify*) _____ School (*Name*) _____

Other (*Specify*) _____

Hospital Employee (*Name & Dept.*) _____

CONFIDENTIAL - HR FILE ONLY ***NOT FOR INTERVIEW PURPOSES*******

FINAL STEP:

AS PART OF THE APPLICATION PROCESS WE REQUIRE YOU TO COMPLETE A SURVEY.

YOU WILL NEED TO COMPLETE THIS SURVEY ONLINE.

YOU MAY COMPLETE THIS SURVEY ON YOUR OWN COMPUTER IF YOU HAVE INTERNET ACCESS.

If you do not have internet access you may use any computer with internet access or you may come to Pondera Medical Center and use our computer lab.

Below you will find instructions to complete the Survey outlined below. It will take approximately 15 – 20 minutes to complete.

INSTRUCTIONS:

GO TO: www.starthsi.com

Please enter the following Login: **PONDERAMC**

Please enter the following Password: **CONRADMT**

After you log in, follow the instructions to complete the Survey.

PLEASE COMPLETE THIS SURVEY BEFORE OR THE SAME DAY YOU SUBMIT YOUR APPLICATION.

THANK YOU.