



APPLICATION FOR EMPLOYMENT

Human Resources Department
1500 E. Sherman Blvd. • Muskegon, Michigan 49443

"Mercy Health Partners (MHP) is an equal opportunity employer that does not discriminate based on religion, race, color, national origin, age, sex, height, weight, marital status, physical or mental disability, military or veteran status, or any other legally protected characteristic."

Personal Information

(PLEASE PRINT)

Name _____ Today's Date _____
Last First Middle Initial

Current Address _____
Number Street
City State Zip Code

Home Telephone () _____ Other Telephone () _____

Indicate any other name you have used for purposes of verifying your work record. _____

Are you at least 18 years of age? Yes No

Do you have the legal right to work in the U.S.? Yes No

Have you ever been employed by MHP or any other Trinity Health Facility? Yes No If yes, when and under what name: _____

Have you ever been convicted of a felony? Yes No If yes, when? (Year) _____

Have you ever been convicted of a misdemeanor? Yes No If yes, when? (Year) _____
(Including any traffic violations)

What was the nature of the conviction? _____

Are there any misdemeanor or felony charges pending against you? Yes No If yes, please explain: _____

U.S. Military Service (inclusive dates) _____ Type of discharge _____

Employment Desired

Position Applied For: _____

Status Desired: Full-Time Part-Time Temporary or Relief

Date available for work: _____

Shifts available: Any 1st 2nd 3rd

Days available: Any Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

Relatives employed in the organization: _____

Can you perform the essential functions of the job for which you are applying, with or without reasonable accommodation?
 Yes No

If you have any questions relative to the duties of the position applied for, please contact the Human Resources Department.

How did you hear about our job opportunities?

MHP Website MHP Telephone Jobline Newspaper Ad Job Posting List at Mercy/ Campuses

Trade Journal Family/Friend Referral Other

Professional Skills and Licensure

Hospital or Industrial Equipment skilled to operate: _____

Computer training/experience: _____

Professional Licenses and/or certificates:

Type	State Issued	Date Issued	Expiration Date	Number
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Modern language skills, including American sign language (those which you consider yourself fluent):

Language _____ Speak Read Write

Language _____ Speak Read Write

Education and Training

School	Name	Address	Dates Attended	Type of Diploma/ Degree	Year Graduated
High School					
College					
College					
Graduate School					
Nursing/ Other School					

List any work training programs, seminars, extra curricular activities or any other education experiences relevant to the position(s) applied for:

Please list courses currently taking: _____

Experience – list most recent first

Dates: Month-Year From: _____ To: _____	Employer	Type of Business
Employer's Address	City	State Zip Code Phone

Title of Position	Employment status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time No. Hrs.	Supervisor's Name	Final Salary \$ <input type="checkbox"/> Mo <input type="checkbox"/> Hr <input type="checkbox"/> Yr.
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Duties (including Supervisory)

Reason for Leaving

Dates: Month-Year From: _____ To: _____	Employer	Type of Business
Employer's Address	City	State Zip Code Phone

Title of Position	Employment status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time No. Hrs.	Supervisor's Name	Final Salary \$ <input type="checkbox"/> Mo <input type="checkbox"/> Hr <input type="checkbox"/> Yr.
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Duties (including Supervisory)

Reason for Leaving

Certification

I certify that all statements made on this Application are true, and that I have not knowingly withheld any requested information. I agree that any false information, misrepresentation, or omissions may disqualify me from further consideration for employment, and, if I am hired, may result in discipline or dismissal if discovered at a later date.

I authorize the thorough investigation of all statements contained in this Application and any further investigation of any information required to determine my qualifications for the positions for which I am applying, including, but not limited to employment history and discipline records. I authorize present and former employers, schools, and other references to release any information requested by Mercy Health Partners (MHP) and hereby release all individuals and organizations from any liability or damages which result from requesting or furnishing such information. I waive any right under Public Act 297 of 1978 to receive written notice from any organization disclosing such requested information.

I hereby certify that I have not been debarred or excluded from participation as a provider of healthcare services in Medicare, Medicaid or any other federally or state funded health care programs and have not been convicted of a health care related criminal offence.

I understand that an offer of employment will be subjected to the results of a criminal history check, a check for exclusion or debarment from any federally or state funded health care program and a check for convictions for health care fraud and abuse.

Should I receive a conditional offer of employment, I agree that Mercy Health Partners may require me to submit to a physical, psychological, and/or medical examination. I further authorize any physician or entity conducting such examinations to release the results of the examination to Mercy Health Partners. I release from all liability and responsibility all persons, employers, and examiners requesting or providing such information, and waive any right to notice of such disclosure. I further understand that, if hired, I may be required to submit to a physical, psychological and/or medical examination periodically thereafter.

I hereby give my consent for Mercy Health Partners, through an authorized testing service of its choice, to collect blood, urine, or others samples from me, and to conduct any other necessary medical test to determine the presence of alcohol, drugs, or controlled substances, and I hereby release Mercy Health Partners from any liability arising out of such test or its results. Further, I give my consent for the release of the test results and other relevant medical information during my employment when, in Mercy Health Partners' judgment, such testing is appropriate, and I understand that my failure to cooperate in testing is grounds for my immediate discharge. I acknowledge that remaining free of illegal drug use and complying with Mercy Health Partners' substance abuse policy is a condition of my employment.

I acknowledge that my employment during any probationary period will be an at-will basis. This means that my employment is subject to termination by me or Mercy Health Partners at any time, with or without prior notice, discipline or warning, and with or without cause. Thereafter, my status will be as provided in either the Human Resource Policy Manual (if I have a non-union position) or by the applicable union contract (if my position is included in a bargaining unit represented by a union),

I understand that no one other than the Chief Executive Officer of Mercy Health Partners has the authority to offer employment for any specified period, or to enter into any oral or written contract or employment contrary to the foregoing. Moreover, no such agreement by the Chief Executive Officer will be enforceable unless it is in writing, pertains specifically to me, and is signed by the Chief Executive Officer of Mercy Health Partners. I acknowledge that if my employment is covered by any such signed, written agreement which provides for a different basis of employment, the terms of such agreement control over any inconsistent terms in this Certification.

Applicant Signature _____

Date _____



MERCY HEALTH PARTNERS

1500 E. Sherman Boulevard • Muskegon, MI 49443 • Phone 231-672-3909

Employment References

Applicant's Name: _____

Applicant's Social Security Number: _____

EMPLOYMENT REFERENCE # ONE:

Company Name: _____

Company Address: _____

City, State, Zip Code: _____

Company Phone Number: () _____

Position Held: _____

Dates of Employment: From _____ To _____

EMPLOYMENT REFERENCE # TWO:

Company Name: _____

Company Address: _____

City, State, Zip Code: _____

Company Phone Number: () _____

Position Held: _____

Dates of Employment: From _____ To _____

I hereby authorize my previous employer to release information regarding my employment and my work performance. I hereby release said previous employer, its affiliates and subsidiaries or persons from all liability for issuing this information. Further, I agree to hold harmless and indemnify Mercy Health Partners and its affiliates and subsidiaries from any and all liability, action, or inaction arising from the acquisition and/or reliance on said information inclusive of the denial of my application for employment by Mercy Health Partners.

Signature

Date

STERLING

CONSENT AND DISCLOSURE

DATE _____

LOCATION MHP

I understand the Mercy Health Partners will utilize the services of STERLING TESTING SYSTEMS, INC., 249 17th Street, New York, NY 10011, as part of the procedure for processing my application for employment. I also understand that if my application for employment is granted, Mercy Health Partners may obtain further information through subsequent investigations by STERLING TESTING SYSTEMS, INC so as to update, renew or extend my employment, to the extent permitted by law.

I understand a consumer reporting agency's investigation may include obtaining information regarding bankruptcies covering up to the last ten (10) years, obtaining information regarding civil suits, civil judgments, arrest records, and paid tax liens covering up to the last seven (7) years, obtaining information regarding any other adverse item of information covering up to the last seven (7) years and obtaining information regarding references and educational and employment verifications without any time limitations, subject to any limitations or exceptions applicable under state and federal law. The investigation also may include obtaining information relating to criminal records without any time limitations, subject to state law.

In the event an investigative consumer report is conducted, I understand such information may be obtained by personal interviews with my acquaintances or associates or with others whom I am acquainted or who may have knowledge concerning my character, general reputation, personal characteristics or standard of living. I understand such information may also be obtained through direct or indirect contact with former employers, schools, financial institutions, landlords and public agencies or other persons who may have such knowledge.

I understand that I have the right to receive notice about the nature and scope of any investigative consumer report requested within five days after the Company receives my request or five days after the investigative consumer report was requested, whichever is later.

By checking the box, I indicate that I wish to receive further disclosure about the nature and scope of any Company request for an investigative consumer report.

I acknowledge that I have received the attached summary of my rights under the Fair Credit Reporting Act.

I also understand that before I am denied employment based, in whole or part, on information obtained in the consumer report and/or investigative consumer report, I will be provided a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act. I understand if I disagree with the accuracy of any information in the report, I must notify Mercy Health Partners within five business days of my receipt of the report that I am challenging the accuracy of the information contained in this report with STERLING TESTING SYSTEMS, INC. and advise Mercy Health Partners as to the basis of my challenge.

In exchange for Mercy Health Partner's consideration of my employment application, I agree not to file or pursue any complaints, claims or legal actions of any kind against STERLING TESTING SYSTEMS, INC. for providing the aforementioned information. I also agree not to file or pursue any complaints, claims or legal actions against Mercy Health Partners or any of its employees, representatives, or agents arising out of or in any way related to conducting a background investigation. I am consenting that a photocopy of this authorization be accepted with the same authority as the original, and I specifically waive any written notice from any entity, which may provide information based on this authorized request.

I hereby consent to this investigation and authorize Mercy Health Partners to procure a consumer report and/or investigative consumer report on my background as stated above from STERLING TESTING SYSTEMS, INC. In order to verify my identify for purposes of the background investigation I am voluntarily releasing my date of birth, social security and the other information below for my own benefit and fully understand that lal employment decisions are based on legitimate non-discriminatory reasons.

First Name

Date of Birth (MM/DD/YYYY)

Last Name

Middle Name/Initial

Other Names Known By

Male Female

Current Address

yrs at this address

City

State

Zip Code

Previous Address

yrs at this address

City

State

Zip Code

Driver's License No.

State

Social Security No.

Signature

Date

Minnesota & Oklahoma applicants Only: I have the right to request a copy of the consumer report obtained by Mercy Health Partners from Sterling Testing Systems, Inc. by checking the box below. Sterling Testing Systems, Inc. will mail the consumer report.