AICOTA HEALTH CARE CENTER, INC.

850 Second Street NW
Aitkin, MN 56431
218-927-2164
Fax # 218-927-6436

APPLICATION FOR EMPLOYMENT

Applicant Note: This application form is for use in evaluating your suitability for employment. It is not an employment contract. Please answer questions completely and to the best of your ability. All qualified applicants will receive consideration for employment without regard to sex, marital status, race, age, creed, national origin, disability or other legally protected classifications.

Please Print

Position Applied For	Referred By	Date of Application

Last Name	First Name		Middle Name
Address	City	State	Zip
Telephone Number		Nursing Assistant Registry # (Social Security#)	

Are you legally authorized to work in the United States? ☐ Yes ☐ No

Have you ever filed an application with us before? If yes, give date:_____ ☐ Yes ☐ No

Are you currently employed? If yes, where?_____ ☐ Yes ☐ No

On what date would you be available for work?_____

Shifts you can work: ☐ Day ☐ Evening ☐ Night Hours Available:_____

Hours Desired: ☐ Full-time ☐ Part-time ☐ Temporary

EDUCATION

	Name of School City & State	Course of Study Degree Earned	Number of completed years	Did you graduate?
High School				
College or Univ.				
Other				

Special skills or training that may qualify you for work with our company:

EMPLOYMENT *List all present and past positions, beginning with most recent*				
From	To	Employer	Phone	City, State
Job Title		Address		
Supervisor's Name		Duties		
Starting Salary/Wages				
Final Salary/Wages		Reason for Leaving		
From	To	Employer	Phone	City, State
Job Title		Address		
Supervisor's Name		Duties		
Starting Salary/Wages				
Final Salary/Wages		Reason for Leaving		
From	To	Employer	Phone	City, State
Job Title		Address		
Supervisor's Name		Duties		
Starting Salary/Wages				
Final Salary/Wages		Reason for Leaving		

REFERENCES *Professional, peer, and work references, not relatives*				
Name	Occupation	Relationship	Address	Years Known

AUTHORIZATION & CERTIFICATION

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and I authorize the references and employers listed above to give you any and all information concerning my previous employment and any other pertinent information they may have, personal or otherwise.

"I further authorize that if I am employed by Aicota Health Care Center, Inc. I will receive a 2-step mantoux test or if contraindicated, I must submit a current chest x-ray (within 45 days of employment) at my own expense. A mantoux or a chest x-ray is a requirement of the Minnesota Department of Health for employment at Aicota Health Care Center, Inc."

_____

Signature Date