



APPLICATION FOR EMPLOYMENT WITH DARKE COUNTY GENERAL
HEALTH DISTRICT

Return to: _____

Equal access to programs, services and employment is available to all persons. Those applicants requiring accommodation to the application and/or interview process should notify the Human Resources Department. We consider all applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status.

Position(s) applied for: _____

Date of Application: _____

How did you hear about the position?

Advertisement: _____ Relative _____ Inquiry _____ Website _____ Friend _____

Employment Agency _____ Other _____

Name: _____
Last First Middle

Mailing Address: _____
Street Apt. City State Zip

Telephone # () _____ Mobile/Other () _____

E-mail: _____ Best time to contact you at home is: _____ am/pm

Have you ever submitted an application to Darke County Health Department? _____ If Yes, when? _____

Have you ever been employed by Darke County Health Department? _____ If Yes, when? _____

Are you legally eligible for employment in the United States? _____

If you are under 18, can you furnish a work permit? _____

Do you have a valid driver's license? _____ State / Number: _____

Are you able to meet all of the attendance requirements of this position? _____

Are you able to work overtime if necessary? _____ Will you travel if the position requires it? _____

Do you have any friends / relatives currently employed by Darke County Health Department? _____

If Yes, who?

What is your desired salary range or rate of pay: \$ _____ per _____

Date available for work: _____

Type of employment desired: _____ Full Time _____ Part Time _____ Seasonal

Employment History: Starting with your most recent employer, provide the following information. Include any relevant volunteer activities, but exclude any organizations that would reveal race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve National Guard or any other similarly protected status.

1. From/To _____ Employer/Organization _____

Telephone # _____ Address _____

Job Title: _____ Supervisor _____ May We Contact? _____

Job Duties/Responsibilities _____

Reason for Leaving _____ Final Rate of Pay: _____

2. From/To _____ Employer/Organization _____

Telephone # _____ Address _____

Job Title: _____ Supervisor _____ May We Contact? _____

Job Duties/Responsibilities _____

Reason for Leaving _____ Final Rate of Pay: _____

3. From/To _____ Employer/Organization _____

Telephone # _____ Address _____

Job Title: _____ Supervisor _____ May We Contact? _____

Job Duties/Responsibilities _____

Reason for Leaving _____ Final Rate of Pay: _____

4. From/To _____ Employer/Organization _____

Telephone # _____ Address _____

Job Title: _____ Supervisor _____ May We Contact? _____

Job Duties/Responsibilities _____

Reason for Leaving _____ Final Rate of Pay: _____

Please Explain Any Gaps In Employment:

Have you ever been fired or asked to resign from a job? _____

If yes, please explain

EDUCATION

	Name and Address of School	Course of Study	Years Completed	Diploma/Degree Obtained
High School				
Undergraduate College				
Graduate Professional				
Other (specify)				

Related Information: Please list any relevant professional or trade organizations of which you are a member. Exclude memberships that would reveal race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve National Guard or any other similarly protected status.

Organization	Offices Held

Please discuss your interest in employment with the Darke County Health Department and any qualifications beyond what is reflected in your application. Use additional sheets if needed.

References: Please provide the names and telephone numbers of three professional references who are not related to you and are not previous supervisors. If professional references are not available, provide school or personal references who are not related to you.

Name:

Title:

Relationship:

Telephone:

Email:

Name:

Title:

Relationship:

Telephone:

Email:

Name:

Title:

Relationship:

Telephone:

Email:

Applicant Statement and Signature:

I certify that all information I have provided in order to apply for and obtain employment with Darke County Health Department is true, complete, and correct. I agree and understand that omissions, misstatements, and falsifications will cause forfeiture on my part of all eligibility to any employment with Darke County Health Department and may be cause for rejection of this application, removal of my name from eligibility lists, or discharge from Health Department service, whenever it is discovered. I give Darke County Health Department the right to investigate and verify any information obtained through the application process. Permission is granted and I release from any and all liability any employer, agency or individual assisting Darke County Health Department in providing relevant, job-related information that will assist in this process. I expressly authorize, without reservation, Darke County Health Department, its representatives, members or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application. I hereby waive any and all rights and claims I may have regarding Darke County Health Department, its agents, members or representatives, for seeking, gathering, and using such information and all other persons, corporations, or organizations for furnishing such information about me.

I understand that an offer of employment may be contingent upon the successful completion of a pre-employment background criminal investigation, physical, psychological, polygraph, and/or drug and alcohol screen. If employed, I agree to provide proof of identity, relevant licensure or credentials, and authorization for employment in the United States. If I am hired, I understand that, unless otherwise defined by applicable law, any employment relationship with Darke County Health Department is of an "at will" nature, which means that I am free to resign at any time and Darke County Health Department reserves the same right to terminate my employment at any time. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that all conditions of employment including, but not limited to hours, benefits and salary are subject to change by Darke County Health Department any time. I understand that no representative of Darke County Health Department is authorized to make any assurances to the contrary and that no implied, oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the appropriate Appointing Authority.

DO NOT SIGN UNTIL YOU READ THE ABOVE APPLICANT STATEMENT

I certify that I have read, fully understand, and accept all terms of the foregoing Applicant Statement.

Applicant Signature: _____

Date: ____ / ____ / ____

CONSENT TO CONDUCT BACKGROUND INVESTIGATION AND RELEASE

I _____ hereby permit **Darke County Health Department** to conduct a background Investigation, including my criminal history, concerning matters related to my application for employment. As a result of this background investigation I understand that **Darke County Health Department** will be seeking information from prior employers and other individuals, including various law enforcement agencies that I may or may not have disclosed. By signing this release, I hereby consent all prior employers, law enforcement agencies and educational institutions to provide necessary information to this employer during the background investigation. I hereby release, hold harmless and agree not to sue or file any claim of any kind against any current or former employer, law enforcement agency or educational institution, and any officer or employee of either, that in good-faith furnishes written or oral references as requested by this employer to complete its background investigation.

A photocopy or facsimile of this form that shows my signature is valid as an original.

Dated this _____ day of _____ 20____

Witness _____

Applicant _____

Social Security Number (for Criminal Records only)

Birth Date: Month/Day/Year

Previous Address

State

Zip

Month/year

Previous Address

State

Zip

Month/year