



# Augustana Care

fostering fullness of life

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### Application for Employment

For current position openings go to [www.augustanacare.org](http://www.augustanacare.org)  
 Augustana Care provides a smoke free environment for employees.  
 An equal opportunity/affirmative action employer.  
 A mission driven, Christian organization since 1896.

APPLICANT INFORMATION				
Last Name	First	M.I.	Date	
Street Address			Apartment/Unit #	
City	State		ZIP	
Home Phone		Cell		
Email		Social Security:		
Position(s) Applied for				
Referral Source	Ad <input type="checkbox"/>	Friend <input type="checkbox"/>	Relative <input type="checkbox"/>	Walk-in <input type="checkbox"/> Web <input type="checkbox"/>
Referred by:				
Have you applied here before?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes give date	
Have you ever worked for this company?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?	
Are you employed now?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	May we contact your present employer?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If hired, can you furnish proof that you are 16 years of age or older?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, please explain	
If hired, can you furnish proof that you are eligible to work in the United States?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, please explain	
On what date would you be available for work?				
Are you available to work...	Full-time <input type="checkbox"/>	Part-time <input type="checkbox"/>	On-call <input type="checkbox"/>	
Shift Preference	Days <input type="checkbox"/>	Evenings <input type="checkbox"/>	Nights (NOC) <input type="checkbox"/>	
Are you on a lay-off and subject to recall?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain	

Licenses held (list type and registration numbers)

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AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER M/F/V/H  
[www.augustanacare.org](http://www.augustanacare.org)

PREVIOUS EMPLOYMENT				
Company			Phone (       )	
Address			Supervisor	
Job Title		Starting Salary	\$	Ending Salary \$
Responsibilities				
From		To	Reason for Leaving	
May we contact your previous supervisor for a reference? Yes <input type="checkbox"/> No <input type="checkbox"/>				
PREVIOUS EMPLOYMENT				
Company			Phone (       )	
Address			Supervisor	
Job Title		Starting Salary	\$	Ending Salary \$
Responsibilities				
From		To	Reason for Leaving	
May we contact your previous supervisor for a reference? Yes <input type="checkbox"/> No <input type="checkbox"/>				
PREVIOUS EMPLOYMENT				
Company			Phone (       )	
Address			Supervisor	
Job Title		Starting Salary	\$	Ending Salary \$
Responsibilities				
From		To	Reason for Leaving	
May we contact your previous supervisor for a reference? Yes <input type="checkbox"/> No <input type="checkbox"/>				
PREVIOUS EMPLOYMENT				
Company			Phone (       )	
Address			Supervisor	
Job Title		Starting Salary	\$	Ending Salary \$
Responsibilities				
From		To	Reason for Leaving	
May we contact your previous supervisor for a reference? Yes <input type="checkbox"/> No <input type="checkbox"/>				

**EDUCATION**

High School		Address			
From	To	Did you graduate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Degree
College		Address			
From	To	Did you graduate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Degree
Further Education		Address			
From	To	Did you graduate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Degree

Other Special Training or skills (Languages, machine operation, typing speed, computer knowledge)

List Professional trade, business or civic activities and offices held.

**REFERENCES**

*Please list three professional references.*

Full Name	Relationship:
Company	Phone:
Address	
Full Name	Relationship:
Company	Phone:
Address	
Full Name	Relationship:
Company	Phone:
Address	

APPLICANT'S STATEMENT

Augustana Care(AC) is an equal employment opportunity employer and will not discriminate against any applicant or employee on any grounds protected under federal, state, or local law, including race, color, creed, religion, age, sex, sexual orientation, sexual harassment, national origin, ancestry, marital status, handicap, disability related to pregnancy or childbirth, membership or activity in any local commission, status regarding public assistance, membership or non-membership in any labor organization, or any other characteristic protected under federal, state or local law. None of the questions in this application are intended to elicit information regarding any protected characteristic protected under federal, state, or local law. None of the questions in this application are intended to elicit information regarding any protected characteristics, nor imply any limitation, illegal preferences, or discrimination based upon non-job-related information or protected characteristics. If you are hired by AC, you will be employed on an at-will basis. As an at-will employee, you may terminate your employment at any time for any reason, without notice. Similarly, if you are hired, AC will have the right to terminate your employment at any time, for any reason, without prior notice. No AC supervisor or manager has the authority to offer or promise anything other than at-will employment.

I understand and agree that:

1. Any material misrepresentations or deliberate omission of a fact in my application may be justification for refusal of, or if employed, termination from employment.
2. By signing this application, I authorize AC to obtain and authorize all state, federal, or local law enforcement agencies or officials to release any and all information they have regarding any criminal convictions I may have, regardless of the date, location, or nature of the conviction. I understand that criminal conviction(s) will not automatically disqualify me from eligibility for employment with AC.
3. I agree that my employment may be terminated by AC at any time without liability for wages or salary except what may have been earned at the date of termination. If requested by the management at any time, I agree to submit to search of my person or of any locker that may be assigned to me, and I hereby waive all claims for damages on account of such examination. I authorize any physician or hospital to release any information which may be necessary to determine my ability to perform the duties of a job I am being considered for prior to employment or in the future during my employment with AC. I consent to take a medical examination by a qualified physician at the discretion of my employer.
4. Although management makes every effort to accommodate individual preferences, business needs may at times make the following conditions mandatory: overtime, shift work, a rotating work schedule other than Monday through Friday. I understand and accept these as conditions of my continuing employment.
5. I further understand that this is an application for employment and that no employment contract is being offered.
6. If applying, understand that some positions may be subject to a labor contract.
7. I acknowledge that: a) if I become employed, I will be free to terminate my employment at any time for any reason and AC retains the same rights; b) AC can change wages, benefits and conditions at any time; and c) no representative of AC has the authority to make any contrary agreement. I understand that AC is a drug-free work environment.
8. I understand that I am required to abide by all rules and regulations of AC.
9. I am not ineligible or excluded from participating in the Federal Health Care programs.

I have read and understand the above.

Date:		Signature:	
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For Management Use Only										
EMPLOYED	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SHIFT	DAY <input type="checkbox"/>	EVE <input type="checkbox"/>	NOC <input type="checkbox"/>	DAYS PER PAY PERIOD			
FULL TIME	<input type="checkbox"/>	PART TIME	<input type="checkbox"/>	ON-CALL	<input type="checkbox"/>	DATE OF EMPLOYMENT				
JOB TITLE			HOURLY RATE					DEPARTMENT		
HIRED BY:										

## APPLICANT DATA RECORD

Applicants are considered for all positions, and employees are treated during employment without regard to race, color, creed, religion, age, sex, national origin, ancestry, sexual orientation, marital or veteran status, medical condition or disability, status regarding public assistance, or any other characteristic protected by federal, state, or local law.

As an employer, we comply with government regulations, including affirmative action responsibilities where they apply.

We request that you please fill out this Applicant Data Record solely to help us comply with government record keeping, reporting and other legal requirements. We appreciate your cooperation.

This data is for periodic government reporting and will be kept in a Confidential File separate from the Application for Employment. Only the Human Resources Office sees this sheet. It is not seen by the person who selects applicants for interviews or the interviewer. **YOUR COOPERATION IS VOLUNTARY.**

Position(s) Applied for					Date:		
Referral Source		AD <input type="checkbox"/>	Friend <input type="checkbox"/>	Relative <input type="checkbox"/>	Walk-in <input type="checkbox"/>	Web <input type="checkbox"/>	
Name	Last			First			Middle
Phone							
Street Address:							
City:				State			Zip

### Voluntary Survey

Government agencies at times require periodic reports on the sex, ethnicity, disability, veteran and other protected status of applicants. This data is for analysis and possible affirmative action only. **SUBMISSION OF INFORMATION IS VOLUNTARY.**

Check one:  Male  Female

Check one of the following:

Race/Ethnic Group:  White  Black or African American  Hispanic or Latino  
 American Indian or Alaskan Native  Asian  
 Native Hawaiian or other Pacific Islands  Two or More Races

Check if any of the following are applicable:

Vietnam Era Veteran  Disabled Veteran  Disabled Individual



# Augustana Care

## EMPLOYEE AUTHORIZATION TO RELEASE INFORMATION MINNESOTA BACKGROUND CHECKS

Please clearly print all information

\_\_\_\_\_  
First Middle Last Maiden

\_\_\_\_\_  
Date of Birth (month, date & year) Social Security Number (9 digits)

\_\_\_\_\_  
MN Driver's License # or MN State ID # Birthplace (city, state)

\_\_\_\_\_  
Eye Color Hair Color Height Weight

Gender:  M  F

Race  White  African/African American  Native American  Asian  
 Two or more races  Hispanic/Latino  Pacific Islander  Other/Unknown

\_\_\_\_\_  
Current Street Address Apt #

\_\_\_\_\_  
City State Zip Code

Phone Number: ( ) \_\_\_\_\_

Form of ID: \_\_\_\_\_ ID #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Other last names I have used: \_\_\_\_\_

Have you lived in another state within the last 5 years?  No  Yes

If yes, what state(s) and when? \_\_\_\_\_

I authorize the release of any and all information to Augustana Care Corporation in their background verification of my criminal history. The Minnesota Department of Human Services Licensing Division is authorized to release to Augustana Care Corporation or its agents any personal information about me relative to the conviction, guilty plea, or nolo contendere (no contest) plea of any crime.

I further understand and waive my rights of privacy in this release of information and hold harmless Augustana Care Corporation and its agents from any liability in this background investigation. I agree that if any misrepresentation has been made by me herein, or the results of a such investigation are not satisfactory, any offer may be withdrawn. This authorization expires one year from this date.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **BACKGROUND STUDY PRIVACY NOTICE**

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that be informed of the following:

1. **Purpose and intended use of the information:** Minnesota Statutes, section 144.057, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees is nursing homes. The background studies are to be completed according to the requirement in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.
2. **Whether you may refuse or are legally required to provide the information:** Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.
3. **Known consequences that may arise from supplying the information:** Individuals who have histories with the characteristics identified in Minnesota Statute 245C, will be disqualified from positions allowing direct contact with (and, where applicable, access to) persons receiving services. Health-related licensing boards will make a determination whether to impose disciplinary or corrective actions on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.
4. **Known consequences that will arise from refusing to supply the requested information:** Only items identified as “optional” may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact with (and, where applicable, access to) persons receiving services.
5. **Identification of other agencies or entities authorized to receive this information:** The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. IF DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney General, agencies with criminal record information systems in other states and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care Provider organizations and health-related licensing boards. If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.