LAC COURTE OREILLES
COMMUNITY HEALTH CENTER

13380 W Trepania Road • Hayward, Wisconsin 54843-2186

Telephone: 715-638-5100

Administration Fax: 715-634-6107

Medical Records Fax: 715-634-2740

APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE   AN EQUAL OPPORTUNITY EMPLOYER

Personal Information: **Name** ______________________ **Date:** ______/______/______

Present Address: ____

Street/Rural Road   Box   City   State   Zip Code

Permanent Address: ____

Street/Rural Road   Box   City   State   Zip Code

Phone Number: ______________ **Social Security Number:** ______________

Do you have reliable transportation? ______ **Yes** ______ **No**   **Valid Drivers License?** ______ **Yes** ______ **No**

Drivers License Number: ______________________ **Car Insurance?** ______ **Yes** ______ **No**

Type of Insurance and name of company: ________________________________

U.S. Citizen? ______ **Yes** ______ **No**   **Are you a Member of an American Indian Tribe?** ______ **Yes** ______ **No**

If so, what Tribe are you affiliated with? ________________________________

Position you are applying for: ________________________________

Type of employment you are applying for: ______ **Full-time** ______ **Part-time** ______ **Seasonal** ______ **Educational Co-op**

Date you are available to work: ______________________ **Salary range:** ______________

Are you employed now? ______ **Yes** ______ **No**   **If so, may we contact your present employer?** ______ **Yes** ______ **No**

Have you applied to this company before? ______ **Yes** ______ **No**   **If so, when?** ______________

EDUCATION	NAME & LOCATION OF SCHOOL	# OF YEARS	DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
Trade Business/ Correspondence School				

The Age Discrimination Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40, but less than 70, years of age.

Are you a member of the National Guard or Reserves? ______ **Yes** ______ **No**   **Branch?** ______________________

FORMER EMPLOYERS: (List below the last four (4) employers, starting with the most current or recent)

Month & Year	Name & Address of Employer	Phone	Salary	Position	Reason for Leaving
From To					
From To					
From To					
From To					

REFERENCES: (Give the names of three (3) persons, not related to you, whom you have known at least one year)

Name	Address	Business	Phone Number	Yrs. Acq.

Do you have any medical, physical or mental impairments that would limit you from performing the job for which you are applying? ______ Yes ______ No
If yes, please explain:

____

In case of emergency contact:

Name: ________________________________ **Phone #:** ____________________

Address: ____

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 the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liabilities for any damage that may result from furnishing this to you. I understand and agree that if hired my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time without prior notice.

Signature: ____________________________ **Date:** ________________________

EMPLOYMENT AGREEMENT WITH THE TRIBE
If hired, I agree as follows:

1. *To work the number of hours per day or week as required by the position*
2. *To accept supervision and/or instruction from assigned supervisors.*
3. *To inform my supervisor, in advance, of any absence from work.*
4. *To not expect pay for absence periods, when absences exceed accumulated compensatory, vacation or sick leave, if such provisions are authorized within my work program.*
5. *To work on projects assigned, even though it does not conform to my hired position or job description.*

Perspective employee signature: ____________________________ **Date:** ______________

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Authorization For Release of Information

I, _________________, hereby empower the Lac Courte Oreilles Community Health Center to obtain criminal history record information for the purpose of employment background investigations.

Signature:________________ Date:______________

Information Needed To Do Background Check:

Full Name:___________________
Maiden, former or alias name:__________________
Race:________________
Date of Birth:_____/_____/_____
Social Security #:_____________
Driver's License #:____________

Present Address:

____

Previous Address:

____

I, ________________, consent to Drug Testing Upon Hire.
print

Signature:_______________________

I, ____________, allow the Lac Courte Oreilles Community Health Center to contact by either phone or letter my references.

Signature:_______________________

Applicants for employment with the Health Center must submit with the completed application form additional documents including the following:

- ☐ *Letter of Interest*
- ☐ *Resume*
- ☐ *Credentials*
- ☐ *Proof of any stated qualifications*
- ☐ *Three (3) Letters of recommendation*
- ☐ *Academic transcripts*

Applications must be submitted by the closing date; no late applications will be accepted.
Submit completed packets to:

Lac Courte Oreilles Community Health Center
Human Resources
13380W Trepania Road
Hayward, WI 54843
(715) 638-5132
(715) 634-6107 FAX
sklecan@lcohc.com