



Sheyenne Care Center

Employment Application

979 North Central Avenue

Valley City, ND 58072

Phone: (701) 845-8222

Fax: (701) 845-8249

www.smphs.org/sheyennecarecenter

Dear Potential Employee,

We are delighted in your interest in becoming a part of the Sheyenne Care Center team! This application could be the start of an exciting opportunity and we want to make sure you understand the initial application process that's in place.

The Pre-Employment Process:

Step 1: Fill out and return your completed application to the business office; be sure to fill out each area of the application or place "n/a" in an area if it does not apply to you. If you have a resume, cover letter, or list of professional references, please include them with your application.

- *Apply in person:* the business office is located just inside the front entrance of the Sheyenne Care Center. If you return your application outside of our normal business hours, please place it in the gold mail slot to the left of the business office window.
- *Apply by email:* SCC.careers@smphs.org
- *Apply by fax:* 701-845-8249 with attention to our recruiter

Step 2: Wait for a response from our employment recruiter. Our recruiter will review your application and respond by phone or mail. You will normally receive a response within 3-10 days of applying, depending on the current volume of applications we have received. If you have not heard from us within 10 days, feel free to contact us at (701)845-8222.

Step 3: If you are selected as a candidate for one of our positions, you will be contacted by our recruiter to set up an interview and English language assessment.

If Offered a Position:

Step 4: You will be contacted by our recruiter to set up an appointment to complete the following:

- Hiring paperwork
- Background and drug testing
- Tuberculosis skin test
- Flu shot (if hired during flu season)
- Schedule initial orientation (online and video training)

Step 5: Once step 4 is complete, you will attend your initial orientation, consisting of computer modules, videos, and a tour of our facility. You may also meet with a representative of the specific department you were hired for to set up the remainder of your training.

Your thoughts, questions, and feedback are always welcomed and we are excited about your desire to join our team!

As an equal employment ministry, Sheyenne Care Center does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, religion, sex, national origin, disability, age, or veteran status in admission, treatment, or participation in its programs, services, and activities, or in employment. – This statement is in accordance with the provisions of Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and regulations of the U.S. Department of Health and Human Services.

Additional information and current career opportunities can be found at our website at: www.sheyennecarecenter.com

SMP Health System

Sponsored by Sisters of Mary of the Presentation



MISSION STATEMENT

Sheyenne Care Center, inspired by the Sisters of Mary of the Presentation, serves those in our care with respect and compassion as we strive to fulfill the healing mission of Jesus.

POSITION APPLYING FOR: _____ **DATE OF APPLICATION** _____

IF NO POSITION IS LISTED, THE APPLICATION MAY NOT BE CONSIDERED FOR EMPLOYMENT

PERSONAL

LAST NAME		FIRST NAME			MID. INT.
HOME ADDRESS		APT. #	CITY	STATE	ZIP CODE
(AREA CODE) TELEPHONE NUMBER	U.S. CITIZEN YES NO IF NO, VISA TYPE AND NUMBER		SOCIAL SECURITY #		UNDER 18 YES <input type="checkbox"/> NO IF YES
LIST ANY REASON KNOWN TO YOU WHY YOU MIGHT NOT BE ABLE TO PERFORM CONSISTENTLY AND PROMPTLY ANY OF THE DUTIES OF POSITION APPLIED FOR: <i>(Please review job description before answering this question)</i>					
DATE AVAILABLE		STARTING SALARY NEEDED		WILL YOU ACCEPT ANOTHER POSITION? YES NO IF YES, PLEASE SPECIFY	
WILL YOU ACCEPT SHIFT WORK YES NO		WILL YOU ACCEPT WEEKEND WORK YES NO		WILL YOU WORK <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> TEMPORARY	
WERE YOU PREVIOUSLY EMPLOYED AT A SISTERS OF MARY OF THE PRESENTATION FACILITY? YES NO IF YES: WHERE WHEN IN WHAT CAPACITY			DO YOU HAVE A FRIEND OR RELATIVE WORKING HERE? YES NO NAME DEPT. RELATIONSHIP		
HAVE YOU EVER APPLIED FOR EMPLOYMENT WITH US? YES NO IF YES: MONTH AND YEAR			HAVE YOU EVER SERVED IN THE U.S. MILITARY? YES NO		
HAVE YOU BEEN CONVICTED OF A CRIME: YES NO IF YES, GIVE DATE(S), OFFENSE(S) AND DISPOSITION:					
HAVE YOU EVER BEEN EXCLUDED FROM PARTICIPATION IN ANY FEDERAL OR STATE MEDICARE, MEDICAID OR ANY OTHER THIRD PARTY PAYOR PROGRAM OR HAVE SUCH PENDING ACTION? YES NO IF YES, A LETTER SHOWING REINSTATEMENT IS REQUIRED FOR FURTHER CONSIDERATION FOR EMPLOYMENT					

EMPLOYMENT HISTORY

LIST MOST RECENT POSITION FIRST		LIST OTHER NAMES USED WHILE EMPLOYED WITH THESE EMPLOYERS			
FROM	NAME OF EMPLOYER	NAME/TITLE LAST SUPERVISOR		TELEPHONE NO.	
MO. YR.					
TO	ADDRESS: STREET CITY STATE ZIP CODE	POSITION HELD	ENDING SALARY PER _____		
MO. YR.					
Briefly describe the work you performed:					
Reason for leaving:					MAY WE CONTACT THIS EMPLOYER? YES NO
FROM	NAME OF EMPLOYER	NAME/TITLE LAST SUPERVISOR		TELEPHONE NO.	
MO. YR.					
TO	ADDRESS: STREET CITY STATE ZIP CODE	POSITION HELD	ENDING SALARY PER _____		
MO. YR.					
Briefly describe the work you performed:					
Reason for leaving:					MAY WE CONTACT THIS EMPLOYER? YES NO
FROM	NAME OF EMPLOYER	NAME/TITLE LAST SUPERVISOR		TELEPHONE NO.	
MO. YR.					
TO	ADDRESS: STREET CITY STATE ZIP CODE	POSITION HELD	ENDING SALARY PER _____		
MO. YR.					
Briefly describe the work you performed:					
Reason for leaving:					MAY WE CONTACT THIS EMPLOYER? YES NO

EDUCATION

SCHOOL	NAME OF SCHOOL	LOCATION	YEARS COMPLETED	DATES				COURSE OF STUDY	DID YOU GRADUATE	DIPLOMA DEGREE
				MO.	TO	YR.	MO.			
HIGH SCHOOL									YES NO GED	
TRADE									YES NO	
COLLEGE									YES NO	

REFERENCES (NAMES OF PERSONS NOT RELATED TO YOU)

NAME	ADDRESS	PHONE

PROFESSIONAL LICENSES, REGISTRATION AND/OR CERTIFICATIONS - DO NOT INCLUDE DRIVER'S LICENSE

TYPE	STATE ISSUED	DATE ISSUED	EXPIRES	NUMBER	ELIGIBLE

SPECIAL SKILLS OR QUALIFICATIONS

PLEASE LIST ANY SPECIAL SKILLS OR QUALIFICATIONS

APPLICANT'S CERTIFICATION

I certify that all matters contained in this application are true, and that any misleading or false statements would render this application void and would be sufficient cause for immediate dismissal in the event of employment.

I understand that this is an application for employment and that no employment contract is being offered.

I further understand that as a condition for employment I may be required to submit to a drug test according to Sheyenne Care Center standards and if my drug test results are unsatisfactory, I will not be employed by Sheyenne Care Center.

I hereby authorize Sheyenne Care Center to investigate all matters contained in this application and to contact prior employers to obtain any and all information related to my past work performance.

I agree, if employed, to abide by all Sheyenne Care Center rules and regulations. I understand that such employment is for an indefinite period of time and that the company can change wages, benefits and conditions of employment at any time.

I understand that I am required to immediately notify Sheyenne Care Center if any action is proposed to exclude me from participation in any federal or state Medicare, Medicaid or other third party payor program.

I have read and understand the above.

DATE _____ SIGNATURE _____

IMPORTANT NOTICE TO ALL APPLICANTS

If you are selected for employment you must be prepared to verify your eligibility to work as required under the Immigration Reform and Control Act of 1986. This requirement applies to all new employees including U.S. citizens, permanent residents and non-immigrants.

You will have to provide documents within 3 days of your hire date to verify your identity and eligibility to work.

**AN EQUAL OPPORTUNITY EMPLOYER**

Voluntary Self Identification

Why are you being asked to complete this form?

This company does business with the government and is obligated to hire, promote and provide equal opportunities to qualified people with disabilities, veteran's status, women and minorities. This form is optional and strictly confidential.

Gender Identification Male Female

Ethnicity/ Race Identification Check one of the boxes below:

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian / Alaskan |
| <input type="checkbox"/> Black | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Pacific Islander / Hawaiian |
| <input type="checkbox"/> Two or more races | | |

Identification of Disability

How do I know if I have a disability? You are considered disabled if you have a physical or mental impairment or medical condition that substantially limits a major life activity or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- | | | | |
|--|--------------------|-------------------------|----------------|
| Blindness | Autism | Bipolar disorder | Cerebral Palsy |
| Cancer | Deafness | Major Depression | HIV/Aids |
| Diabetes | HIV/Aids | Multiple Scleroses | PTSD |
| Epilepsy | Muscular Dystrophy | Missing limbs | OCD |
| Epilepsy | Schizophrenia | Intellectual disability | |
| Impairments requiring use of wheel chair | Other | | |

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY

Protected Veteran Identification

Who is a Protected Veteran? You are a Protected Veteran **if** you belong to one of the four categories listed below.

- 1. Disabled Veteran:** a Veteran who served on active duty in the U.S. military and is entitled to disability compensation or was discharged or released from active duty because of a service connected disability
- 2. Other Protected Veteran:** A veteran who served on active duty in the U.S. military during a war or in a campaign or expedition for which a campaign badge was authorized from the department of defense.
- 3. Recently Separated Veteran:** A Veteran separated during the three year period beginning of the date of the veterans discharged or released from active duty in the U.S. military.
- 4. Armed Forces Service Medal Veteran:** A veteran who while serving on active duty in the U.S. military participated in a U.S. military operation that received an Armed Forces service medal.

- YES, I AM A PROTECTED VETERAN
- NO, I AM NOT A PROTECTED VETERAN

(Optional) Your Name: _____ Today's Date: _____