Sheyenne Care Center

979 North Central Avenue
Valley City, ND 58072
Phone: (701) 845-8222
Fax: (701) 845-8249
www.smphs.org/sheyennecarecenter

EMPLOYMENT APPLICATION PACKET

Dear potential employee,
Welcome to the Sheyenne Care Center, a 170 bed skilled nursing facility and the possibility to a future employment opportunity with us.

This process is the start of an exciting opportunity and we want to make sure you understand the initial application process we have in place.

The Pre-employment steps: *Its possible to complete all the pre-employment requirements at one time if an appointment is set up in advance.*

Step 1: Return the completed application and signed background check agreement to the business office inside the front entrance of Sheyenne Care Center.

Step 2: Upon being a good fit for our team, someone will contact you to set up an appointment for a possible interview and other employment requirements including completing an English language assessment to determine the ability to read, write, and comprehend the English language. (This is not a pass/fail assessment, but rather assists with finding the best position for you.)

Step 3: All applicants will be checked for tuberculosis and drug tested.

Once a position is offered for employment:

Step 4: Flu shots will be given once an employment offer is made. The annual flu shot is mandatory for employment.

Step 5: Approximately eight to twelve hours of online facility orientation will be scheduled.

Step 6: Orientation will begin within hired department.
Certified Nursing Assistant (CNA) position:

- If already certified as a CNA, we will validate your North Dakota CNA certificate or assist you to obtain North Dakota CNA certification by endorsement from another state.
- CNA Course: a class schedule will be presented or a date will be schedule to challenge the North Dakota CNA Exam.
- Orientation to a CNA position will be scheduled once your CNA Certificate is obtained or validated.

Your thoughts, questions, and feedback are always welcomed and we are excited you have decided 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 can be found at our website: sheyennecarecenter.com

Sheyenne Care Center
SMP Health System

EMPLOYMENT APPLICATION

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

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 ❑ 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:
(Please review job description before answering this question)

DATE AVAILABLE WILL YOU ACCEPT SHIFT WORK ❑ YES ❑ NO	STARTING SALARY NEEDED WILL YOU ACCEPT WEEKEND WORK ❑ YES ❑ NO	WILL YOU ACCEPT ANOTHER POSITION? ❑ YES ❑ NO IF YES, PLEASE SPECIFY WILL YOU WORK ❑ FULL-TIME ❑ PART-TIME ❑TEMPORARY	DAYS/HOURS AVAILABLE

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 MO. YR.	NAME OF EMPLOYER	NAME/TITLE LAST SUPERVISOR	TELEPHONE NO.
TO MO. YR.	ADDRESS: STREET CITY STATE ZIP CODE	POSITION HELD	ENDING SALARY _____PER_____
Briefly describe the work you performed:			
Reason for leaving:			MAY WE CONTACT THIS EMPLOYER? ❑ YES ❑ NO

FROM MO. YR.	NAME OF EMPLOYER	NAME/TITLE LAST SUPERVISOR	TELEPHONE NO.
TO MO. YR.	ADDRESS: STREET CITY STATE ZIP CODE	POSITION HELD	ENDING SALARY _____PER_____
Briefly describe the work you performed:			
Reason for leaving:			MAY WE CONTACT THIS EMPLOYER? ❑ YES ❑ NO

FROM MO. YR.	NAME OF EMPLOYER	NAME/TITLE LAST SUPERVISOR	TELEPHONE NO.
TO MO. YR.	ADDRESS: STREET CITY STATE ZIP CODE	POSITION HELD	ENDING SALARY _____PER_____
Briefly describe the work you performed:			
Reason for leaving:			MAY WE CONTACT THIS EMPLOYER? ❑ YES ❑ NO

AN EQUAL OPPORTUNITY EMPLOYER

EDUCATION

SCHOOL	NAME OF SCHOOL	LOCATION	YEARS COMPLETED	DATES MO. TO YR.	DATES MO. TO YR.	COURSE OF STUDY	DID YOU GRADUATE	DIPLOMA DEGREE
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
TYPE	STATE ISSUED	DATE ISSUED	EXPIRES	NUMBER	ELIGIBLE
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 you 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.

Sheyenne Care Center
SMP Health System

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. Position Applied for: _____

Gender Identification ☐ Male ☐ Female

Ethnicity/ Race Identification Check one of the boxes below:

☐ White ☐ Asian ☐ American Indian / Alaskan
☐ Black ☐ Hispanic ☐ Pacific Islander / Hawaiian
☐ Two or more races

Identifieation 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: _____