



CHIPPEWA COUNTY HEALTH DEPARTMENT

508 ASHMUN STREET, SUITE 120

SAULT STE. MARIE, MI 49783

APPLICATION FOR EMPLOYMENT

Last Name	First Name	Middle Initial	Maiden (if applicable)
Street Address	City	State	Zip
Home Phone	Social Security Number	Driver's License Number	
Date Available for Work	E-Mail Address		

Licensed or Registered in Michigan as a(n) _____ Expiration Date of License: _____
 Position applying for: _____ Minimum Salary you would accept? _____/yr.
 From what source did you learn of this employment opportunity? _____
 Check type of employment you would accept. Part-Time Full Time Temporary
 Do you have any relatives employed by this agency? yes no If "yes" please specify name and relationship to you: _____
 Are you currently on layoff or leave from another company? yes no If so, please specify: _____

EDUCATION

(Please check highest level of education completed)

- High School Diploma
- Associates Degree in _____
- Bachelor's Degree in _____
- Other _____

If you did not complete high school, do you have a high school equivalency diploma? yes no
 If you expect to complete an educational program in the near future, please indicate what type of degree or program and expected completion date: _____

EXPERIENCE

Starting with most recent, please describe your knowledge, skills, and abilities that best demonstrate your qualifications for the position in which you are applying.

Employer		Address	
From: Month/year	To: Month/Year	Hours per week	Title
Last Salary: \$ _____ per	Supervisor	May we contact? <input type="checkbox"/> yes <input type="checkbox"/> no	Phone
No & type of employees you supervised			
Reason for Leaving			
Duties			

Employer		Address	
From: Month/year	To: Month/Year	Hours per week	Title
Last Salary: \$ per	Supervisor	May we contact? <input type="checkbox"/> yes <input type="checkbox"/> no	Phone
No & type of employees you supervised			
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Last Salary: \$ per	Supervisor	May we contact? <input type="checkbox"/> yes <input type="checkbox"/> no	Phone
No & type of employees you supervised			
Reason for Leaving			
Duties			

CONTACTS/REFERENCES

Please list three professional references of persons **not** related to you and who know your qualifications.

Name	Address	City	State	Zip	Phone	Relationship
Name	Address	City	State	Zip	Phone	Relationship
Name	Address	City	State	Zip	Phone	Relationship

May we contact your present supervisor? yes no

May we contact your references? yes no

Have you ever been convicted of an offense in a court of law? yes no If "yes" please give dates, details, and penalties for each occurrence on an attached sheet of paper. Do not include minor traffic violations. An answer of "yes" to this question does not constitute an automatic bar to employment.

CERTIFICATION (*Application requires current date and original signature to process*).

I hereby certify that all entries on both sides and attachments are true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part of any employment with Chippewa County Health Department (CCHD). I understand that all information on this application is subject to verification and I consent to criminal history background checks. I also consent that CCHD may contact references, former employers, and educational institutions listed regarding this application. I further authorize CCHD to rely upon and use, as it sees fit, any information received from such contacts. Information contained on this application may be disseminated to other agencies, nongovernmental organizations, or systems on a need-to-know basis for good cause shown as determined by the agency head or designee.

Date: _____ Applicant Signature: _____

OFFICE USE ONLY

Application reviewed by:

Name/Title

Date



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508 ASHMUN STREET, SUITE 120
SAULT STE. MARIE, MI 49783

To Whom It May Concern:

_____ has applied for a position with our agency and identified you as a reference. We would consider it a courtesy to both the applicant and us if you would please take a moment to complete the enclosed form and return it in the self-addressed, stamped envelope provided for you. All information will be held in the strictest confidence.

Sincerely,

David Martin, Health Officer
Chippewa County Health Department

AUTHORIZATION TO RELEASE INFORMATION

As an applicant for a position with the Chippewa County Health Department, I have been asked to furnish information for use in reviewing my background and qualifications. In this connection, I hereby authorize the investigation of my past and present work, character, education, military, police, and driving records to ascertain any and all information which may be pertinent to my employment qualifications.

The release in any manner of any and all information by you is authorized whether such information is of record or not, and I do hereby release all persons, firms, agencies, or companies, whomsoever, from any damage resulting from furnishing such information.

I have written notice from my current employer and from any of my former employers regarding the disclosure of disciplinary reports, letters of reprimand, or other notices of disciplinary action contained in my personnel records (even if more than four years old). This waiver is made pursuant to the Bullard-Plawecki Employee Right-To-Know Act.

This authorization shall be valid for six months from the date of my signature below. You may retain this copy of my release for your files. Thank you for your assistance.

Signature of Applicant

Date

Typed or Printed Name

Witnessed by

Date