



This facility is an equal opportunity employer and fully subscribes to the principles of equal employment opportunity. It is the policy of this facility to provide employment, compensation and other benefits related to employment based on qualifications, without regard to race, color, religion, national origin, age, sex, veteran status or disability, or any other basis prohibited by federal or state law. As an equal opportunity employer, this facility intends to comply fully with all federal and state laws and the information requested on this application will not be used for any purpose prohibited by law. Disabled applicants may request any needed accommodation.

APPLICATION FOR EMPLOYMENT

Please print plainly – be sure to sign this application

PERSONAL	Last Name _____ First Name _____ Middle _____			Date _____
	Street Address _____			Home Telephone _____
	City, State, Zip _____			Business Telephone _____
	Have you ever applied for employment with us? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Month and Year _____ Location _____ Previous Name: _____			Social Security # _____
	Position Desired _____			
	What type of employment are you looking for? <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time If part-time, list ideal number of hours per week: _____			What hours can you work? <input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
	Have you been convicted of any crimes, relevant to the job duties of the position for which you are applying, in the past ten years, excluding misdemeanors and summary offenses, which have not been annulled, expunged or sealed by a court? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes', describe in full: _____			Would you anticipate problems with travel throughout Healthfirst's 9 counties? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other special training or skills (languages, certifications, qualifications, etc.,) _____			Do you have a reliable means of transportation to and from work? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a valid Wisconsin driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If applicable: do you have a valid Wisconsin RN License? <input type="checkbox"/> Yes <input type="checkbox"/> No If applicable: do you have Nurse Practitioner certification? <input type="checkbox"/> Yes <input type="checkbox"/> No If applicable: please check all that apply to your Dietetics Credentialing <input type="checkbox"/> ADA Registered <input type="checkbox"/> Wisconsin Certification
Are you able to perform the essential duties of the position for which you are applying, with reasonable accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No				

EDUCATION	School	Name and Location of School	Course of Study	No. of Years Completed	Did you Graduate?	Degree or Diploma
	Graduate				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	College				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Business/Trade/Technical				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	High School				<input type="checkbox"/> Yes <input type="checkbox"/> No	

EMPLOYMENT

Please give accurate, complete full-time and part-time employment record. Start with your present or most recent employer.

1	Company Name	Telephone
	Address	Employed – (State month and year) From To
	Name of Supervisor	Weekly pay Start Last
	State Job Title and Describe Your Work _____	Reason for Leaving

2	Company Name	Telephone
	Address	Employed – (State month and year) From To
	Name of Supervisor	Weekly pay Start Last
	State Job Title and Describe Your Work _____	Reason for Leaving

3	Company Name	Telephone
	Address	Employed – (State month and year) From To
	Name of Supervisor	Weekly pay Start Last
	State Job Title and Describe Your Work _____	Reason for Leaving

4	Company Name	Telephone
	Address	Employed – (State month and year) From To
	Name of Supervisor	Weekly pay Start Last
	State Job Title and Describe Your Work _____	Reason for Leaving

We may contact the employers listed above unless you indicate those you do not want us to contact.

DO NOT CONTACT

Employer Number(s) _____ Reason _____



REFERENCES:

We require two work references and one personal. Please provide name, title, place of employment and phone number for each reference below.

Work Reference #1	Work Reference #2	Personal Reference
Name:	Name:	Name:
Title:	Title:	Acquaintance:
Place of Employment:	Place of Employment:	Phone Number:
Phone Number:	Phone Number:	

ADDITIONAL INFORMATION

Membership in professional and civic organizations, special accomplishments, awards, etc.

(Exclude those which may disclose your race, color, religion, age, or national origin)

Have you ever had restrictions on your license? Explain:

Do you have a current Covid-19 Vaccination? If no, do you have a current medical or religious exemption?

Do you have a current Flu Vaccination? If no, do you have a current medical or religious exemption?

APPLICANT'S SIGNATURE

Please read the following statements carefully before you sign your name.

"I HEREBY CERTIFY that the answers given by me to the above questions and statements are true and correct and hereby authorize you to contact references, past or present employers, persons, schools, law enforcement agencies and any other sources of information which may be relevant to my application for employment. It is understood and agreed that any misrepresentation, false statement or omissions by me in this Application will be sufficient reason for rejection of my application or for dismissal at any time during my employment, without liability to this Facility. I have read, understand and agree to the above statement.

(Please initial here). _____

I further understand that no representative of the Facility has the authority to enter into any agreement for employment for any specified period of time and that this Facility is not guaranteeing employment for anyone. No employment contract is created by virtue of my being hired by this Facility. I have read, understand and agree to the above statement.

(Please initial here). _____

I understand that this application will remain on file for 6 months for consideration. After 6 months, if I am still interested in a position with this Facility, it will be necessary for me to complete a new application form."

SIGN HERE _____ DATE _____

Please attach a resume and/or additional letter(s) of recommendation to the last page of this application.

Please send this application to:

Healthfirst Network, Inc.
Corporate Office
216 South 3rd Avenue
Wausau, WI 54401

Check out our website at:
www.healthfirstnetwork.org

EMPLOYER'S USE ONLY

REFERENCE CHECK	Employer	Person Contacted	Comments
	Work Reference #1		
	Work Reference #2		
	Personal Reference		

TEST RESULTS	Tests Administered	Score	Review and Comments
	Problems Sheet		
	Positive and Negative Feedback Sheet	Not Applicable	

INTERVIEW RESULTS	Interviewer's Names	Comments