



Madison Community Hospital
917 N Washington Avenue
Madison, South Dakota 57042

Phone (605) 256-6551
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E-mail at info@madisonhospital.com

Application for Employment

Personal Information

Date of Application _____ Date Available _____

Name _____ Social Security # _____
First Middle Last

Address _____ Phone # _____
Street City/State/Zip

Employment Desired

	Type of Work Desired	Shift	Salary
First Choice	_____	_____	_____
Second Choice	_____	_____	_____
Third Choice	_____	_____	_____

Will you accept employment of full-time? part-time? temporary?
 Are you 18 years of age or older? yes no

How did you learn of this opening? _____

Education

	Name of School	Location	Courses Taken	Type of Degree/Certification
Grammar or Grade School	_____	_____	_____	_____
High School	_____	_____	_____	_____
College	_____	_____	_____	_____
Other	_____	_____	_____	_____

Extra curricular activities while in school _____

Member of professional organizations _____

Honors received, volunteer or community service or other qualifications you have which you feel are related to the position for which you are applying _____

Employment Record

(list last or present position first)

Present/Former Employers	Dates	Salary	Position/Duties
Name _____	From	Beginning	_____
Address _____	_____	_____	_____
City/State/Zip _____	To	Ending	_____
Supervisor _____	_____	_____	_____
Name _____	From	Beginning	_____
Address _____	_____	_____	_____
City/State/Zip _____	To	Ending	_____
Supervisor _____	_____	_____	_____
Name _____	From	Beginning	_____
Address _____	_____	_____	_____
City/State/Zip _____	To	Ending	_____
Supervisor _____	_____	_____	_____
Name _____	From	Beginning	_____
Address _____	_____	_____	_____
City/State/Zip _____	To	Ending	_____
Supervisor _____	_____	_____	_____

If your former employment references or education are under a name other than indicated on the front of the application, please indicate _____

May we contact your present or past employers? yes no

Have you ever been convicted of a crime? yes no

If yes, for what, when, and where? _____

References

Use this space to give us further information which will assist us in placing you, including at least three personal references not related to you, whom you have know at least one year.

I certify that all of the information in this application is true and correct to the best of my knowledge. If this information is found to be untrue or incorrect, Madison Community Hospital reserves the right to deny and destroy the application. I also understand that this application form simply expresses my interest in employment at Madison Community Hospital, and that this is not a guarantee that I will be employed at Madison Community Hospital.

Signature

Date