



# Mason County Health Department

1002 East Laurel Ave, Havana, IL 62644

Phone: (309) 210-0110 ■ Fax: (309) 543-2063

## Application for Employment

The Mason County Health Department is an equal opportunity employer. All applicants will be considered for employment without attention to race, color, religion, sex, sexual orientation, gender identity, national origin, veteran or disability status.

### APPLICANT INFORMATION:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Position Applying For: \_\_\_\_\_ Date Available to Start: \_\_\_\_\_

Desired Salary: \_\_\_\_\_ Are you legally authorized to work in the United States?  Yes  No

Are you at least 18 years of age?  Yes  No (employment is limited to applicants 18 and older)

### EDUCATION

High School or Equivalent Program (e.g., GED, adult diploma): \_\_\_\_\_

City/State: \_\_\_\_\_ Did you graduate?  Yes  No

College and/or Vocational School: \_\_\_\_\_

City/State: \_\_\_\_\_ Degree/Field of Study: \_\_\_\_\_

Other Training or Degrees: \_\_\_\_\_

### REFERENCES

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Company/Job Title: \_\_\_\_\_

Length of time you've know individual: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Company/Job Title: \_\_\_\_\_

Length of time you've know individual: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Company/Job Title: \_\_\_\_\_

Length of time you've know individual: \_\_\_\_\_

**EMPLOYMENT HISTORY**

(Please list your most recent employment first).

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Employment Dates: from \_\_\_\_\_ to \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

If this is your present employer, may we contact them?  Yes  No

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Employment Dates: from \_\_\_\_\_ to \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Employment Dates: from \_\_\_\_\_ to \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Have you ever been employed by Mason County, including MCHD?  Yes  No

If yes, please provide the facility name and dates of employment: \_\_\_\_\_

\_\_\_\_\_

**APPLICANT STATEMENT & SIGNATURE**

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that false or misleading information may result in my disqualification or termination if employed. I authorize Mason County Health Department to verify any information provided and conduct a background check if required.

I understand that any employment offered is at-will, meaning that either the employer or I may terminate the employment relationship at any time, with or without notice or cause. This employment relationship is not for a fixed duration and does not alter the at-will nature of employment.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_