



Western Upper Peninsula Health Department

EMPLOYMENT APPLICATION

540 Depot Street, Hancock, MI 49930 Phone: (906) 482-7382

www.wuphd.org

OFFICE LOCATIONS:	210 N. Moore Street Bessemer, MI 49911 Phone: 667-0200	303 Baraga Ave. L'Anse, MI 49946 Phone: 524-6142	408 Copper Street Ontonagon, MI 49953 Phone: 884-4485
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Name: _____
Last First Middle

Address: _____
Street City State Zip

Phone No/Area Code: _____
Home Mobile Other

Email Address: _____

Are you at least 18 years old? Yes No Are you legally authorized to work in the U.S.? Yes No
If no, you may be required to provide authorization to work.

EMPLOYMENT DESIRED

Date of Application: _____

Position Applied For: _____

Full-Time ____ Part-Time ____ Call-In ____ Temporary ____ Date Available for Work: _____

Specify Hours/Days Available for Work: _____

WESTERN U.P. HEALTH DEPARTMENT IS AN EQUAL OPPORTUNITY EMPLOYER

Western U.P. Health Department unequivocally supports the principle and spirit of equal opportunity and non-discrimination in employment, programs, services and activities provided by the agency. We offer Equal Employment Opportunity to all based upon individual merit and do not discriminate on the basis of race, color, religion, national origin or ancestry, age, sex, height, weight, arrest record, sexual orientation, marital or veteran status, handicap or disability, unless required to do so by law or bona fide occupational qualification. The questions in this application are intended to be non-discriminatory in nature and applicants are not required to submit any information which could be used for discriminatory purposes. A person with a disability or handicap requiring accommodation for employment must notify Western U.P. Health Department in writing within 182 days after the need is known, or should have been known. A person with a disability or handicap requiring accommodation for completing the application should notify the Human Resources office as soon as possible.

PERSONAL INFORMATION

Have you ever been terminated from employment, or asked to resign by an employer? Yes No

If yes, please provide company name and details:

Have you ever worked for this Agency before? Yes No If yes, when _____ Name, if different _____

Do you know anyone who works for this Agency? Yes, No. If yes, who? _____

MILITARY EXPERIENCE

Are you a military veteran? Yes No Duties performed: _____

Dates of service and rank during service at time of discharge: _____

Are you presently in the Military? Yes No Active Reserve Present rank or status: _____

EDUCATION AND TRAINING

Name of School - List High School first, then Trade / Post-Secondary School(s)	Location (City, State)	# Yrs./Mos. Completed	Diploma, Degree, Certificate Received

PROFESSIONAL OR TECHNICAL LICENSURE/CERTIFICATION AND SKILLS

Type: _____ State/Certifying Board: _____ Exp. Date: _____

Type: _____ State/Certifying Board: _____ Exp. Date: _____

Type: _____ State/Certifying Board: _____ Exp. Date: _____

Use the spaces below or the back of this form to list special training, skills, management experience, computer/software skills, equipment operation skills, or any other qualifications you feel are relevant to the position applied for:

EMPLOYMENT HISTORY

List below, beginning with the most recent, all present and past employment (use back of form or separate sheet of paper, if necessary).

Company Name	Dates of Employment
Street Address	Telephone with Area Code
Position Held/Job Title	Name of Supervisor
Brief Description of Duties	
Reason for Leaving	May we contact employer for references?
Company Name	Dates of Employment
Street Address	Telephone with Area Code
Position Held/Job Title	Name of Supervisor
Brief Description of Duties	
Reason for Leaving	May we contact employer for references?
Company Name	Dates of Employment
Street Address	Telephone with Area Code
Position Held/Job Title	Name of Supervisor
Brief Description of Duties	
Reason for Leaving	May we contact employer for references?
Company Name	Dates of Employment
Street Address	Telephone with Area Code
Position Held/Job Title	Name of Supervisor
Brief Description of Duties	
Reason for Leaving	May we contact employer for references?

WORK RELATED REFERENCES

Name	City/State	Phone	Occupation	Relationship

THIS APPLICATION IS VALID ONLY FOR SIXTY (60) DAYS FROM THE DATE SIGNED/DATED BELOW.

APPLICANT'S AGREEMENT

I certify that all of the information and all statements made on or in connection with my application are true, complete and correct. I understand and agree that any falsification, misrepresentation or omission of fact, either on this application or during the pre-hire process, will disqualify me from further consideration for employment or, if hired, subject me to dismissal.

I understand that consideration for employment at Western U.P. Health Department is conditional upon a review of my qualifications, work history, and references. I authorize Western U.P. Health Department to request and obtain verification that the information given by me on this application is true, accurate and complete. I understand that such verification may include, but may not be limited to background information pertinent to the position for which I have applied, verification of education, verification of employment history, and investigation of criminal history. I therefore authorize my current and all previous employers, schools and other references to cooperate with Western U.P. Health Department, and to release, on a confidential basis, any information they may have concerning me, including information in my personnel record or otherwise known to them, to Western U.P. Health Department, in connection with my application for employment with Western U.P. Health Department. I specifically release from liability any current or former employer(s) and schools, their agents, representatives, employees, officers and directors, for or on account of their providing/disclosing such information to Western U.P. Health Department. I waive any right under Public Act 397 to receive written notice from Western U.P. Health Department and any prior employer or any other party referred to in this application that such information has been released. I understand that this may include a record of disciplinary action assessed by Western U.P. Health Department or any current/previous employers.

I understand that neither the completion of this application nor any other part of my consideration for employment is not an offer for, or contract of employment, or establishes any obligation for Western U.P. Health Department to hire me. I understand that employment or any offer made to me is contingent upon satisfactory completion of employment procedures, which may include police background checks, drug testing, and other procedures as required under Michigan law,

I understand and agree that my employment and compensation, if hired, are for no definite period and may, regardless of the time and manner of payment of my wages and salary, be terminated at any time by me or by Western U.P. Health Department, with or without cause, and without any previous notice, except as modified by law or collective bargaining agreements which may apply. I also understand and agree that Western U.P. Health Department has the right to unilaterally modify and/or terminate any policies, practices, procedures and standards it has adopted or implemented, to the extent not limited by law or collective bargaining agreements which may apply. I acknowledge that no agency employee or representative, other than its Health Officer/Administrator has either the power or authority to enter into any agreement for employment for any specified period of time, or to make any representations or agreements contrary to any of the foregoing, unless that agreement is in writing and signed by the Health Officer/Administrator. I understand that any prior representations, promises, contracts or statements made by or on behalf of Western U.P. Health Department are expressly superseded by the foregoing.

I hereby release Western U.P. Health Department of any liability and obligation, including any obligation to provide me with written notification of any disclosure made by Western U.P. Health Department upon my written authorization to provide/disclose information to credit bureaus, agencies, future employers, etc. I understand that this may include a record of disciplinary action assessed by Western U.P. Health Department.

The Immigration Reform and Control Act of 1986 states that employers must require all persons hired to submit documents to the employer showing their identity and their right to be lawfully employed in the United States. It also requires that the employee complete and sign a government form to this effect. I understand that if hired by Western U.P. Health Department, I will furnish documents for inspection that verify my identity and that I am legally permitted to work in the United States. I also understand that if hired, my employment will be terminated if I fail to timely provide the required necessary documents.

SIGNATURE OF APPLICANT

DATE

10/2018