





**Public Health**  
Prevent. Promote. Protect.  
**Perry County**  
Health Department

# PERRY COUNTY HEALTH DEPARTMENT

## Application for Employment

DESCRIBE YOUR DUTIES, RESPONSIBILITIES, EQUIPMENT OPERATED, PROMOTIONS, ETC.:

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WHY DID YOU LEAVE?

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PREVIOUS EMPLOYER:

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ADDRESS:

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PHONE NUMBER:

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DATES EMPLOYED: \_\_\_\_\_ TO: \_\_\_\_\_

JOB TITLE:

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SUPERVISOR'S NAME:

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BEGINNING SALARY: \_\_\_\_\_ PER \_\_\_\_\_ CURRENT SALARY: \_\_\_\_\_ PER \_\_\_\_\_

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BEGINNING SALARY: \_\_\_\_\_ PER \_\_\_\_\_ CURRENT SALARY: \_\_\_\_\_ PER \_\_\_\_\_  
 DESCRIBE YOUR DUTIES, RESPONSIBILITIES, EQUIPMENT OPERATED, PROMOTIONS, ETC.: \_\_\_\_\_

WHY DID YOU LEAVE? \_\_\_\_\_

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*If you need to list any additional previous employers, please use a blank sheet of paper to do so.*

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### EDUCATION AND TRAINING

*This section is intended to give the employer information about the education and training that the applicant has completed, and to demonstrate the skills, knowledge, and abilities of the applicant to perform the job duties of the position.*

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HIGH SCHOOL ATTENDED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DID YOU GRADUATE? \_\_\_\_\_ HIGH SCHOOL EQUIVALENT? \_\_\_\_\_

COURSES PERTAINING TO JOB APPLIED FOR: \_\_\_\_\_

ACTIVITIES, AWARDS, SPORTS, ETC.: \_\_\_\_\_

COLLEGE OR TRADE SCHOOL ATTENDED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DID YOU GRADUATE? \_\_\_\_\_ DEGREE: \_\_\_\_\_

COURSES PERTAINING TO JOB APPLIED FOR: \_\_\_\_\_

ACTIVITIES, AWARDS, SPORTS, ETC.: \_\_\_\_\_

GRADUATE SCHOOL(S) ATTENDED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DID YOU GRADUATE? \_\_\_\_\_ DEGREE: \_\_\_\_\_



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*Please use the following space to provide any further information on training, education, skills, abilities, hobbies, volunteer work, etc., that you possess or have experienced that may be helpful in the evaluation of your application.*

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### PERSONAL INFORMATION

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DO YOU HAVE ANY COMMITMENTS (I.E., SECOND JOB, SCHOOL, ETC.) WHICH MIGHT INTERFERE WITH, OR ADVERSELY AFFECT, YOUR EMPLOYMENT SHOULD WE SELECT YOU FOR A POSITION? YES  NO

IF YES, PLEASE EXPLAIN:  
\_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES  NO

IF YES, PLEASE EXPLAIN:  
\_\_\_\_\_  
(THE EMPLOYER WILL ONLY CONSIDER SPECIFIC CRIMES RELATED TO QUALIFICATIONS FOR POSITIONS APPLIED FOR.)

DO YOU POSSESS A VALID DRIVERS LICENSE?

YES  NO

IF NO, CAN YOU OBTAIN ONE PRIOR TO EMPLOYMENT?

YES  NO

ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES?

YES  NO

ARE YOU RELATED TO ANYONE THAT IS CURRENTLY EMPLOYED BY THE PERRY COUNTY HEALTH DEPARTMENT?

YES  NO



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REFERENCES:

PLEASE LIST THREE PROFESSIONAL REFERENCES WHO ARE NOT RELATED TO YOU THAT YOU HAVE KNOWN AT LEAST ONE YEAR:

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ TYPE OF REFERENCE: \_\_\_\_\_

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ TYPE OF REFERENCE: \_\_\_\_\_

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ TYPE OF REFERENCE: \_\_\_\_\_



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*Please read each of the following paragraphs carefully. Indicate your understanding of, and consent to, the contents and conditions of each paragraph by placing your initials at the end of each paragraph. If you have any questions regarding these paragraphs, contact the employer before initialing the paragraph.*

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1. I understand and accept that, if I am selected for employment, my employment may be conditioned upon my passing any medical examination that the employer deems necessary to determine whether I can physically perform the essential functions of the position, with reasonable accommodation when necessary. I understand and accept that this may include drug, alcohol or substance abuse testing.

Initials: \_\_\_\_\_

2. If employed, I understand and accept that, depending on the department in which I am applying for employment, I may be required to work evening shifts or night shifts, including weekends and be on call and work mandatory overtime hours.

Initials: \_\_\_\_\_

3. I understand and accept that if any information required in this application is found to be falsified or intentionally excluded, my application may be disqualified from further consideration. I further understand and accept that if I am employed by an Appointing Authority of Perry County Health Department, I may be subject to disciplinary action, including termination, if any information required by this application has been falsified or intentionally excluded.

Initials: \_\_\_\_\_

4. I understand and accept that the employer requires a high degree of integrity and confidentiality of its employees. I also understand and accept that the various law enforcement and informational agencies that exchange information and data with the employer require that the employer's employees do not have a past record of unlawful activities. Therefore, I understand and accept that, depending on the department in which I am applying for employment, it may be necessary for the employer to investigate my background for any criminal or unlawful activity.

Initials: \_\_\_\_\_

5. I hereby authorize the employers, schools and personal references named in this application to provide information regarding me to the employer. I further authorize the release of personnel, academic and other records to the employer.

Initials: \_\_\_\_\_

6. READ CAREFULLY BEFORE INITIALING



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"I agree that any claim or lawsuit relating to my service with Perry County Health Department or any of its subsidiaries must be filed no more than six (6) months after the date of the employment action that is the subject of the claim or lawsuit. I waive any statute of limitations to the contrary."

Initials: \_\_\_\_\_

I SOLEMNLY SWEAR THAT ALL OF THE INFORMATION FURNISHED IN THIS EMPLOYMENT APPLICATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT ANY MISREPRESENTATION OR FALSIFICATION OF THE INFORMATION PROVIDED MAY LEAD TO WITHDRAWAL OF AN EMPLOYMENT OFFER OR TERMINATION FOLLOWING EMPLOYMENT. I RECOGNIZE THAT MY FUTURE EMPLOYMENT WITH THE EMPLOYER WILL BE JEOPARDIZED IF I ENGAGE IN SUBSTANCE ABUSE, ILLEGAL DRUG USE, OR ALCOHOL ABUSE.

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(Applicant's Signature)

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(Date)



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**EEO DATA: VOLUNTARY DISCLOSURE FORM**

Regulations of the Equal Employment Opportunity Commission (EEOC) require employers to compile data regarding the nature and make-up of their work forces in order to further the goals of Title VII of the Civil Rights Act of 1964, as amended. Your responses to the following questions will help the employer comply with this requirement. Completion of this questionnaire is entirely voluntary on your part. Should you opt to complete the questionnaire, your response will be used by the employer solely for the purposes of preparing the reports required by the EEOC. Your response will be kept confidential, and will play no part in the employer's evaluation of your employment performance or status, or your treatment as an employee. The completed questionnaire will be kept separate from your personnel file.

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

**RACIAL AND ETHNIC CATEGORIES:**

- White (not of Hispanic origin)
- Black (not of Hispanic origin)
- Hispanic
- Asian or Pacific Islander
- American Indian or Alaska Native

**DO NOT WRITE BELOW THIS LINE**

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HIRED: \_\_\_\_\_ Yes \_\_\_\_\_

No \_\_\_\_\_ POSITION \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

SALARY/WAGE \_\_\_\_\_

DATE REPORTING TO WORK \_\_\_\_\_

SHIFT \_\_\_\_\_