JOHNSON COUNTY HOSPITAL

APPLICATION FORM INSTRUCTIONS

Completion of all pages is required.

Directions to complete application form:

Pages 1-2: Application Form – Complete all sections, sign and date.

Page 3: Applicant's Background Check Acknowledgement Form. Complete, sign and date.

Pages 4-5: Voluntary Self-Identification of Disability Form. Complete, sign and date.

Pages 6: Voluntary Veterans Self Identification Form. Complete, sign and date.

Once completed, the application can be mailed or dropped off at the reception desk at the following address:

Johnson County Hospital
ATTN: Human Resources
PO Box 599
202 High Street
Tecumseh, NE 68450

You may also fax your application to 402-335-6342 or email to shessheimer@jchosp.com.

If you have any questions in completing the employment application, please call Human Resources at 402-335-3361.

Thank you for your employment interest at Johnson County Hospital.

EEO Employer/Vet/Disabled

JOHNSON COUNTY HOSPITAL
APPLICATION FOR EMPLOYMENT

202 High Street, P.O. Box 599
Tecumseh, NE 68450
(402) 335-3361, Fax (402) 335-6342

Johnson County Hospital is an Equal Opportunity Employer. JCH does not discriminate against any employee or applicant on the basis of race, color, national origin, sex, disability, religion, marital status, age or any other protected status in employment decisions. Applicants who need a reasonable accommodation during the selection process may contact Human Resources for assistance.
All applications are kept on file for 180 days.

APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date Available		Desired Salary	
Position Applied for			
Are you lawfully authorized to work in the U.S.? YES ☐ NO ☐	If yes, can you provide proof of eligibility to be employed in the U.S.? YES ☐ NO ☐		
Have you ever worked for this company? YES ☐ NO ☐	If so, when?		

EDUCATION					
High School			Address		
From	To	Did you graduate?	YES ☐	NO ☐	Degree
College			Address		
From	To	Did you graduate?	YES ☐	NO ☐	Degree
Other			Address		
From	To	Did you graduate?	YES ☐	NO ☐	Degree

REFERENCES	
Please list three professional references.	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	

PREVIOUS EMPLOYMENT

Company		Phone ( )
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		
Company		Phone ( )
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		
Company		Phone ( )
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		

ADDITIONAL INFORMATION

List all job-related skills and qualifications acquired from previous employment or other experience.

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

I understand that this application is not a contract of employment and I understand that if hired my employment at JCH is At-Will. This means that, if hired, either JCH or I can end the employment relationship at any time and for any or no reason. Johnson County Hospital and all its physician clinics are a no smoking campus as of January 1, 2014.

I authorize investigation of all statements contained in this application for any employment related purpose. I release the listed references and all employers to provide you with any and all applicable information they may have. I hereby release these references and former employers from all liability for any information they may give you.

Signature	Date

JOHNSON COUNTY HOSPITAL

APPLICANT'S BACKGROUND CHECK ACKNOWLEDGEMENT

Johnson County Hospital is committed to providing a safe and secure environment for its customers and employees. Reference and background checks will be conducted in order to:

- Prohibit the employment of personnel who have been convicted of a crime or who have a conviction of a prior history of child or adult abuse, neglect, or mistreatment, in accordance to state and federal law and organizational policy.

I understand that, as a condition of my employment, verifications and reference and background checks will be conducted, which may include but are not limited to:

- NE Department of Health and Human Services Adult/Child Protective Services Central Registries
- NE State Patrol Criminal Records
- NE State Patrol Sex Offender Registry
- State Licensing Records
- Officer of Inspector General Exclusions Report
- Employment Reference
- Personal Reference
- Nurse Aide Registry

Name: _____
Last First Middle

Applicant Signature: _____

Date: _____

Johnson County Hospital

202 High St, Box 599
Tecumseh, NE 68450
402-336-3362
Fax: 402-335-6342

APPLICANT INFORMATION FORM

Date: _____ Position Applied For: _____

Print Full Name:_____

Johnson County Hospital is an Affirmative Action/Equal Opportunity Employer and does not discriminate on the basis of race, color, religion, sex, age, sexual orientation, gender identity, national origin, disability, veteran status, or any other classification protected by Federal, state, or local law.

This information will be used strictly for statistical record-keeping purposes and will be kept confidential. Providing—or not providing—the gender/race/ethnic/veteran's status information on this form will neither impact whether or not you are hired, nor will it affect your employment in any manner if you are hired. If you choose not to self-identify, you *must* select the declination box below to move forward with the application process. The person(s) making hiring and personnel decisions will not see this form.

SEX/GENDER: (Please check the appropriate response.)

□ I decline to self-identify.

□ Male □ Female

RACE/ETHNIC GROUP: (Please check the race/ethnic groups with which you most identify.)

□ I decline to self-identify.

□ Hispanic or Latino

□ White (Not Hispanic or Latino)

□ Black or African American (Not Hispanic or Latino)

□ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)

□ Asian (Not Hispanic or Latino)

□American Indian or Alaskan Native (Not Hispanic or Latino)

□ Two or More Races (Not Hispanic or Latino)

Johnson County Hospital is a federal contractor or subcontractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 ("VEVRAA"), which requires federal contractors/subcontractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

(1) A “disabled veteran” is one of the following:

a. A veteran of the U.S. military, ground, naval or air force who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or

b. A person who was discharged or released from active duty because of a service-connected disability.

(2) A “recently separated veteran” means any veteran during the three-year period beginning on the date of such veteran’s discharge or release from active duty in the U.S. military, ground, naval, or air service.

(3) An “active duty wartime or campaign badge veteran” means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

(4) An “Armed Forces service medal veteran” means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

If you believe you are a member of any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a federal contractor or subcontractor subject to VEVRAA, we request this information to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA. Your decision to provide the relevant information is purely voluntary on your part, and refusal to provide such information will not subject you to any adverse treatment. The information will not be used in a manner inconsistent with VEVRAA, as amended.

The information will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

□ I identify as one or more of the classifications of protected veteran status listed above

□ I am not a protected veteran

□ I decline to self-identify.

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability

☐ I Don't Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

FOR EMPLOYER USE ONLY

Job Title: _____ Date of Hire: _____