



**OSF**<sup>®</sup>  
HEALTHCARE  
*A commitment to life.*

**OSF St. Francis Hospital**  
3401 Ludington Street, Escanaba, MI 49829

**OSF Saint Anthony Medical Center**  
5666 E. State Street, Rockford, IL 61108

**OSF Saint James - John W. Albrecht Medical Center**  
2500 W. Reynolds, Pontiac, IL 61764

**OSF St. Joseph Medical Center**  
2200 E. Washington Street, Bloomington, IL 61701

**OSF Saint Francis Medical Center**  
530 N.E. Glen Oak Avenue, Peoria, IL 61637

**OSF St. Mary Medical Center**  
3333 N. Seminary, Galesburg, IL 61401

**OSF Home Care**  
8001 N. University, Suite C, Peoria, IL 61615

**OSF Saint Clare Home**  
5533 N. Galena Road, Peoria Hts., IL 61614

**OSF Health Plans, Inc.**  
7915 N. Hale, Suite D, Peoria, IL 61615

**OSF Saint Francis, Inc.**  
8001 N. University, Suite C, Peoria, IL 61615

**OSF Holy Family Medical Center**  
1000 W. Harlem Avenue, Monmouth, IL 61462

**OSF Healthcare System**  
800 N.E. Glen Oak Avenue, Peoria, IL 61603

# APPLICATION FOR EMPLOYMENT

OSF HealthCare is an equal employment opportunity employer.

We comply with all applicable local, state and federal civil rights and equal employment laws and regulations.

## PLEASE PRINT

LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NO.
STREET ADDRESS					HOME PHONE ( )
CITY		STATE		ZIP CODE	ALTERNATE PHONE ( )
POSITION(S) DESIRED			DATE AVAILABLE		PAY RATE DESIRED
HAVE YOU EVER APPLIED AT OSF HEALTHCARE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHEN?		WHERE?	
DO YOU HAVE ANY RELATIVES WORKING AT THIS FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST NAMES AND RELATIONSHIP			
WERE YOU EVER EMPLOYED BY OSF HEALTHCARE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHEN? UNDER WHAT LAST NAME?		WHAT FACILITY? WHAT CAPACITY?	
IF UNDER AGE 18, GIVE BIRTHDATE.			ARE YOU A U.S. CITIZEN OR AN ALIEN LEGALLY AUTHORIZED TO WORK IN THE U.S.A.? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Have you ever pled guilty to or been convicted of any criminal offense (other than minor traffic violations)?  Yes  No  
If "yes," please explain. Note: A criminal conviction is not an automatic bar to employment.

OSF HealthCare will conduct periodic checks of the Office of Inspector General Sanctions List as required by law. Have you ever been sanctioned by the Office of Inspector General or are you on the Office of Inspector General Sanctions List?  YES  NO

## EMPLOYMENT DATA

WHAT SHIFT(S) ARE YOU WILLING TO WORK? 1ST 2ND 3RD OTHER: _____	CIRCLE DAYS YOU CAN WORK MON. TUES. WED. THURS. FRI. SAT. SUN. ARE YOU WILLING TO WORK OT IF REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU WILLING TO WORK WEEKENDS? <input type="checkbox"/> YES <input type="checkbox"/> NO HOLIDAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO	STATUS DESIRED <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> PRN <input type="checkbox"/> TEMPORARY IF APPLYING FOR PART-TIME, HOW MANY HOURS PER WEEK ARE YOU ABLE TO WORK? _____
WHAT PROMPTED YOUR APPLICATION? (PLEASE BE SPECIFIC) <input type="checkbox"/> EMPLOYEE REFERRAL _____ <input type="checkbox"/> NEWSPAPER _____ <input type="checkbox"/> OWN ACCORD _____ <input type="checkbox"/> JOB LINE _____ <input type="checkbox"/> OTHER _____			

DATE

POSITION DESIRED

MIDDLE INITIAL

FIRST

LAST

NAME

## EDUCATION

	NAME & ADDRESS OF SCHOOL	COURSE OF STUDY	CIRCLE LAST YEAR COMPLETED	DID YOU GRADUATE	LIST DEGREE OR DIPLOMA
HIGH SCHOOL			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO	
COLLEGE			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO	
POST GRADUATE			1 2 3 4	<input type="checkbox"/> YES <input type="checkbox"/> NO	
OTHER					

IF NOW ATTENDING SCHOOL, PLEASE GIVE ANTICIPATED GRADUATION DATE.

## EMPLOYMENT HISTORY

PRESENT OR MOST RECENT EMPLOYER	NAME OF EMPLOYER		STREET ADDRESS, CITY, STATE, ZIP		PHONE NUMBER	
					(      )	
	YOUR LAST NAME AT THAT TIME?		JOB TITLE		DATE OF EMPLOYMENT	
					FROM:                      TO:	
	REASON FOR LEAVING?		SUPERVISOR'S NAME		ENDING SALARY	
CONTACT FOR REFERENCE? IF NO, WHY?		DUTIES, SKILLS, EQUIPMENT USED:				
<input type="checkbox"/> YES <input type="checkbox"/> NO						
PREVIOUS EMPLOYERS LIST MOST RECENT FIRST	NAME OF EMPLOYER		STREET ADDRESS, CITY, STATE, ZIP		PHONE NUMBER	
					(      )	
	YOUR LAST NAME AT THAT TIME?		JOB TITLE		DATE OF EMPLOYMENT	
					FROM:                      TO:	
	REASON FOR LEAVING?		SUPERVISOR'S NAME		ENDING SALARY	
	CONTACT FOR REFERENCE? IF NO, WHY?		DUTIES, SKILLS, EQUIPMENT USED:			
	<input type="checkbox"/> YES <input type="checkbox"/> NO					
	NAME OF EMPLOYER		STREET ADDRESS, CITY, STATE, ZIP		PHONE NUMBER	
					(      )	
	YOUR LAST NAME AT THAT TIME?		JOB TITLE		DATE OF EMPLOYMENT	
					FROM:                      TO:	
	REASON FOR LEAVING?		SUPERVISOR'S NAME		ENDING SALARY	
	CONTACT FOR REFERENCE? IF NO, WHY?		DUTIES, SKILLS, EQUIPMENT USED:			
	<input type="checkbox"/> YES <input type="checkbox"/> NO					
	NAME OF EMPLOYER		STREET ADDRESS, CITY, STATE, ZIP		PHONE NUMBER	
					(      )	
	YOUR LAST NAME AT THAT TIME?		JOB TITLE		DATE OF EMPLOYMENT	
					FROM:                      TO:	
REASON FOR LEAVING?		SUPERVISOR'S NAME		ENDING SALARY		
CONTACT FOR REFERENCE? IF NO, WHY?		DUTIES, SKILLS, EQUIPMENT USED:				
<input type="checkbox"/> YES <input type="checkbox"/> NO						

## PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS

ARE YOU CURRENTLY:     REGISTERED                       LICENSED                       CERTIFIED

TYPE	STATE ISSUED	DATE	NO.
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TYPE	STATE ISSUED	DATE	NO.
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TYPE	STATE ISSUED	DATE	NO.
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HAVE YOU EVER HAD YOUR LICENSES, REGISTRATION OR CERTIFICATION REVOKED, SUSPENDED OR PUT ON PROBATION?     YES     NO  
 IF YES, PLEASE EXPLAIN.


IF THE JOB YOU ARE APPLYING FOR REQUIRES THE DRIVING OF A MOTOR VEHICLE WHILE ON DUTY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

DRIVER'S LICENSE NO. \_\_\_\_\_ STATE \_\_\_\_\_

## ADDITIONAL SKILLS

PLEASE CHECK ANY SKILLS BELOW IN WHICH YOU ARE PROFICIENT:

- TYPING \_\_\_\_\_ WPM
- SHORTHAND OR SPEEDWRITING
- MACHINE TRANSCRIPTION
- MEDICAL TERMINOLOGY
- FOREIGN LANGUAGE \_\_\_\_\_
- OTHER: \_\_\_\_\_

COMPUTER SKILLS: (SPECIFY SOFTWARE)

- WINDOWS
- WORD PROCESSING
- SPREADSHEET
- DATABASES
- GRAPHICS
- ALPHANUMERIC DATA ENTRY \_\_\_\_\_ SPH

PLEASE NOTE ANY ADDITIONAL SKILLS, EXPERIENCE, OR TRAINING THAT YOU FEEL IS IMPORTANT. PLEASE INCLUDE EQUIPMENT OR COMPUTER SOFTWARE USED.


## CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW

I hereby affirm that the information on this application (and accompanying resume, if any) is true and complete. I understand that any false or misleading representations or omissions made on the application or during the hiring process may disqualify me from further consideration for employment and may result in discharge even if discovered at a later date.

I understand that employment may be conditioned upon successfully passing a medical examination and that I may be required to satisfactorily complete a drug screening as a condition of employment.

I hereby authorize persons, schools, my current employer (if applicable) and previous employers and other organizations to provide this facility and its affiliates with any requested information regarding my application or suitability for employment, and I completely release all such persons or entities from any and all liability related to the providing of or use of such information.

I understand that my employment is at-will which means that I may terminate the employment relationship at any time and for any reason with or without notice, and that the facility has the same right. I understand that no one has the authority to enter into any agreement contrary to the preceding sentence, except for a written agreement signed by an administrative representative of this facility and notarized.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

