





601 Village Drive, Marshall, MN 56258 (507) 532-3834 FAX (507) 537-2488

604 Village Drive, Marshall, MN 56258 (507) 929-1234 601 Village Drive, Marshall, MN 56258 (507) 537-2412 FAX (507) 537-2430

Application for Employment

Equal access to programs, services and employment is available to all persons. Those applicants requiring reasonable accommodations to the application and/or interview process should notify a representative of the Human Resources Department.

Please Print					
Date of Application: _					
Position Desired:		_ Building:	Boulder Estates	Boulder Creek	
NAME:					
F	ïrst	Middle	Last		
ADDRESS:					
S	treet	City	State	Zip Code	
TELEPHONE: Cell:		Home: _			
When would you be abl	le to start work?		-		
Referral Source: (check	k one) Advertisement	Er	mployment Agen	су	
	Friend/Relative	e 🗆 Ot	ther:		
Are you legally eligible	e for employment in the Unite	ed States? Ye	es 🗌 No		
Have you ever been em	ployed by Boulder Estates a	nd/or Stepping Stor	ne Home Care? [Yes No	
If Yes, Employment Date(s): Position(s):					
Do you have any relativ	ves that work or have worked	l for Boulder Estate	es and/or SSHHC	? Yes No	
If Yes, please list the	e name(s), position and dates	of employment: _			
EDUCATIONAL BAC	KGROUND				
	Name & Location of School	Years Complet		Type of Diploma or Degree	
High School/GED		1 2 3	4 ☐ Yes ☐ No		
College/Vocational		1 2 3	4 ☐ Yes ☐ No		
Graduate School		1 2 3	4 ☐ Yes ☐ No		

EMPLOYMENT HISTORY (Starting with the most recent) Job Title: _____ Present/Last Employer: City Dates of Employment: ____ Address: ___ Street State From Supervisor's Name & Title: Telephone Number Duties performed at job: Reason(s) For Leaving: Previous Employer: _____ Job Title: Address: _____ City State Dates of Employment: Street From Supervisor's Name & Title: ______ Telephone Number _____ Duties performed at job: Reason(s) For Leaving: Previous Employer: _____ Job Title: Dates of Employment: ______ City State Address: _____ Supervisor's Name & Title: ______ Telephone Number _____ Duties performed at job: Reason(s) For Leaving: **SKILLS & QUALIFICATIONS** Summarize any training, skills, licenses, and/or certificates that may qualify you as being able to perform iob-related functions in the position for which you are applying: REFERENCES Name Relationship to Applicant Telephone Number Years Known ()) The information provided in the application is true, correct and complete. If employed, any misstatement or omission of fact on this application may result in my dismissal. I give the employer the right to contact and obtain information from all references, employers, educational institutions and to otherwise verify the accuracy of the information contained in this application. I understand that acceptance of an offer of employment does not create a contractual obligation upon the employer to continue to employ me in the future.

Signature of Applicant

Date



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REFERENCE INFORMATION RELEASE FORM

To whom it may concern:

I authorize Boulder Estates/Boulder Creek/Stepping Stone Home Health Care to contact any individual or organization listed on my application or resume. And I hereby request and authorize the release of information from my records to Boulder Estates/Boulder Creek/Stepping Stone Home Health Care.

I understand that this release of information can involve records or assessments of my abilities, performance, attendance, productivity, attitude, conduct, and other work-related characteristics or issues.

I hereby agree not to file or pursue any complaints, claims or legal actions against any organization or individual that provides work-related information about me to Boulder Estates/Boulder Creek/Stepping Stone Home Health Care. I also agree not to file or pursue any complaints, claims or legal actions against Boulder Estates/Boulder Creek/Stepping Stone Home Health Care or any of its employees arising out of their efforts to obtain work-related information about me.

Please check one:							
This release <u>does</u> apply to my current employer							
This release does not apply to my current employer							
Print Name:							
First	Middle	Last					
Signature:		Date:					







ADDITIONAL INFORMATION

NAME:				
	First	Middle		Last
TELEPHONE: Cell:		Hom	ne:	
	Registered Nurse Lie			
	Home Health Aide			Patient Care Assistant
Is your CPR card curre Date of Expirat	ent? Yes No			
Work Schedule Prefere	ence: Full Time	Part-Time	Casual	
Shift Desired: Da	y 🗌 Evening 🔲	Overnight [Short Shift	
Chaok Days Vou Can	Work: Mon Tues	Wed Thu	ro Eri Sot	Sun Holidaya