



# Community Health Services

**Please select preferred location(s)**

- Prairie Nursing Facility LLC (d.b.a. – Prairie Maison)**  
700 S. Fremont Prairie du Chien, WI
- Prairie Memorial Housing LLC (d.b.a. – Residence on Bluff Haven)**  
720 S. Fremont Prairie du Chien, WI
- Sannes-Skogdalen-Heim Nursing Facility LLC (d.b.a. Sannes Skogdalen Heim)**  
177 Sunshine Blvd, Soldiers Grove, WI

## Application for Employment

*This Application for Employment must be completed in full. **Incomplete applications may not be considered.** Don't forget to read, sign and date the last page. If you have questions, please ask for assistance from HR.*

Name \_\_\_\_\_ Position(s) \_\_\_\_\_ Date \_\_\_\_\_

(Last, First, MI)

Other Names by which you have been known (including Maiden Name) \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Are you a US citizen or an alien authorized to work in the US?  Yes  No

Are you 18 years or older?  Yes  No

Position(s): \_\_\_\_\_ Pay Required: \_\_\_\_\_

Circle most preferred shift: 1<sup>st</sup> shift 2<sup>nd</sup> shift 3<sup>rd</sup> shift      Circle most preferred: Full-time Part-time

Date you can start: \_\_\_\_\_

Have you ever applied here before?  No  Yes      When? \_\_\_\_\_

Have you ever worked here before?  No  Yes      When? \_\_\_\_\_ Reason for leaving? \_\_\_\_\_

Are you currently employed?  No  Yes      If so, may we contact your present employer?  Yes  No

How did you hear about this position?  Employee Referral \_\_\_\_\_  Newspaper \_\_\_\_\_

Mailing  Flyer  Radio  Govt. Agency  Walk-In  Job Fair  Internet  School  Other

### Education

#### Name & Location

#### # of Years Completed

#### Area of Study / Degree?

Education	Name & Location	# of Years Completed	Area of Study / Degree?
High School			
Colleges			
Other			

**Previous Employment** (List accurate, complete full-time and part-time employment record. List ALL employers; **start with your present or most recent employer**).

Name of Present or Last Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Starting Date (Month/Year): \_\_\_\_\_ Ending Date (Month/Year): \_\_\_\_\_ Hrs per week: \_\_\_\_\_ Shift: \_\_\_\_\_

Starting Pay: \_\_\_\_\_ Final Pay: \_\_\_\_\_ Name & Title of Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Description of Work: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

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Name of Present or Last Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Starting Date (Month/Year): \_\_\_\_\_ Ending Date (Month/Year): \_\_\_\_\_ Hrs per week: \_\_\_\_\_ Shift: \_\_\_\_\_

Starting Pay: \_\_\_\_\_ Final Pay: \_\_\_\_\_ Name & Title of Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Description of Work: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

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Name of Present or Last Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Starting Date (Month/Year): \_\_\_\_\_ Ending Date (Month/Year): \_\_\_\_\_ Hrs per week: \_\_\_\_\_ Shift: \_\_\_\_\_

Starting Pay: \_\_\_\_\_ Final Pay: \_\_\_\_\_ Name & Title of Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Description of Work: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

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Address: \_\_\_\_\_

Starting Date (Month/Year): \_\_\_\_\_ Ending Date (Month/Year): \_\_\_\_\_ Hrs per week: \_\_\_\_\_ Shift: \_\_\_\_\_

Starting Pay: \_\_\_\_\_ Final Pay: \_\_\_\_\_ Name & Title of Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Description of Work: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

**References (Not Relatives)**

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**Specialized Skills/Other Qualifications**

Personal Computer   
 Fax   
 Microsoft Access   
 Email/Internet  
 Microsoft Word   
 Microsoft Excel   
 Typewriter   
 Other

Machinery (List) \_\_\_\_\_

Summarize special *job-related* skills and qualifications acquired from employment, volunteer, or other personal experience.

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**Other Information**

As a health care facility, we are required to comply with the Wisconsin Caregiver Background Check Law. If hired, we are required to check your criminal history. Have you ever been convicted of any crimes that would be substantially related to the job you are applying for?  Yes  No

For CNAs only: Are you on the WI State Nurse Aide Registry?  Yes  No

When and where did you receive your training? \_\_\_\_\_

List all current licenses:

License: \_\_\_\_\_ License #: \_\_\_\_\_ State of issuance: \_\_\_\_\_ Date issued: \_\_\_\_\_ Expiration date: \_\_\_\_\_

License: \_\_\_\_\_ License #: \_\_\_\_\_ State of issuance: \_\_\_\_\_ Date issued: \_\_\_\_\_ Expiration date: \_\_\_\_\_

If driving a vehicle is required for the position: Do you have a valid Wisconsin driver's license?  Yes  No

Driver's license # (only if required for position): \_\_\_\_\_

## Read, understand, sign and date if you agree

I certify that the facts set forth in this application are true, correct and complete without misrepresentation or omissions of any kind whatsoever. I authorize investigation of the statements I have made herein.

I hereby release from any and all liability all representatives of Community Health Services Corporation, Prairie Nursing Facility, LLC, Prairie Memorial Housing, LLC, and Sannes-Skogdalen-Heim Nursing Facility, LLC, (henceforth referred to as The Company) for their acts performed in connections with evaluating my application, background, credentials and qualifications. I hereby further authorize any party (including the companies, schools and organizations listed in this application form) to release any information they may have about me to The Company, including all of my personnel records with prior employers. I also release all persons, companies, schools and organizations (and all persons connected with them) who provide such information to The Company from any and all liability for any damage for giving this information. I understand that if any of the information on this application form is discovered to be incorrect, false or misleading or if there are any misrepresentations or omissions of any kind whatsoever, then The Company may deny me employment or terminate my employment, and I agree that The Company shall not be liable in any respect if it does so.

I also understand that my employment at The Company is contingent upon the satisfactory completion of a physical examination which will include a drug screen and TB skin test/chest x-ray and an investigation of my work record and references. I consent to a pre-placement physical examination and such future examinations as may be required by The Company, which include drug screens as required. I also understand that I must affirm that I am a citizen of the United States or present proof that I have lawful work status if I am offered a position.

I understand that if I am employed by The Company, any such employment is not binding on either party for any specific period of time. I further understand that no representative of The Company, other than the governing board, has any authority to enter into any agreement for employment for any specific period of time. Any such agreement must be in writing and signed by the President of the Board of Directors of Community Health Service Corporation. I understand that any other written or oral statement to the contrary, even if made by a supervisor, manager or officer of The Company is invalid and should not be relied on by me. I understand that if employed I will be an employee-at-will and that either The Company or I may terminate that employment relationship at any time, for any reason, with or without notice. I consent to release of a good faith reference to any and all potential employers who may request information about my employment and performance at The Company.

I understand that this application will remain active for 12 months. After that time, I will not be considered for the position for which I applied unless I submit a new application.

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Signature of Applicant

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Date

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We are an Equal Opportunity Employer.