

Jo Daviess County Health Department  
9483 US 20 West; P.O. Box 318  
Galena, IL 61036  
(815) 777-0263

# Application for Employment

TO APPLICANT: We deeply appreciate your interest in our organization. Thank you for taking the time to complete this application.

The Civil Rights Act of 1965 prohibits discrimination in employment because of race, color, religion, sex or national origin. Federal law also prohibits other types of discrimination such as age, citizenship, disability, veteran status, attainment of benefits, and participation in union activities. The laws of most states and many localities also prohibit some or all of the above types of discrimination as well as some additional types including, but not limited to, discrimination based upon ancestry, marital status, parental status, sexual orientation, or source of income. The Fair Credit Reporting Act imposes restrictions with respect to information obtained from a consumer reporting agency, including but not limited to information regarding credit data, personal character, general reputation and mode of living. **This list, however, is not exhaustive of the grounds on which discrimination is prohibited.**

## PERSONAL

Date \_\_\_\_\_ Position(s) applied for \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
No. Street City State Zip

Telephone No. \_\_\_\_\_

Are you legal eligible for employment in the U.S.A.?  Yes  No. If hired, you are required to submit proof of your eligibility to work in the U.S.A.

Are you over the age of eighteen?  Yes  No. If no, hire is subject to verification that you are of minimum legal age.

In case of emergency, please contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever been employed by Jo Daviess County?  Yes  No. If yes, when? \_\_\_\_\_

Relatives employed by Jo Daviess County \_\_\_\_\_

Have you ever served in the Armed Forces?  Yes  No. If yes, which branch? \_\_\_\_\_

What date are you available to begin work? \_\_\_\_\_

Please attach all college and post-graduate transcripts.

Please attach all applicable professional licenses and certificates.

## EMPLOYMENT HISTORY

**List and describe your present and past work experience beginning with your present position. List any supervisory responsibilities, indicate the number of months involved, and the number and title of personnel supervised. Please attach separate sheet/if more space needed.**

Name & Address of Employer	From		To		Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
	Mo.	Yr.	Mo.	Yr.				
	Describe the work you did:							

Name & Address of Employer	From		To		Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
	Mo.	Yr.	Mo.	Yr.				
	Describe the work you did:							

Name & Address of Employer	From		To		Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
	Mo.	Yr.	Mo.	Yr.				
	Describe the work you did:							

Name & Address of Employer	From		To		Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
	Mo.	Yr.	Mo.	Yr.				
	Describe the work you did:							

**REFERENCE LIST**

Please list three references, persons from places where you were previously employed.  
Two of the three references must have supervised you in that position.

1) _____ Name	_____ Position	_____ Place of Employment
_____ Phone Number—Work	_____ Phone Number—Home	_____ City, State, Zip Code
2) _____ Name	_____ Position	_____ Place of Employment
_____ Phone Number—Work	_____ Phone Number—Home	_____ City, State, Zip Code
3) _____ Name	_____ Position	_____ Place of Employment
_____ Phone Number—Work	_____ Phone Number—Home	_____ City, State, Zip Code

**EDUCATION**

Highest level attained—High School Graduate,      GED,      Associate,  
 Diploma Nursing,      Bachelor,      Masters,      Other \_\_\_\_\_

High School of Business Name and Address	Specialty If Any	Did You Graduate	Date Graduated or Last Attended

Advanced Education Name and Address of Institu- tion or Agency	Credits		Name of Major	Name of Minor	Dates		Type of Degree Earned	Date Issued
	Sem.	Earned Qtr.			From Mo/Yr	Attended To Mo/Yr		

**EDUCATION (Continued)**

Registration, Certification or Other Professional License	Number	State In Which Issued	Date Issued	Date Applied For

May we telephone you to follow up on this application at work?  Yes  No

If yes, what is the best time to call? \_\_\_\_\_

What is your business telephone number? \_\_\_\_\_

**PLEASE READ AND SIGN BELOW**

The facts set forth in my application for employment are true and complete. I understand that if employed, any false statement on this application may result in my dismissal. I further understand that this application is not and is not intended to be a contract of employment, nor does this application obligate the employer in any way if the employer decides to employ me. I understand and agree that my employment is at-will and can be terminated by either party with or without notice, at any time, for any reason or no reason.

\_\_\_\_\_  
Signature of Applicant

**AUTHORIZATION FOR BACKGROUND, REFERENCE CHECK AND RELEASE**

I authorize the Jo Daviess County Health Department to thoroughly investigate my references, work record, education, criminal conviction record and any other matters relevant to my suitability for employment. I also authorize my former employers to disclose to the Jo Daviess County Health Department and its designees, or to anyone acting on behalf of the Jo Daviess County Health Department, any and all of my employment records, including my disciplinary reports and letters of reprimand, without giving me notice of such disclosure. I hereby fully release and discharge the Jo Daviess County Health Department and Jo Daviess County, my former employers, their respective officers, employees and agents, and all other persons and entities from any and all claims, demands, and liabilities arising out of or in any way relating to such investigation or disclosure.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

OFFICE USE ONLY:

STATEMENT BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH (I.D.P.H.)

\_\_\_\_\_ MEETS THE QUALIFICATION REQUIREMENT FOR THE POSITION OF \_\_\_\_\_  
AS OUTLINED IN THE "RULES AND REGULATIONS" CONCERNING MINIMUM QUALIFICATIONS FOR THE PUBLIC HEALTH PERSONNEL EMPLOYED BY FULLTIME LOCAL HEALTH DEPARTMENTS, AS REVISED.

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

I.D.P.H. REPRESENTATIVE \_\_\_\_\_