



3901 West Norfolk Avenue  
Norfolk, NE 68701

**Norfolk Medical Group, LLC | Application for Employment**

*It is our policy to provide equal employment opportunities to all qualified persons without regard to race, color, religion, sex, national origin, disability or any other characteristic protected by state or federal law.*

**Personal Information**

Name				Social Security Number	
	<i>Last</i>	<i>First</i>	<i>Middle</i>		

Present Address					
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>	

Permanent Address					
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>	

Phone Number	( )	Alternate Phone Number	( )
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Email address:	
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Have you ever been employed with us before?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, list dates
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Have you ever worked under another name(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If yes, list name(s)	
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Are you a U.S. citizen or otherwise authorized to work in the U.S. on unrestricted basis?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Have you ever been convicted of a crime, including misdemeanors and felonies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If yes, please state the nature of the offense and the date of the conviction in the space below.

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**NOTE: Answering "yes" to the above question does not constitute an automatic bar from employment. Factors such as the date of the conviction, seriousness and nature of the conviction, and position applied for will be considered.**

**Employment Desired**

Position(s) applying for	
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<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> On-Call	Hours per Week	Minimum:	Maximum:
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Date you can start		Salary Desired	
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Are you currently employed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, may we contact your present employer?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you applied at Norfolk Medical Group within the past 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, list when:		
How did you hear about Norfolk Medical Group?					

Education				
Type	Name & Location	# of Years Completed	Did you Graduate?	Degree Received
High School			<input type="checkbox"/> No <input type="checkbox"/> Yes	
College or University			<input type="checkbox"/> No <input type="checkbox"/> Yes	
Nursing or Vocational School			<input type="checkbox"/> No <input type="checkbox"/> Yes	
Other			<input type="checkbox"/> No <input type="checkbox"/> Yes	

Professional Licenses, Registrations and/or Certifications (RN, LPN, Technologist, Etc)				
Type		License/Certificate Number		
State Issued		Expiration Date		
Other State(s)		License/Certificate Number		
If not currently licensed, have you applied?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date Applied:	
Type of license/certification applied for				
Has your professional license (in any state) ever been revoked or limited in any way?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
If yes, give reason:				
Has your license ever been on probationary status?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
If yes, give reason:				



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<b>Employment History</b>			
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<b>Employer</b>		<b>From</b>		<b>To</b>	
		<i>Date</i>			<i>Date</i>
<b>Employer Address</b>		<b>Phone Number</b>	( )		
<b>Job Title</b>		<b>Salary</b>			
<b>Reason for Leaving</b>					

<b>Employer</b>		<b>From</b>		<b>To</b>	
		<i>Date</i>			<i>Date</i>
<b>Employer Address</b>		<b>Phone Number</b>	( )		
<b>Job Title</b>		<b>Salary</b>			
<b>Reason for Leaving</b>					

<b>Employer</b>		<b>From</b>		<b>To</b>	
		<i>Date</i>			<i>Date</i>
<b>Employer Address</b>		<b>Phone Number</b>	( )		
<b>Job Title</b>		<b>Salary</b>			
<b>Reason for Leaving</b>					

<b>Employer</b>		<b>From</b>		<b>To</b>	
		<i>Date</i>			<i>Date</i>
<b>Employer Address</b>		<b>Phone Number</b>	( )		
<b>Job Title</b>		<b>Salary</b>			
<b>Reason for Leaving</b>					

*\*Note: If you have additional work experience, please attach an extra sheet of paper.*



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**References** (please give names of three persons not related to you, whom you have known at least one year)

Name	Address	Telephone	Relationship to You

Please list any additional information you would like us to consider (i.e. specialized skills, certifications, etc.):


**Authorizations and Certification**

I understand that Norfolk Medical Group requires applicants to participate in a Pre-Employment Physical Assessment upon receiving a conditional offer of employment. Norfolk Medical Group pays all costs involved with the Pre-Employment Physical Assessment. I understand and acknowledge that any offer of employment may be conditioned upon my successful completion of this Pre-Employment Physical Assessment, to which I hereby consent.

**Certification**

I certify that all information given by me on this employment application is true and complete to the best of my knowledge. Unless I have specifically indicated herein to the contrary, I authorize Norfolk Medical Group to investigate all statements contained in this application for employment and to investigate my character and qualifications. I authorize the references listed above to provide Norfolk Medical Group any and all information regarding my previous employment. Further, I release all parties and persons from any and all liability and from any damages that may result from furnishing this information to Norfolk Medical Group as well as from the use or disclosure of this information by Norfolk Medical Group or any of its agents, employees or representatives. I understand that any false information, omissions, or misrepresentations discovered during interviews or discovered on this employment application will disqualify me from further consideration, and if discovered after I am hired, will constitute grounds for immediate dismissal.

I understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States. I understand that this employment application will expire sixty (60) days from the signature date below, at which time I will no longer be considered an applicant. If I am interested in any available positions following this 60-day period, I understand that it is my obligation to complete a new application.



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### Disclaimer

I understand that nothing in this employment application or in my communications with Norfolk Medical Group employee is intended to create an employment contract between Norfolk Medical Group and me. I acknowledge that no oral representations have been made, and that no one within Norfolk Medical Group has the authority to make oral contracts of employment. I understand that Norfolk Medical Group has the right to modify its policies without giving me any notice of the change(s). I understand that if any employment relationship is established, it will be employment at-will and I have a right to terminate my employment at any time, for any reason. I also understand that Norfolk Medical Group retains the right to terminate my employment at any time, for any reason.

I certify that I have read, fully understand, and accept all the terms of the employment application.

X

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Applicant Signature

X

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Date