



APPLICATION OF EMPLOYMENT

Name of Applicant: _____

Position Applying For: _____

Date: _____

Please return completed applications to:

Tasha Tommer, Human Resources
tashatommer@mckayhealthcare.org



APPLICATION FOR EMPLOYMENT

All applicants are considered for all positions without regard to race, religion, color, sex, gender, sexual orientation, pregnancy, age, national origin, ancestry, physical/mental disability, medical condition, military/veteran status, genetic information, marital status, ethnicity, citizenship or immigration status or any other protected classification, in accordance with applicable federal, state, and local laws. By completing this application, you are seeking to join a team of hardworking professionals dedicated to consistently delivering outstanding service to our customers and contributing to the financial success of the organization, its clients, and its employees. Equal access to programs, services, and employment is available to all qualified persons. Those applicants requiring accommodation to complete the application and/or interview process should contact a management representative.

Please print.

Position(s) Applied for		Date of Application		
Print Name (Last, First, & Middle)				
Street Address	City	State	Zip Code	
Main Phone Number	Alternate Phone Number	Email		

EMPLOYMENT EXPERIENCE

Please list the names of your present or previous employers in chronological order with present or most recent employer listed first. Be sure to account for all periods of time. If self-employed, give firm name and supply business references. Add additional page if necessary.

Name of Employer	Supervisor	May we contact?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Street Address		
Phone Number	Dates Employed (Month/Year)	
	From	To
Job Title and Duties	Reason for Leaving	

Name of Employer	Supervisor	May we contact?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		
Phone Number	Dates Employed (Month/Year)	
	From	To
Job Title and Duties	Reason for Leaving	

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Street Address		
Phone Number	Dates Employed (Month/Year)	
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Street Address		
Phone Number	Dates Employed (Month/Year)	
	From	To
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		<input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		
Phone Number	Dates Employed (Month/Year)	
	From	To
Job Title and Duties	Reason for Leaving	

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Have you ever been involuntarily terminated or asked to resign from any job?..... Yes No

If yes, please explain

Please explain any gaps in your employment history:

Please list any other experience, job related skills, additional languages, or other qualifications that you believe should be considered in evaluating your qualifications for employment.

EDUCATION

Please describe your educational background in the table provided below.

	School Name	Years Completed	Diploma/ Degree (Yes/No)	Area of Study/Major	Specialized Training, Skills, or ExtraCurricular Activities
High School					
College/ University					
Graduate/ Professional School					
Trade School					
Other					

BUSINESS AND PROFESSIONAL REFERENCES

Please list three professional references of individuals who are **not** related to you.

Name and Title	Relationship	Phone Number or Email

PERSONAL REFERENCES

Please list three people who know you well.

Name and Title	Relationship and Years Acquainted	Phone Number or Email

GENERAL INFORMATION

1. Have you ever used another name?..... Yes No
2. Is any additional information relative to name changes, use of an assumed name, or nickname necessary to

enable a check on your work and educational record?..... Yes No a.

If yes to either of the above, please explain:

3. Have you ever worked for McKay Healthcare & Rehab before?.....

Yes No

a. If yes, please give dates and position: TO

4. Do you have friends and/or relatives working for this company?..... Yes No

a. If yes, name(s) and relationship(s): Click or tap here to enter text.

5. On what date are you available to begin work? Click or tap to enter a date.

6. Days/Hours available to work: Click or tap to enter a date.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

7. Are you available to work? Full-time Part-time Shift Work Temporary/On Call

8. If hired, would you have a reliable means of transportation to and from work?..... Yes No

9. Can you relocate if the position requires it?..... Yes No

10. Are you at least 18 years old? Yes No

a. Note: If under 18, hire is subject to verification that you are of minimum legal age.

11. If hired, can you present evidence of your identity and legal right to work in this country?..... Yes No

12. Are you able to perform the essential job functions of the job for which you are applying with or without reasonable accommodation?..... Yes No

a. Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for qualified applicants/employees to perform essential job functions.

APPLICANT STATEMENT AND AGREEMENT

Please read and initial each paragraph below. If there is anything that you do not understand, please ask.

I hereby authorize McKay Healthcare & Rehab to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the prior employers and references I have listed to disclose to McKay Healthcare & Rehab any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release McKay Healthcare & Rehab, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

In the event of my employment with McKay Healthcare & Rehab, I understand that I am required to comply with all rules and regulations of McKay Healthcare & Rehab.

If hired, I understand and agree that my employment with McKay Healthcare & Rehab is at-will, and that neither I, nor McKay Healthcare & Rehab is required to continue the employment relationship for any specific term. I further understand that McKay Healthcare & Rehab or I may terminate the employment relationship at any time, with or without cause, and with or without notice. I understand that the at-will status of my employment cannot be amended, modified, or altered in any way by any oral modifications.

I understand that safety of employees is extremely important to McKay Healthcare & Rehab and that McKay Healthcare & Rehab is committed to ensuring a safe working environment. I understand that I, and every employee, have a responsibility to prevent accidents and injuries by observing all safety procedures and guidelines and following the directions of my site supervisor. I understand and agree to comply with federal, state, and local regulations related to on the-job safety and health.

I hereby certify that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

I understand that if I am selected for hire, it will be necessary for me to provide satisfactory evidence of my identity and legal authority to work in the United States, and that federal immigration laws require me to complete an I-9 Form in this regard.

I understand that if any term, provision, or portion of this Agreement is declared void or unenforceable, it shall be severed and the remainder of this Agreement shall be enforceable.

MY SIGNATURE BELOW ATTESTS TO THE FACT THAT I HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE ABOVE TERMS.

Signature: _____

Name (print): _____ **Date:** _____

Supplemental Profile Data

Government agencies require periodic reports about the state workforce for equal opportunity and affirmative action efforts. Providing such information about yourself is voluntary and your response will be used only in accordance with Washington State's equal opportunity and affirmative action efforts. For more information view the [Affirmative Action Definitions](#).

Name (Last, First, Middle Initial)		Job Number
Male <input type="checkbox"/> Female <input type="checkbox"/>	Are you a person with a disability? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you 40 years or older? Yes <input type="checkbox"/> No <input type="checkbox"/>

What race or culture do you consider yourself? If you consider yourself two or more races, select all that apply.

- | | |
|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White or Caucasian |

Veterans Information – Employment preference is given to veterans who meet state qualifications, their spouses or registered domestic partner. *Note: To qualify and receive veteran's preference, you may be asked to provide a copy of your record of discharge, DD214 or NGB Form 22 or alternate verification of military service with your application.*

Are you a US Veteran? Yes No

Are you a Vietnam Era Veteran? Yes No

Are you entitled to compensation under laws administered by the US Department of Veterans Affairs (USDVA) for disability?

- Yes, I have a service disability rated at 30 percent or more.
- Yes, I have a service disability rated at 10 or 20 percent as determined by the USDVA which has resulted in a serious employment handicap and I can provide a letter from the USDVA confirming this status.
- Yes, I was discharged or released from active duty for a disability incurred or aggravated in the line of duty.
- No, I am not entitled to compensation as stated.

Are you the spouse or registered domestic partner of an honorably discharged deceased veteran, OR are you the spouse or registered domestic partner of an honorably discharged 100% service disability veteran? Yes No

Did you serve during a period of war or a military campaign for which a campaign ribbon shall have been awarded?

Yes No

Are you currently employed in permanent or permanent project positions in a state agency? Yes No

If **yes**, were you called to active duty from employment with the state for at least 180 days? Yes No

If **yes**, Dates ___ to ___ and Type of Discharge: _____.