AULTMAN College
OF NURSING AND HEALTH SCIENCES

AULTMAN COLLEGE ADJUNCT FACULTY APPLICATION

THE QUESTIONS FOUND ON THIS FORM ARE BEING ASKED TO PROPERLY EVALUATE YOUR ABILITY AND CHANCE FOR SUCCESS IN THE POSITION FOR WHICH YOU ARE APPLYING. EVERY EFFORT HAS BEEN MADE TO COMPLY WITH THE APPLICABLE FEDERAL LAW AND LAWS OF OUR STATE. IT IS NOT OUR INTENT TO DISCRIMINATE IN EMPLOYMENT ON ACCOUNT OF COLOR, RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN OR DISABILITY.

POSITION DESIRED:

Primary:	Secondary:

PERSONAL DATA:

Name (last) (first) (middle)		Social Security No.
Present Address (Number & Street)	How long at this address?	Home Phone
City, State & Zip	Email address	Cell Phone

EMERGENCY CONTACT INFORMATION: (Please provide 2 people to contact in case of emergency.)

Name (last) (first)		Relationship
Home Phone	Cell Phone	Work Phone
Name (last) (first)		Relationship
Home Phone	Cell Phone	Work Phone

BACKGROUND:

Have you ever worked for Aultman Health Foundation or any of its affiliates? If yes, when? ☐ YES ☐ NO	Have you since the age of 18 ever been convicted of, charged with or pled to a felony or violent misdemeanor? If yes, explain and give dates. ☐ YES ☐ NO
For checking prior records, provide other names under which you have worked.	Have you ever been discharged (fired) from a job? If yes, explain and give dates. ☐ YES ☐ NO
Do you have relatives presently working for Aultman Health Foundation or any of its affiliates? If so, who? ☐ YES ☐ NO	Have you ever been suspended, sanctioned, excluded, or precluded from participating in Medicare, Medicaid, or other private or Governmental Health Insurance Program? If yes, when? ☐ YES ☐ NO
Are you currently a user of tobacco products on a regular basis? ☐ YES ☐ NO	

PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS (IF APPLICABLE):

Type	State Issued	Date	No.
Type	State Issued	Date	No.

REFERENCES: (Give name(s) of person (non-relatives) we may contact to verify your qualifications for the position.)

Name/Occupation	Business Address City, State & Zip Phone	Home Address City, State & Zip Phone
Name/Occupation	Business Address City, State & Zip Phone	HOME ADDRESS City, State & Zip Phone
Name/Occupation	Business Address City, State & Zip Phone	Home Address City, State & Zip Phone

I HEREBY CERTIFY THAT THE ANSWERS TO ALL QUESTIONS AND STATEMENTS IN THIS APPLICATION ARE CORRECT. I UNDERSTAND THAT ANY FALSE STATEMENT, MISINTERPRETATION, OR OMISSION WILL BE CAUSE FOR IMMEDITE DISMISSAL. I AUTHORIZE THE COMPANIES, SCHOOLS LISTED ABOVE, OR ANY AGENCY OR PERSON HAVING KNOWLEDGE OF, TO GIVE ANY INFORMATION REGARDING MY EMPLOYMENT CHARACTER, GENERAL REPUTATION, PERSONAL CHARACTERISTICS, EDUCATION, WORK HISTORY OR POLICE RECORD, TO THE AULTMAN HEALTH FOUNDATION OR ANY OF ITS AFFILIATES.

I UNDERSTAND THAT MY EMPLOYMENT IS CONTINGENT ON PASSING ALL ASPECTS OF A PRE-EMPLOYMENT PHYSICAL EXAMINATION. I UNDERSTAND THAT IF EMPLOYED BY THE AULTMAN HEALTH FOUNDATION, A SMOKE-FREE ENVIRONMENT, OR ONE OF ITS AFFILIATES, I AGREE TO ABIDE BY ALL RULES AND POLICIES OF THOSE COMPANIES. FURTHER, I UNDERSTAND THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED AT ANY TIME AT THE OPTION OF EITHER THE AULTMAN HEALTH FOUNDATION, ITS AFFILIATES, OR MYSELF, AND THAT THIS APPLICATION DOES NOT CONSTITUTE AN EMPLOYMENT CONTRACT.

UPON TERMINATION, MY PHOTO I.D., AND ANY OTHER PROPERTY BELONGING TO THE AULTMAN HEALTH FOUNDATION MUST BE RETURNED.

Signature _____ Date _____