Eastport Health Care, Inc.
Our Specialty is YOU!

Rowland B. French Medical Center
Vogl Behavioral Health Center
30 Boynton Street
Eastport, Maine 04631
Phone: 207-853-6001
Fax: 207-853-6180

APPLICATION FOR EMPLOYMENT

*Today's Date:*_____

APPLICANT NOTE: *This Employment Application is intended for use in evaluating your qualifications for employment. It is not an employment contract. Please answer all questions completely and to the best of your ability. False or misleading statements are grounds for refusal or termination of employment and benefits. It is the policy of this Company as an Equal Opportunity Employer to ensure that there shall be no discrimination against any employee or applicant for employment on the basis of age, race, color, creed, marital status, religion, sex, national origin, disability or veteran status, or any other status protected by law.*

PLEASE PRINT CLEARLY

PERSONAL DATA

NAME (LAST)	FIRST	MIDDLE		
HOME ADDRESS	CITY	STATE	ZIP	
HOME PHONE	CELL PHONE	Email		
ARE YOU ELIGIBLE TO WORK IN THE U.S.? YES _____ NO _____				

POSITION

POSITION DESIRED?
HOW DID YOU HEAR ABOUT THIS POSITION?
WHAT DATE ARE YOU AVAILABLE TO BEGIN WORK?
ARE YOU WILLING TO TRAVEL TO DIFFERENT EHC SITES?

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EMPLOYMENT HISTORY

PRESENT/LAST EMPLOYER	COMPANY NAME		FROM	TO
	COMPANY ADDRESS			
	PHONE NUMBER	POSITION HELD		
EMPLOYER	COMPANY NAME		FROM	TO
	COMPANY ADDRESS			
	PHONE NUMBER	POSITION HELD		
EMPLOYER	COMPANY NAME		FROM	TO
	COMPANY ADDRESS			
	PHONE NUMBER	POSITION HELD		
EMPLOYER	COMPANY NAME		FROM	TO
	COMPANY ADDRESS			
	PHONE NUMBER	POSITION HELD		
EMPLOYER	COMPANY NAME		FROM	TO
	COMPANY ADDRESS			
	PHONE NUMBER	POSITION HELD		

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EDUCATION

SCHOOL	NAME OF SCHOOL	COURSE OF STUDY	DEGREE RECEIVED
HIGH SCHOOL			
COLLEGE			
COLLEGE			
TRADE SCHOOL			

REFERENCES

PLEASE PROVIDE THE NAMES OF THREE PROFESSIONAL REFERENCES.

NAME	ADDRESS, PHONE, EMAIL	COMPANY	YEARS ACQUAINTED

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IMPORTANT, PLEASE READ AND SIGN

We are an equal opportunity employer and provider and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law.

I understand that neither the completion of this application nor any other part of my consideration for employment establishes any obligation for Eastport Health Care, Inc. to hire me. If I am hired, I understand that either Eastport Health Care, Inc. or I can terminate my employment at any time and for any reason, with or without cause and without prior notice. I understand that no representative of Eastport Health Care, Inc. has the authority to make any assurance to the contrary.

I attest with my signature below that I have given to Eastport Health Care, Inc. true and complete information on this application. No requested information has been concealed. I authorize Eastport Health Care, Inc. to contact references provided for employment reference checks. If any information I have provided is untrue, or if I have concealed material information, I understand that this will constitute cause for the denial of employment or immediate dismissal.

Applicant Signature: _____ Date: _____