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.*

**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 | | |

Machias Behavioral Health
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-3400
Fax: (207)-255-3401

Machias Family Practice
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-8290
Fax: (207)-255-4109

Machias Pediatrics
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-0980
Fax: (207)-255-3897

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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**

*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 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: _____

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