ROSEBUD HEALTH CARE SYSTEMS, INC.
WHITE RIVER HEALTH CARE CENTER
PO BOX 310
WHITE RIVER SD 57579
PH. 605-259-3161 FAX 605-259-3106

APPLICATION FOR EMPLOYMENT

PERSONAL

LAST NAME FIRST NAME MIDDLE	DATE
PO BOX OR STREET ADDRESS	HOME TELEPHONE
CITY, STATE, ZIP	OTHER TELEPHONE
HAVE YOU EVER BEEN EMPLOYED WITH US?	SOCIAL SECURITY #
POSITION DESIRED	PAY EXPECTED
ARE YOU ABLE TO WORK FULL TIME? Y N IF NO, WHAT HOURS CAN YOU WORK?	DATE OF BIRTH
ARE YOU ELIGIBLE FOR WORK IN THE UNITED STATES?	WHEN WILL YOU BE AVAILABLE TO BEGIN WORK?
OTHER SPECIAL TRAINING OR SKILLS: (LANGUAGES, MACHINE OPERATIONS, ETC.)	
ARE YOU A UNITED STATES CITIZEN?	
HOW LONG AT PRESENT ADDRESS?	
ARE YOU OVER 18 YEARS OF AGE? Y N IF NOT, EMPLOYMENT IS SUBJECT TO VERIFICATION OF AGE.	
STATE NAMES OF RELATIVES AND FRIENDS WORKING FOR US.	
HAVE YOU BEEN CONVICTED OF A VIOLENT CRIME ? Y N IF YES, DESCRIBE IN FULL.	

A POINT SYSTEM HAS BEEN ESTABLISHED BY THE ROSEBUD SIOUX TRIBE TO ASSIST IN THE SELECTION PROCESS OF EMPLOYMENT.
TO INSURE A COMPLETE APPLICATION AND TO SPEED THE PROCESSING PLEASE ATTACH ALL APPLICABLE VERIFICATIOON AS LISTED BELOW:

1. VETERENS PREFERENCE ( )
2. TRIBAL ABSTRACT OF CENSUS ( )
3. HIGH SCHOOL DIPLOMA OR GED ( )
4. COLLEGE DEGREE ( )
5. ANY CERTIFICATES ( )
6. UPDATED RESUME ( )
7. IMMUNIZATION RECORDS ( )

IT IS THE RESPONSIBILITY OF THE APPLICANT TO ATTACH THE PROPER DOCUMENTATION TO THE APPLICATION.

ROSEBUD SIOUX TRIBAL MEMBERS ARE GIVEN PREFERENCE FOR JOBS.

ARE YOU CURRENTLY EMPLOYED?	YES OR NO
MAY WE CONTACT YOUR CURRENT EMPLOYER?	YES OR NO
ARE YOU CURRENTLY ON "LAY OFF" STATUS AND SUBJECT TO RECALL?	YES OR NO
ARE YOU AN ENROLLED MEMBER OF THE ROSEBUD SIOUX TRIBE?	YES OR NO
ARE YOU A NON-ENROLLED MEMBER OF THE ROSEBUD SIOUX TRIBE?	YES OR NO
ARE YOU AN INDIAN MARRIED TO A ROSEBUD SIOUX TRIBAL MEMBER?	YES OR NO
ARE YOU NON-INDIAN MARRIED TO A ROSEBUD SIOUX TRBAL MEMBER?	YES OR NO
ARE YOU PREVENTED FROM LAWFULLY BECOMING EMPLOYED IN THIS COUNTRY BECAUSE OF VISA OR IMMIGRATION STATUS? (PROOF OF CITIZENSHIP OR IMMIGRATION STAUS WILL BE REQUIRED UPON EMPLOYMENT)	YES OR NO
DO YOU HAVE AN IMMEDIATE MEMBER OF YOUR FAMILY WORKING FOR THE TRIBE?	YES OR NO
IF YES, PLEASE INDICATE RELATIONSHIP/PROGRAM.	
DO YOU HAVE A VALID SOUTH DAKOTA DRIVER'S LICENSE?	YES OR NO
IF YES, WHAT CLASS?	
DO YOU HAVE RELIABLE TRANSPORTATION?	YES OR NO
HAVE YOU SERVED IN THE UNITED STATES MILITARY?	YES OR NO
WERE YOU DISCHARGED FROM THE MILITARY SERVICE UNDER HONORABLE CONDITIONS? (PLEASE ATTACH VERIFICATION)	YES OR NO
LIST DATES AND BRANCH FOR ALL ACTIVE DUTY MILITARY SERVICE.	
HAVE YOU EVER HAD ANY JOB-RELATED TRAINING IN THE UNITED STATES MILITARY?	YES OR NO
IF YES, PLEASE DESCRIBE.	
ARE YOU PHYSICALLY OTHERWISE UNABLE TO PERFORM THE DUTIES OF THE JOB FOR WHICH YOU ARE APPLYING?	YES OR NO

EDUCATION:

SCHOOL	NAME AND LOCATION OF SCHOOL	COURSE OF STUDY	# OF YEARS	DID YOU GRADUATE?	DEGREE OR DIPLOMA
GRADUATE					
COLLEGE					
BUSINESS/TRADE/ TECHNICAL					
HIGH SCHOOL					
ELEMENTARY					

MEMBERSHIP IN PROFESSIONAL OR CIVIC ORGANIZATIONS:

EMPLOYMENT: (PLEASE GIVE ACCURATE, COMPLETE FULL-TIME AND PART-TIME EMPLOYMENT RECORD. START WITH YOUR PRESENT OR MOST RECENT EMPLOYER.)

COMPANY NAME	TELEPHONE:
ADDRESS:	EMPLOYMENT DATES FROM: TO:
NAME OF SUPERVISOR:	WAGE: START: END
STATE JOB TITLE AND DESCRIBE YOUR WORK:	REASON FOR LEAVING:
PREVIOUS EMPLOYER CONTACTED DATE: BY WHOM:	FAVORABLE OR UNFAVORABLE

COMPANY NAME:	TELEPHONE:
ADDRESS:	EMPLOYMENT DATES: FROM: TO:
NAME OF SUPERVISOR:	WAGE: START: END:
STATE JOB TITLE AND DESCRIBE YOUR WORK:	REASON FOR LEAVING:
PREVIOUS EMPLOYER CONTACTED DATE: BY WHOM:	FAVORABLE OR UNFAVORABLE

COMPANY NAME:	TELEPHONE:
ADDRESS:	EMPLOYMENT DATES: FROM: TO:
NAME OF SUPERVISOR	WAGE: START: END:
STATE JOB TITLE AND DESCRIBE YOUR WORK:	REASON FOR LEAVING:
PREVIOUS EMPLOYER CONTACTED DATE: BY WHOM:	FAVORABLE OR UNFAVORABLE

WE MAY CONTACT THE EMPLOYERS LISTED ABOVE UNLESS YOU INDICATED THOSE YOU DO NOT WANT US TO CONTACT.

REFERENCES: GIVE NAME, ADDRESS AND TELEPHONE NUMBER OF THREE REFERENCES WHO ARE NOT RELATED TO YOU OR A PREVIOUS EMPLOYER.

1.
2.
3.

OFFICE USE ONLY

REFERENCE 1: DATE CONTACT DONE:	BY:
COMMENTS:	

REFERENCE 2: DATE CONTACT DONE:	BY:
COMMENTS:	

REFERENCE 3: DATE CONTACT DONE:	BY:
COMMENTS:	

UPDATE ANY ADDITIONAL INFORMATION YOU FEEL MAY BE HELPFUL TO AND IN CONSIDERING YOUR APPLICATION.

YOU MUST SIGN THIS APPLICATON. READ THE FOLLOWING CAREFULLY BEFORE YOU SIGN.

A FALSE STATEMENT TO ANY PART OF YOUR APPLICATION MAY BE GROUNDS FOR NOT EMPLOYING YOU OR FOR DISMISSING YOU AFTER YOU BEGIN WORK.

IT IS MY UNDERSTANDING THAT THE WHITE RIVER HEALTH CARE CENTER WILL MAKE A THOROUGH INVESTIGATION OF MY ENTIRE WORK HISTORY AND MAY VERIFY ALL DATA GIVEN IN MY APPLICATION FOR EMPLOYMENT, RELATED PAPERS, OR ORAL INTERVIEWS. I AUTHORIZE SUCH INVESTIGATION AND THE GIVEN AND RECEIPT OF ANY INFORMATION REQUESTED BY THE WHITE RIVER HEALTH CARE CENTER AND I RELEASE FROM LIABILITY ANY PERSON GIVING OR RECEIVING ANY SUCH INFORMATION. I UNDERSTAND THAT FALSIFICATION OF DATA SO GIVEN OR OTHER DEROGATORY INFORMATION DISCOVERED AS A RESULT OF THIS INVESTIGATION MAY PREVENT MY BEING HIRED, OR IF HIRED MAY SUBJECT ME TO IMMEDIATE DISMISSAL.

IN THE EVENT OF EMPLOYMENT, I UNDERSTAND THAT FALSE OR MISLEADING INFORMATION GIVEN IN MY APPLICATION OR INTERVIEWS MAY RESULT IN DISCHARGE. I UNDERSTAND ALSO, THAT I AM REQUIRED TO ABIDE BY ALL RULES AND REGULATIONS OF THE EMPLOYER.

I CERTIFIY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL MY STATEMENTS ARE TRUE, CORRECT, COMPLETE AND MADE IN GOOD FAITH.

_____ _____

SIGNATURE OF APPLICANT DATE

PLEASE PROVIDE TWO FORMS OF ID WITH THIS APPLICATION.

WHITE RIVER HEALTH CARE CENTER
DRUG AND ALCOHOL POLICY

The possession, use, distribution and /or sale of illicit drugs, or non-medical use of prescription drugs, are unlawful. Such use jeopardizes the health and safety of employees, co-workers and residents in the workplace. It is for this reasons the following policy is adopted.

1. Prior to employment, all applicants offered employment must successfully complete a PRE-EMPLOYMENT drug test as determined by the company.
2. Any employee whose behavior demonstrates REASONABLE CAUSE to believe he/she is involved with drugs and alcohol will be requested to immediately submit to drug and alcohol testing (specimens may include urine, blood, saliva, breath or other appropriate specimen.)
3. Any employee sustaining an injury or illness which must be recorded in the OSHA log as Worker's Compensation claim or who is involved in an accident resulting in damage to property or injury to others will be requested to immediately submit to a POST ACCIDENT drug and alcohol testing (specimens may include urine, blood, saliva, breath or other appropriate specimen).
4. Any employee driving a company vehicle will be requested to submit to alcohol and drug testing (specimens may include urine, blood, saliva, breath or other appropriate specimen).
5. The company shall conduct RANDOM and/or blanket testing of the staff.

Refusal to cooperate with and submit to any of these requested test occasions will be grounds for employment denial or discharge. The facility will pay for the drug tests and will assist in arranging transportation home after the testing for occasions of reasonable cause. In cases of injury or illness, the drug and alcohol test will be conducted in conjunction with any necessary medical treatment.

If an applicant or employee tests positive for illicit drugs, or prescription drugs outside of a physician's directions, a final written warning will be placed in their employee file. The employee will be subjected to random testing for a period of ninety (90) days.

A second positive test at any point is grounds for immediate termination. As an option, an employee may choose to seek counseling at his/her expense and submit to random testing, also at his/her expense, and therefore retain the privilege of employment. Monthly random testing will begin for the balance of two (2) years. After two years, the employee will be subject to the normal random testing described.

A third positive test at any point will be grounds for immediate dismissal without the opportunity for cure or appeal (personally paid treatment is a one time opportunity).

Employees who possess, use, distribute or sell illicit drugs or un-prescribed medical drugs on company property are subject to immediate dismissal and prosecution of law enforcement officials. Any employee approached at the company by anyone with regard to possession, use, distribution or sale of controlled substance must report this immediately to their supervisor.

_____ _____

Applicant/Employee Signature and Date Witness Signature and Date

WHITE RIVER HEALTH CARE CENTER

I hereby consent to submit to urinalysis and/or other tests as shall be determined/required by White River Health Care Center for the purpose of determining any drug and/or alcohol thereof.

I agree that Piya Mani Otipe or other designated collection sites may collect these specimens for these tests and may test them or forward them for analysis to a certified testing laboratory designated by the company.

I further agree to and hereby authorize the release of the results of said tests to an authorized MRO, the Company or authorized agent of the Company.

I understand that it is the current, illegal use of drugs and/or abuse of alcohol that would prohibit me from being employed at this Company.

I further agree to hold harmless the Company and its agents (including the above named collection site and the laboratory) from any liability arising in whole or part out of the collection of specimens, testing, and use of the information from said testing in connection with this Company's consideration of my employment application.

I further agree a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I also hereby certify that I have received and read the White River Health Care Center's substance abuse and testing policy and have had the drug-free workplace program explained to me. I understand that if any performance indicates it is necessary, I will submit to a drug and/or alcohol test. I also understand that failure to comply with a drug and/or alcohol testing request or a confirmed positive result for the illegal use of drugs and/or alcohol will lead to discipline up to and including termination of employment and/or forfeiture of workers' compensation benefits (pursuant to T.C.A. Section 50-9-100 et Seq.)

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant/Employee:
Print Name: _____ S/S # ____-____-____
Applicant/Employee:
Signature: _____ Date: _____
Witness Printed Name: _____
Witness Signature: _____

This form will become part of an employee's personnel file.