JAMES MENDRICK
SHERIFF
COUNTY OF DUPAGE

CLINICAL EMPLOYMENT APPLICATION
DUPAGE COUNTY SHERIFF'S OFFICE

DATE: _____

PLEASE TYPE OR PRINT. PLEASE ANSWER ALL QUESTIONS.

Personal Information

_____ _____ _____ _____
Last Name First Name Middle Name Social Security Number

_____ _____ _____ _____
Address City State Zip

(_____)_____ (_____)_____ (_____)_____
Home telephone Best time to call Work telephone Other (pager, fax, cellular)

Position of Interest: [ ] RN [ ] LPN [ ] NP [ ] PA [ ] Other _____

Employment Status: [ ] F/T [ ] P/T [ ] P. Diem [ ] Other _____

Desired Shift: _____ Earliest Available Date: _____

How did you hear about the DuPage County Sheriff's Medical Unit?

[ ] Friend/Relative [ ] Walk-in [ ] Mailing
[ ] Employment Agency [ ] Newspaper/Magazine Ad

[ ] Other _____

References

Please provide complete addresses (including zip codes). Name three (3) medical or health care professionals who have personal knowledge of your current clinical abilities, ethical character, and ability to work cooperatively with others who will provide specific written comments on these matters upon request. Previous supervisors preferred.

	Full Name	Relationship	Address	City	State	ZIP	Phone
1.	_____	_____	_____	_____	_____	_____	H (_____)_____ W (_____)_____
2.	_____	_____	_____	_____	_____	_____	H (_____)_____ W (_____)_____
3.	_____	_____	_____	_____	_____	_____	H (_____)_____ W (_____)_____

Nursing/Medical Education

	College or University	City	State	Degree	Year of Graduation
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____

Undergraduate/Graduate Education

	College or University	City	State	Degree	Year of Graduation
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Hospital Privileges **(Only applicable for NPs or PAs)**

List all medical facilities where you were granted privileges of any type for the last 5 years. Attach additional sheet if necessary.

	Institution Name	Address/City/State/Zip	Dept. Privileges	Dates (from-to)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Employment Experience (Must be completed even if resume is attached. Attach additional sheet if necessary)

Start with your present or last job. You may include job-related military service assignments and volunteer activities. You may exclude organizations, which indicate race, color, religion, gender, national origin, disabilities, or other protected status.

1. _____
Employer

_____
Address

_____
City State ZIP

_____
Telephone Numbers

_____
Date Employed (from-to)

_____
Hourly Rates/Salary (Beginning) (Current)

_____
Job Title

_____
Supervisior

_____
Reason for leaving

_____
Job Description

_____

_____

EMPLOYMENT STATUS: [ ] F/T [ ] P/T
[ ] P. Diem/PRN [ ] Other

2. _____
Employer

_____
Address

_____
City State ZIP

_____
Telephone Numbers

_____
Date Employed (from-to)

_____
Hourly Rates/Salary (Beginning) (Current)

_____

_____
Supervisior

_____
Reason for leaving

_____
Job Description

_____

_____

EMPLOYMENT STATUS: [ ] F/T [ ] P/T
[ ] P. Diem/PRN [ ] Other

Additional Information

Please answer the following questions. If you answer "yes" to any of the following questions, please write a brief summary on a separate sheet.

1. Has your professional license ever been denied, surrendered, limited, suspended, revoked, or subject to probationary conditions, or are proceedings toward any of those ends presently pending? [ ] YES [ ] NO

2. Have you ever been subject to disciplinary action in any medical organization? [ ] YES [ ] NO

3. Have you ever been convicted of a misdemeanor or felony? [ ] YES [ ] NO

4. Has a claim or a lawsuit ever been brought against you? Have you ever reported a professional liability claim, lawsuit, or incident to an insurance carrier or insurance trust? [ ] YES [ ] NO

5. Have you ever been or are you presently the subject of an investigation by any city, state, or federal agency or other governmental body regarding you professional activities or personal conduct? [ ] YES [ ] NO

Acknowledgement

Applicant agrees: 1) that all of the information contained herein is true and correct and that if anything contained herein is false, the DuPage County Sheriff's Office may immediately terminate applicant's employment and 2) applicant shall notify the DuPage County Sheriff's Office in writing if any of the answers contained herein become incorrect or incomplete.

X _____ _____ _____

Signature of applicant | Printed name of applicant | Date

Authorization and Release

The DuPage County Sheriff's Office and its employees are hereby authorized to consult with the employees and medical staff members of any healthcare facility with which I have been associated, as well as other individuals or organizations including past and present insurance malpractice carriers, state medical boards of which I have been a member, private practitioners, hospitals with which I have been associated and medical institutions I have attended or others to obtain information bearing on my academic record, work record, professional performance or other evaluations. I will supply any and all necessary information required to complete a background investigation and criminal history check. In consideration of the furnishing of the above information, I hereby release and discharge the DuPage County Sheriff's Office and any other individuals or organizations providing such information and any and all persons, employees, representatives or agents of any of the above from any and all liability or claims of any nature in connection with the information furnished hereunder. I further consent to the release of information obtained to the DuPage County Sheriff Office's, client hospitals, clinics, and health care providers. I understand and agree that I will not have access to this information and I waive any right of access to such information that I may have under the laws of any state or of the United State except as may be required by court order. A copy of this authorization shall be the same as an original and may be provided to each individual, hospital, or organization where information on my credentials is sought and shall remain in effect until specifically revoked in writing by me.

_____

Printed name of applicant

X_____

Signature of applicant

Documents Requested Please attach copies of the following documents

1. Resume or C.V.
2. Nursing Diploma
3. PA/NP Certificate/Diploma
4. College Diploma(s)/Certificate(s)
5. National Certification Certificate(s) (if applicable)
6. Current State Licensure
7. BLS, ACLS, ATLS, PALS Certification Cards