EPILEPSY FOUNDATION Minnesota

1600 University Avenue W, Suite 300, St Paul MN 55104 Phone: (651) 287-2300 Fax (651) 287-2325
2229 Roosevelt Road, St Cloud, MN 56301 Phone: (320) 529-0000 Fax (320) 529-0505

EMPLOYMENT APPLICATION

Please complete all sections of this form. If you are applying for more than one position, complete one application for each position. Resumes and other attachments are acceptable as long as they are accompanied by an application. If you have any questions on the application or position you are applying for, please contact the Human Resources Department at the address and number listed above.

Position Applying For	Today's Date
What Type of Employment are you seeking? ☐ Full Time ☐ Part Time ☐ Temporary ☐ Internship	How did you find out about this opening? Date Available to Start?

GENERAL INFORMATION

First Name:	MI:	Last Name:	
Street Address:			Apt #
City:		State:	Zip:
Home Telephone	Mobile Telephone	Email (REQUIRED)	
Are you legally eligible for employment in the U.S.A.? ☐ Yes ☐ No		Are you over 18 years old? ☐ Yes ☐ No	

Are you a current employee of the Epilepsy Foundation of Minnesota? ☐ Yes ☐ No

Have you ever been employed by the Epilepsy Foundation of Minnesota? ☐ Yes ☐ No

Have you ever applied for employment with the Epilepsy Foundation of Minnesota? ☐ Yes ☐ No

EDUCATION

Did you graduate from high school or receive a GED? Yes☐_____ No☐_____

Post Secondary Education	Name of School & Location	Course of Study	Did you graduate?	Degree or Diploma
Vocational			YES☐ NO☐	
College			YES☐ NO☐	
Other			YES☐ NO☐	

List any other education, seminars, or relevant coursework to benefit the Epilepsy Foundation of Minnesota

Please give us your employment history. Request additional sheets if needed.
Please list most recent job first. Do not state "See Resume"

Name (Last, First, MI) ______________________________

EMPLOYMENT HISTORY

Company Name

Street Address

City State Zip

Job Title | From (mo/date/year) | To (mo/date/year)

Full Time ☐ Part Time ☐ # of Hours__________________ Temporary ☐

Name and Title of Supervisor Telephone

Description of job duties

Reason for Leaving
If you are still working in this position, may we contact this Company? ☐ Yes ☐ No

Company Name

Street Address

City State Zip

Job Title | From (mo/date/year) | To (mo/date/year)

Full Time ☐ Part Time ☐ # of Hours__________________ Temporary ☐

Name of Supervisor Telephone

Description of job duties

Reason for Leaving
If you are still working in this position, may we contact this Company? ☐ Yes ☐ No

Company Name

Street Address

City State Zip

Job Title | From (mo/date/year) | To (mo/date/year)

Full Time ☐ Part Time ☐ # of Hours__________________ Temporary ☐

Name of Supervisor Telephone

Description of job duties

Reason for Leaving
If you are still working in this position, may we contact this Company? ☐ Yes ☐ No

Company Name

Street Address

City State Zip

Job Title | From (mo/date/year) | To (mo/date/year)

Full Time ☐ Part Time ☐ # of Hours__________________ Temporary ☐

Name of Supervisor Telephone

Description of job duties

Reason for Leaving
If you are still working in this position, may we contact this Company? ☐ Yes ☐ No

Name (Last, First, MI)

PROFESSIONAL REFERENCES

Please provide the names of three professional references familiar with the quality of your work, have worked directly with you, and have known you at least one year.

Name			
Work Phone Number	Other Phone Number		
Company Name			
Street Address			
City	State	Zip	
How do you know this person?			Years acquainted

Name			
Work Phone Number	Other Phone Number		
Company Name			
Street Address			
City	State	Zip	
How do you know this person?			Years acquainted

Name			
Work Phone Number	Other Phone Number		
Company Name			
Street Address			
City	State	Zip	
How do you know this person?			Years acquainted

VOLUNTEER, COMMUNITY, CHARITABLE, AND/OR OTHER NONPAID EXPERIENCE

Organization Name		Telephone	
Street Address			
City	State	Zip	
Service FROM month/year	Service TO month/year		
Name of Supervisor			
Title of Position			
Description of duties			

Organization Name		Telephone	
Street Address			
City	State	Zip	
Service FROM month/year	Service TO month/year		
Name of Supervisor			
Title of Position			
Description of duties			

_____

Name (Last, First, MI)

ACKNOWLEDGEMENT

I certify that all information provided by me in this application is true and accurate. I understand false or misleading statements made by me or consequential omissions of any kind in the application process are sufficient for my not being hired or for my dismissal if I am already employed no matter when discovered.

I understand and agree if, in the opinion of the Epilepsy Foundation of Minnesota, the results of any obtained background check are unsatisfactory, an offer of employment that has been made may be withdrawn or my employment with the Epilepsy Foundation of Minnesota may and can be terminated.

I authorize the Epilepsy Foundation of Minnesota to investigate all information contained within this application. The employers, schools, or individuals named are authorized to give information regarding my employment, character, performance, and qualifications. I hereby release all persons, agencies, or firms, from any and all liabilities resulting from providing such information.

I understand if I am hired, my employment is not for any definite period of time or successions of periods, is not governed by any written or oral contract, and is considered an "at-will" arrangement. This means either the Epilepsy Foundation of Minnesota or I am free to terminate my employment at any time for any reason, so long as there is no violation of any applicable law.

I have read and understand this application in its entirety.

_____ _____

APPLICANT SIGNATURE DATE

THIS APPLICATION AND ALL ADDITIONAL MATERIAL SUBMITTED WILL BECOME THE PROPERTY OF THE EPILEPSY FOUNDATION OF MINNESOTA AND WILL NOT BE RETURNED.

Incomplete information may cause your application to be rejected.