LOCAL HEALTH DEPARTMENTS ARE REQUIRED TO HAVE AN AFFIRMATIVE ACTION PROGRAM THAT PROHIBITS DISCRIMINATION IN EMPLOYMENT PRACTICES ON THE BASIS OF RACE, SEX, COLOR, RELIGION, NATIONAL, ORIGIN, PHYSICAL OR MENTAL HANDICAP.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH PERSONNEL INFORMATION FORM

THE PURPOSE OF THIS FORM IS TO ADVISE THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH OF ALL PERSONS HIRED OR TO BE HIRED BY LOCAL HEALTH DEPARTMENTS AS AN EXECUTIVE OFFICER FOR WHICH A MINIMUM PERSONNEL QUALIFICATION STANDARD HAS BEEN ESTABLISHED. A DETERMINATION AS TO WHETHER THE APPLICANT MEETS ALL APPLICABLE EDUCATIONAL AND EXPERIENTIAL QUALIFICATIONS WILL BE MADE AND RETURNED TO THE ORIGINATOR WITHIN 45 DAYS OF RECEIPT OF COMPLETED FORMS. SUBMIT THIS FORM AND ALL ATTACHMENTS TO: ILLINOIS DEPARTMENT OF PUBLIC HEALTH, IPLAN ADMINISTRATOR TO: DPH.IPLAN@ILLINOIS.GOV

PLEASE PRINT OR TYPE

Local Health Dept:						Date:				
Applicant's Name:										
Position: Public Health Administrator Medical Health Officer						Date of Hire: (or to be hired)				
College Transcripts Attached: □Ye	s □No		Copy of	Applica	ble Certificates o	or Licenses At	tached: □Y	′es □No		
Signature of Board of Health President	dent or Auth	orized Des	ignee: _							
Board of Health President or Authorized Designee Name:					Contact Email:					
			APPLIC	ANT INF	FORMATION .					
LAST NAME	FIRST		MIDDLE		MIDDLE	MAIDEN				
STREET ADDRESS	CITY	CITY		COUNTY		ZIP CODE PH		PHONE #		
				EDUCA	<u>TION</u>					
NAME AND ADDRESS OF INSTITUTION	CREDITS EARNED		NAME OF MAJOR		NAME OF MINOR	DATES A	DATES ATTENDED		DATE ISSUED	
	SEM.	QTR.				FROM MO/YR	TO MO/YR	EARNED		
PROFESSIONAL LICENSE OR CERTIFICATION		NUMBER		STATE IN WHICH ISSUED		DATE ISSUED		DATE APPLIED FOR		
I SIGNIFY THAT THE INFORMATION REALIZE THAT MISREPRESENTAT APPLICATION.										
SIGNATURE OF APPLICANT				(OVE						

LIST AND DESCRIBE YOUR WORK EXPERIENCE. BEGIN WITH PRESENT POSITION AND WORK BACKWARDS. IF YOU HAD SUPERVISORY RESPONSIBILITIES INDICATE THE NUMBER OF MONTHS INVOLVED AND THE NUMBER AND JOB TYPE OF PERSONNEL SUPERVISED (i.e. CLERICAL, TECHNICAL, PROFESSIONAL, ADMINISTRATIVE, ETC.)

EMPLOYMENT HISTORY

EMPLOYED BY:	DATES OF EMPLOYMENT: from to						
	mo/yr mo/yr						
ADDRESS:	HOURS WORKED PER WEEK:						
	PAYROLL TITLE:						
LIST AND DESCRIBE DUTIES AND RESPONSIBILITIES:							
*******************	**********						
EMPLOYED BY:	DATES OF EMPLOYMENT: from to						
	mo/yr mo/yr						
ADDRESS:	HOURS WORKED PER WEEK:						
	PAYROLL TITLE:						
LIST AND DESCRIBE DUTIES AND RESPONSIBILITIES:							
******************	*********						
EMPLOYED BY:	DATES OF EMPLOYMENT: from to						
	mo/yr mo/yr						
ADDRESS:	HOURS WORKED PER WEEK:						
	PAYROLL TITLE:						
LIST AND DESCRIBE DUTIES AND RESPONSIBILITIES:							
ATTACH SEPARATE SHEET IF MORE SPACE IS NEEDED.							
ATTACH SEPARATE SHEET IF MORE SPACE IS NEEDED.							
OFFICE USE ONLY:							
STATEMENT BY THE ILLINOIS DEPA	ARTMENT OF PUBLIC HEALTH						
MEETS TH	IE QUALIFICATION REQUIREMENTS FOR THE						
POSITION OFAS DEFINED IN THE "CERTIFIED LOCAL HEALTH DEPARTMENT CODE", 77 ILL.							
ADM. CODE 600 SUBPART C: PERSONNEL REQUIREMENTS							
DATE:							
IPLAN ADMINISTRAT	OR, ILLINOIS DEPARTMENT OF PUBLIC HEALTH						