APPLICATION FOR EMPLOYMENT

HEALTHREACH COMMUNITY HEALTH CENTERS

We consider applicants for all positions without regard to race, color, sex, age, national origin, religion, physical or mental disability, gender identity, or sexual orientation.

Position(s) Applied For	Location(s)	Date of Application

How did you learn about us?

If Website - which one? _____

If Advertisement- which publication? _____

If employee referral, please give name ☐ Friend ☐ Relative

Last Name	First Name	Middle Name

Address	City	State	Zip Code

Telephone Number(s)	Email Address

Best time to contact you at home is: _____a.m. or _____p.m.

If you are under 18 years of age, can you provide required proof of your eligibility to work? ☐ *Yes* ☐ *No*

Are you authorized to work in the United States? ☐ *Yes* ☐ *No*
(Proof of citizenship or immigration status will be required upon employment)

Have you ever filed an application with us before? If yes, give date _____ ☐ *Yes* ☐ *No*

Have you ever been employed with us before? ☐ *Yes* ☐ *No*

If yes, give date _____

Do any of your friends or relatives work here? ☐ *Yes* ☐ *No*

Are you currently employed? ☐ *Yes* ☐ *No*

May we contact your present employer? ☐ *Yes* ☐ *No*

Date availabletowork__/__/__

Are you available to work:
- ☐ *Full-time*
- ☐ *Per Diem*
- ☐ *Part-time (please indicate ☐ Mornings ☐ Afternoons ☐ Evenings)*
- ☐ *Temporary (please indicate dates available _/_/_-_/_/_*

Can you travel if a job requires it? ☐ *Yes* ☐ *No*

EDUCATION

	Name, City & State of School	Course of Study	Year of Degree	Diploma/Degree Received
High School				
Undergraduate College				
Graduate College				
Specialized Training, Apprenticeship, Skills, and Extra-curricular activities				

PROFESSIONAL REFERENCES

1. *Name:* _____ *Phone #:* _____

Adress: _____

2. *Name:* _____ *Phone #:* _____

Adress: _____

3. *Name:* _____ *Phone #:* _____

Adress: _____

EMPLOYMENT EXPERIENCE

Start with your present or last job. Include any job related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, sex, age, national origin, religion, physical or mental disability, gender identity, or sexual orientation.

1.	Employer	**Dates Employed**		**Work Performed**
		From	**To**	
	Address			
	Telephone Number(s)			
	Job Title			
	Supervisor	May We contact?		
	Reason for leaving			
2.	Employer	**Dates Employed**		**Work Performed**
		From	**To**	
	Address			
	Telephone Number(s)			
	Job Title			
	Supervisor	May We contact?		
	Reason for leaving			
3.	Employer	**Dates Employed**		**Work Performed**
		From	**To**	
	Address			
	Telephone Number(s)			
	Job Title			
	Supervisor	May We contact?		
	Reason for leaving			
4.	Employer	**Dates Employed**		**Work Performed**
		From	**To**	
	Address			
	Telephone Number(s)			
	Job Title			
	Supervisor	May We contact?		
	Reason for leaving			

Please explain any period of time you were not working

SPECIAL SKILLS

Do you type? ☐ *Yes* ☐ *No* *WPM* _____

Working knowledge of computer software? ☐ *Yes* ☐ *No*

If yes, what programs?

EHR	*Which Program?* _____	_____	_____
Word	☐ *Beginner*	☐ *Intermediate*	☐ *Advanced*
MS Excel	☐ *Beginner*	☐ *Intermediate*	☐ *Advanced*
MS PowerPoint	☐ *Beginner*	☐ *Intermediate*	☐ *Advanced*
MS Access	☐ *Beginner*	☐ *Intermediate*	☐ *Advanced*
Adobe	☐ *Beginner*	☐ *Intermediate*	☐ *Advanced*
Other	_____		

Clinical Skills: RN/LPN/MA please check areas in which you have experience/certification

☐ *BCLS* ☐ *Physician Office Practice* ☐ *Pediatrics*

Professional Memberships:

_____

_____

Special skills applicable to the job for which you have applied:

_____

_____

Office equipment you operate:

_____

_____

List other job-related skills, including medical procedures you are qualified to perform:

_____

_____

List professional, trade, business or civic activities and offices held.
You may exclude organizations which indicate race, color, sex, age, national origin, religion, physical or mental disability, gender identity, or sexual orientation

If you need additional space, please continue* on *a separate sheet of paper,

LICENSES *(If you are a licensed health care or dental provider)*

Professional Licensure

License/Certification	State/License No.	Date/Year Issued	Expiration Date	Temporary	Permanent

Has a state licensing authority ever revoked, suspended or placed conditions upon your professional license(s)?
☐ *Yes* ☐ *No* ☐ *N/ A*

If yes, please explain circumstances and outcome:

_____

_____

_____

Have you ever been investigated by, sanctioned by, or otherwise had your ability to participate as a provider in Medicaid, Medicare or other government sponsored health insurance program, been suspended, revoked, limited or terminated? ☐ Yes ☐ No ☐ N/ A

If yes, please explain circumstances and outcome:

_____

_____

_____

OTHER REQUIRED INFORMATION

1. Have you ever been terminated from, or asked to resign from a previous position? ☐ Yes ☐ No

If yes, describe: _____

2. Have you ever been convicted of, or plead guilty to, or plead nolo contendere (no contest) to a crime, or are you presently charged with a crime? ☐ Yes ☐ No

If yes, describe: _____

3. Have you ever had a complaint filed against you of client abuse, neglect or misappropriation of client funds or property? ☐ Yes ☐ No

If yes, describe: _____

Failure to list convictions at the time of application may result in rejection of application or dismissal if hired.

APPLICANT'S STATEMENT

I certify that answers given herein are true and complete.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that t i m e .

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

_____ _____

Signature of Applicant Date

Note to Applicants: DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB FOR WHICH YOU ARE APPLYING.

Are you capable of performing in a reasonable manner, with or without a reasonable accommodation, the activities involved in the job or occupation for which you have applied? A review of the activities involvedin such a job or occupation has been provided. ☐ *Yes* ☐ *No*

Please download or save this form for your records and email as an attachment to: personnel@healthreach.org

HealthReach Community Health Centers

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