



SHASTA COMMUNITY HEALTH CENTER

APPLICATION FOR EMPLOYMENT
AN EQUAL EMPLOYMENT OPPORTUNITY EMPLOYER

1. NAME (FIRST) (MIDDLE) (LAST)	2. DATE	<p style="text-align: center;">INSTRUCTIONS PLEASE READ BEFORE COMPLETING THIS FORM.</p> <ul style="list-style-type: none"> Please type or print clearly. Use blue or black ink. Each item on the form must be completed. If an item does not apply, write Not-Applicable (N/A) in the space provided. In item 5, list the position for which you wish to be considered (you will only be considered for a position which is open at the time you apply.) Do not abbreviate if possible. Before signing this form, carefully read the Release Authorization Notice on the last page. Applications must be signed and dated by the applicant on the last page of this form. Reasonable accommodations will be made for applicants when requested. Do not write "please see resume". 	
3. ADDRESS (NUMBER, STREET, CITY, ZIP CODE)			
4. PHONE NO.			
HOME WORK CELL			
5. POSITION APPLIED FOR	6. WEEKENDS Yes No		
FULL TIME PART TIME PER DIEM			
7. If you work for Shasta Community Health Center currently, or have in the past, complete items 7a through d below:			
(a) Dates of Employment (month, year)	(b) Position	(c) Department	(d) Reason for Leaving
From: To:			
8. If any members of your family presently work for Shasta Community Health Center, complete items 8 a through c below			
(a) Name and relationship	(a) Title of Position held	(c) Department to which assigned	
9. If you have ever as an adult been convicted of a misdemeanor or felony other than a minor traffic violation, give details in item 9. Include date of conviction, nature and disposition of offense. NOTE: A conviction does not necessarily prevent your employment with Shasta Community Health Center.			

10. Are you legally authorized to work in the United States? Yes No

All new employees will be required to complete a Form I-9 and provide documents establishing their identity and eligibility to work in the United States.

11. EDUCATION

(a) Do you have a high school diploma? Yes No If no, highest grade completed _____

Name & location of High School attended _____

(b) If no high school diploma earned, do you have a GED? Yes No

(a) Name and location (City, State, and Zip Code, if known) of college or university. (If you expect to graduate within one year, give month and year you expect to receive your degree.)	Location		CREDITS COMPLETED		MAJOR	TYPE OF DEGREE	DID YOU GRADUATE? YES/NO
	City	State/ Zip Code	SEMESTER HOURS	QUARTER HOURS			

- (a) Other schools or training (for example, trade, vocational, armed forces, or business). Give for each the course name, dates, and training organization.
Use additional sheet(s) if necessary.

12. List special qualifications and skills (licenses, foreign language competency, patents or inventions, publications, computer proficiency, etc.)

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Type of License/Certification:	License/Certification #	State:
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Type of License/Certification:	License/Certification #	State:
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Indicate whether there has ever been any adverse action (s) against any license (s) or certification (s) held Yes No

13. Do you possess a valid California Driver's License? Yes No
If no, and you possess a valid Driver's License: What state?

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14. Employment History (must be completed in full)

Are you presently employed? Yes No	May we contact your present employer? Yes No
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15. Experience: (Start with your present position and work back) Account for periods of unemployment. Include military experience, summer, part time jobs and work performed on a voluntary basis. You may include unpaid experience or volunteer work if you feel that it represents qualifying experience for the position for which you are applying.

DATES OF EMPLOYMENT (MONTH/YEAR)		TITLE OF POSITION:	
FROM:	TO:		
SALARY OR EARNINGS		AVG. HOURS PER WEEK	NAME AND ADDRESS OF EMPLOYER KIND OF BUSINESS OR ORGANIZATION (MANUFACTURING, ACCOUNTING, INSURANCE, ETC.)
STARTING \$	PER YR.	NAME	
ENDING \$	PER YR.	ADDRESS	
NAME AND TITLE OF IMMEDIATE SUPERVISOR		CITY	STATE ZIP
AREA CODE AND PHONE NO.		REASON FOR LEAVING	

DESCRIPTION OF WORK	Are your employment records listed under another name? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what name? _____
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15. EXPERIENCE – CONTINUED					
DATES OF EMPLOYMENT (MONTH/YEAR) FROM: _____ TO: _____			TITLE OF POSITION:		
SALARY OR EARNINGS		AVG. HOURS PER WEEK	NAME AND ADDRESS OF EMPLOYER		KIND OF BUSINESS OR ORGANIZATION (MANUFACTURING, ACCOUNTING, INSURANCE, ETC.)
STARTING \$	PER YR.		NAME		
ENDING \$	PER YR.		ADDRESS		
NAME AND TITLE OF IMMEDIATE SUPERVISOR			CITY	STATE	ZIP
AREA CODE AND PHONE NO.			REASON FOR LEAVING		

DESCRIPTION OF WORK

Are your employment records listed under another name? Yes No
If yes, what name? _____

15. EXPERIENCE – CONTINUED					
DATES OF EMPLOYMENT (MONTH/YEAR) FROM: _____ TO: _____			TITLE OF POSITION:		
SALARY OR EARNINGS		AVG. HOURS PER WEEK	NAME AND ADDRESS OF EMPLOYER		KIND OF BUSINESS OR ORGANIZATION (MANUFACTURING, ACCOUNTING, INSURANCE, ETC.)
STARTING \$	PER YR.		NAME		
ENDING \$	PER YR.		ADDRESS		
NAME AND TITLE OF IMMEDIATE SUPERVISOR			CITY	STATE	ZIP
AREA CODE AND PHONE NO.			REASON FOR LEAVING		

DESCRIPTION OF WORK

Are your employment records listed under another name? Yes No
If yes, what name? _____

15. EXPERIENCE – CONTINUED

DATES OF EMPLOYMENT (MONTH/YEAR) FROM: _____ TO: _____				TITLE OF POSITION:			
SALARY OR EARNINGS			AVG. HOURS PER WEEK	NAME AND ADDRESS OF EMPLOYER			KIND OF BUSINESS OR ORGANIZATION (MANUFACTURING, ACCOUNTING, INSURANCE, ETC.)
STARTING \$		PER YR.		NAME			
ENDING \$		PER YR.	ADDRESS				
NAME AND TITLE OF IMMEDIATE SUPERVISOR			CITY STATE ZIP				
AREA CODE AND PHONE NO.				REASON FOR LEAVING			
DESCRIPTION OF WORK		Are your employment records listed under another name? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what name? _____					

DATES OF EMPLOYMENT (MONTH/YEAR) FROM: _____ TO: _____				TITLE OF POSITION:			
SALARY OR EARNINGS			AVG. HOURS PER WEEK	NAME AND ADDRESS OF EMPLOYER			KIND OF BUSINESS OR ORGANIZATION (MANUFACTURING, ACCOUNTING, INSURANCE, ETC.)
STARTING \$		PER YR.		NAME			
ENDING \$		PER YR.	ADDRESS				
NAME AND TITLE OF IMMEDIATE SUPERVISOR			CITY STATE ZIP				
AREA CODE AND PHONE NO.				REASON FOR LEAVING			
DESCRIPTION OF WORK		Are your employment records listed under another name? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what name? _____					

NOTE: USE ADDITIONAL SHEETS IF NECESSARY. ATTACH INSIDE APPLICATION FORM

16. References: References must be provided with a completed application. List below a minimum of three persons not related to you who have knowledge of your professional work performance within the last three years.

Name: Name:
 Address: Address:
 Occupation: Occupation:
 Telephone number: Telephone number:
 Number of years acquainted: Number of years acquainted:

Name: Name:

Address: Address:

Occupation: Occupation:

Telephone number: Telephone number:

Number of years acquainted: Number of years acquainted:

CERTIFICATION/AGREEMENT

I have read and understand the above Record Release and Privacy Act Notice For Employment Forms. I hereby certify that this application is a complete record and that all entries and all attachments are true and accurate to the best of my knowledge. I understand that false or incomplete statements herein supplied are grounds for disqualification from employment consideration or termination of employment. I authorize SCHC to conduct a thorough background investigation, except as it pertains to race, origin, sex, age, or other non-job related criteria, to be used relative to my employment with the SCHC. I authorize my former employers and any other persons or organizations to provide any information they have about me, and I release all concerned from any liability in connection therewith. If permanent employment is offered, I understand that I will be required to pass a physical examination and drug screening given at SCHC's expense, and that my employment may be contingent upon successfully passing that examination. I release SCHC and any individual or entity providing information to SCHC from all liability for any damages from the disclosure of this information.

APPLICANT'S SIGNATURE

DATE (Month/Day/Year)

How were you referred to Shasta Community Health Center?

Internet

Newspaper

College Posting: List Name of College

Employment Agency

Other

Shasta Community Health Center Employee: Name