



**FAMILY HEALTH CENTERS
APPLICATION FOR EMPLOYMENT**

**Family Health
Centers**

716 – 1st Ave. S. / P.O. Box 1340, Okanogan, WA 98840
Ph: 509-422-5700 – Fax: 509-422-7680

MUST BE COMPLETED IN FULL TO BE CONSIDERED

PLEASE PRINT

Name: _____ Today's Date: _____
Last First Middle

Previous Name(s): _____ Social Security#: _____

Position Applied for: _____ Date Avail. To Work: _____ Wage Desired: _____

Address: _____
Street/PO Box City State Zip

Professional License #: _____ Expiration: _____ State(s): _____

Drivers License #: _____ State: _____ E-Mail: _____

Phone: (____) _____ (____) _____ (____) _____
Home Daytime Message / Cell

How did you learn about this job?: Ad Work Source Walk In Internet Other

FHC Employee – Name (for employee referral program): _____

Do you have any relatives employed here?: No Yes Name/Relationship: _____

Have you been employed here previously?: No Yes Dates (if yes): From: _____ To: _____

If you are under 18, can you furnish a work permit?: No Yes

Are you legally eligible to work in the United States?: No Yes

Type of employment desired: Full Time Part Time Temporary

If required, are you willing to work: Weekends Overtime

Check Site Preference: Okanogan Okanogan Dental Brewster Tonasket

Are you willing to drive between clinic sites if the job requires it?: No Yes

Have you ever been convicted of, or pleaded guilty to, a felony (in the last 7 years)?: No Yes

EDUCATION: (Please list actual dates attended)

School	Did you Graduate	Name of School	Location	Dates Attended	Course of Study	Diploma/Degree
<i>High School</i>						
<i>College/University</i>						
<i>Graduate School</i>						
<i>Other</i>						

LANGUAGE SKILLS: List any foreign language(s) and check skill level

Language: _____	<input type="checkbox"/> Read/Write/Speak	<input type="checkbox"/> Read/Write	<input type="checkbox"/> Read/Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Speak
Language: _____	<input type="checkbox"/> Read/Write/Speak	<input type="checkbox"/> Read/Write	<input type="checkbox"/> Read/Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Speak
Language: _____	<input type="checkbox"/> Read/Write/Speak	<input type="checkbox"/> Read/Write	<input type="checkbox"/> Read/Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Speak

EMPLOYMENT HISTORY

List most recent employer first. Include at least 10 years and account for any time gaps in your employment history, including any military service. (Attach additional sheet or resume if desired.) Please complete this section even if you are attaching a resume. “See Resume” is not sufficient.

Name of Employer: _____ Phone: (____) _____

Address: _____
Street/PO Box *City* *State* *Zip*

Job Title: _____ Date employed (mo/yr): From: _____ To: _____

Starting Salary: _____ hour _____ month Ending Salary: _____ hour _____ month

Supervisor: _____ May we contact your employer for a reference?: No Yes Later

Job Duties: _____

Your reason for leaving: _____

If you were unemployed at this time, list dates: From: _____ To: _____

Reason unemployed: _____

Name of Employer: _____ Phone: (____) _____

Address: _____
Street/PO Box *City* *State* *Zip*

Job Title: _____ Date employed (mo/yr): From: _____ To: _____

Starting Salary: _____ hour _____ month Ending Salary: _____ hour _____ month

Supervisor: _____ May we contact your employer for a reference?: No Yes Later

Job Duties: _____

Your reason for leaving: _____

If you were unemployed at this time, list dates: From: _____ To: _____

Reason unemployed: _____

EMPLOYMENT HISTORY

Name of Employer: _____		Phone: (____) _____	
Address: _____			
<i>Street/PO Box</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Job Title: _____		Date employed (mo/yr): From: _____ To: _____	
Starting Salary: _____ hour _____ month		Ending Salary: _____ hour _____ month	
Supervisor: _____ May we contact your employer for a reference?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Later			
Job Duties: _____			

Your reason for leaving: _____			

If you were unemployed at this time, list dates: From: _____ To: _____	
Reason unemployed: _____	

Name of Employer: _____		Phone: (____) _____	
Address: _____			
<i>Street/PO Box</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Job Title: _____		Date employed (mo/yr): From: _____ To: _____	
Starting Salary: _____ hour _____ month		Ending Salary: _____ hour _____ month	
Supervisor: _____ May we contact your employer for a reference?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Later			
Job Duties: _____			

Your reason for leaving: _____			

If you were unemployed at this time, list dates: From: _____ To: _____	
Reason unemployed: _____	

REFERENCES

List name and telephone number of three business/work/professional references that are NOT related to you.

Name: _____

Address: _____

Street/PO Box

City

State

Zip

Phone: (____) _____ or (____) _____

How do you know this person?: _____

Name: _____

Address: _____

Street/PO Box

City

State

Zip

Phone: (____) _____ or (____) _____

How do you know this person?: _____

Name: _____

Address: _____

Street/PO Box

City

State

Zip

Phone: (____) _____ or (____) _____

How do you know this person?: _____

SKILLS OR SPECIAL TRAINING

Check all skills, training or experience boxes that apply to you:

- Typing _____ WPM Data Entry Ten-Key by touch Multi-line phones Reception
- Medicare/Medicaid Medical Transcription Medical Terminology
- Patient Billing Insurance Billing ICD-9 & CPT Coding Collections
- Computers PowerPoint MSWord Excel Access Outlook
- Bookkeeping General Accounting AR/AP General Ledger Payroll

Patient Care: Dental Medical Sterile Technique Lab X-Ray Vital Signs Charting

I understand that Family Health Centers is obligated to provide a drug-free workplace in order to receive state and federal grant funds and that I will be required to pass a drug test before a final offer of employment is made.

Employment at Family Health Centers is at-will and that means my employment and compensation can be terminated with or without cause and with or without notice, at any time at the option of either the agency or myself.

I certify that the information set forth in this Application for Employment is true and complete to the best of my knowledge. I understand that, if employed, falsified statements on this application shall be considered sufficient cause for my dismissal. I understand that my employment shall be contingent upon proof of identity and verification of eligibility for employment in the United States in accordance with the Immigration Reform and Control Act of 1986. I further understand that my employment is contingent upon the checking of references furnished by me, and give the Employer the right to check and investigate such references. I consent to and authorize Family Health Centers and its personnel to request any information concerning my previous employment record as indicated on this Application for Employment. I hereby release all parties and persons connected with any request for information from all claims, liabilities and damages for whatever reason arising out of furnishing such job related information.

Signature of Applicant: _____

Date: _____



Request for Diploma

If you have indicated on your application that you have a degree, we will require proof of the degree from you. Please present a copy of your diploma(s) to Human Resources on your first day of employment.

Failure to produce proof of a degree may result in immediate termination of employment.

Please contact Human Resources with any questions you may have. Gail Cusick at gcusick@myfamilyhealth.org or 422-7603. Dolores Edelman at dedelman@myfamilyhealth.org or 422-7604.

VOLUNTARY AFFIRMATIVE ACTION INFORMATION

(COMPLETION OF INFORMATION BELOW IS VOLUNTARY & WILL BE KEPT CONFIDENTIAL)

We are an Equal Opportunity Employer and do not discriminate on the basis of race, color, religion, sex, age, national origin, disability, veteran status, sexual orientation or any other classification protected by Federal, state, or local law.

In an effort to comply with requirements regarding government recordkeeping, reporting and other legal obligations, we ask that you complete this applicant data survey. Your cooperation is appreciated.

Please be advised that your survey is not a part of your official application for employment. It is considered confidential information that will not be used in any hiring decision.

PLEASE PRINT & COMPLETE IN FULL:

Date: _____ Position Applied For: _____

Referral Source:

- Advertisement Relative Government Employment Agency Walk-in Internet/Website
- Private Employment Agency Employee _____ Other _____

Applicant's Full Name: _____ Date of Birth: _____

Check one: Male Female

Check one of the following Race/Ethnic Group:

- American Indian or Alaskan Native White Asian Asians, not Hispanic or Latino
- Native Hawaiian or Other Pacific Islander, not Hispanic or Latino Hispanic or Latino (All races)
- Hispanic or Latino (White race only) Hispanic or Latino (all other races)
- Two or more races, not Hispanic or Latino Black or African American

SPECIAL NOTICE TO VIETNAM ERA VETERANS, DISABLED VETERANS AND INDIVIDUALS WITH PHYSICAL OR MENTAL HANDICAPS OR DISABILITIES:

Government contractors subject to the Vietnam Era Veterans Readjustment Act of 1974 and the Rehabilitation Act of 1973 are required to take affirmative action to employ and advance in employment qualified disabled veterans and veterans of the Vietnam Era, and qualified handicapped individuals.

You are invited to volunteer this information, if you qualify, to assist in proper placement and determining reasonable accommodation. This information will be considered confidential, and refusal to provide this information will not adversely affect your consideration for employment.

IF YOU SO WISH TO BE IDENTIFIED, PLEASE CHECK IF ANY OF THE FOLLOWING ARE APPLICABLE:

- Vietnam Era Veteran Disabled Veteran Individual with Disability

Signature: _____ Date: _____

To be completed by applicant – Not for interview purposes – To be filed separately from application. This information is used to satisfy the Affirmative Action requirements of section 503 of the Rehabilitation Act or necessitated by another federal law or regulation.