FAMILY HEALTH CENTERS
APPLICATION FOR EMPLOYMENT

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: _____
Last *First* *Middle*

Today's Date: _____ **Date Avail. to Work:** _____ **Wage Desired:** _____

Position(s) applying for: _____

_____

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

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

E-Mail:_____

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

How did you learn about this job?: ☐ **Newspaper** ☐ **Walk In** ☐ **Internet** ☐ **Other**

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

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

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

Are you under age 18?: ☐ **Yes** ☐ **No** **If yes, can you furnish a work permit?:** ☐ **Yes** ☐ **No**

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

Type of employment desired: ☐ **Full Time** ☐ **Part Time** ☐ **Per Diem** ☐ **Temporary**

If required, are you willing to work: ☐ **Weekends** ☐ **Overtime**

Check Site Preference:
☐ **Okanogan Admin.** ☐ **Okanogan Dental** ☐ **Okanogan Call Center** ☐ **Omak Medical**
☐ **Brewster Jay Ave.** ☐ **Brewster Indian Ave.** ☐ **Brewster Dental** ☐ **Tonasket** ☐ **Oroville Dental**
☐ **Bridgeport Medical/Dental** ☐ **Twisp Medical**

Have you ever been convicted of a criminal offense?: ☐ **Yes** ☐ **No** *(If the answer is yes, you must explain on a separate sheet of paper and attach it to this application. Do not include any convictions that were sealed, eradicated, expunged or any convictions that resulted in a referral to a diversion program. A conviction record will not necessarily disqualify you from employment).*

FHC employees are required by the State of Washington Proclamation by the Governor to be fully vaccinated against COVID-19 with an authorized vaccine by October 18, 2021, unless an individual has declared and received an authorized exemption. Are you willing to receive a Covid19 Vaccination? ☐ **Yes** ☐ **No**

Have you ever in any way been excluded or otherwise ineligible for participation in federal health care programs?:
☐ **Yes** ☐ **No** *(A "yes" answer to this question will not necessarily bar the application from employment. If "yes", please explain in detail on a separate sheet of paper).*

EDUCATION:

School	Did you Graduate	Name of School	Location	Course of Study	Diploma/ Degree
High School					
College/ University					
Graduate School					
Other					

If you have indicated on your application that you have a degree, we will require proof should you become employed by Family Health Centers.

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

Language: _____ ☐ **Read/Write/Speak** ☐ **Read/Write** ☐ **Read/Speak** ☐ **Read** ☐ **Speak**

Language: _____ ☐ **Read/Write/Speak** ☐ **Read/Write** ☐ **Read/Speak** ☐ **Read** ☐ **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: _____

Supervisor: _____May we contact your employer for a reference?: ☐Yes ☐ No ☐ 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:** _____

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

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

Supervisor: _____ **May we contact your employer for a reference?:** ☐ **Yes** ☐ **No** ☐ **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: _____ **City** _____ **State** _____ **Zip** _____

Phone: (_____) _____ **or** (_____) _____

How do you know this person?: _____

Name: _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone: (_____) _____ **or** (_____) _____

How do you know this person?: _____

Name: _____

Address: _____ **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** ☐ **Data Entry** ☐ **Multi-line phones** ☐ **Reception** ☐ **Medicare/Medicaid** ☐ **EMR / EHR / EDR**
☐ **Medical Terminology** ☐ **Patient Billing** ☐ **Insurance Billing** ☐ **ICD-9 & CPT Coding**
☐ **Payroll** ☐ **Microsoft Office** ☐ **Google App.'s** ☐ **Google Docs/Sheets** ☐ **Medical Interpreting**
☐ **General Accounting** ☐ **AR/AP** ☐ **General Ledger** ☐ **Customer Service**
Patient Care: ☐ **Dental** ☐ **Medical** ☐ **Lab**

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. (A positive test result for Marijuana whether from recreational use or medically prescribed use will disqualify you for employment regardless of WA State law).

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.

Family Health Centers is committed to ensuring equal employment opportunities for all job applicants and employees. Employment decisions are based upon job-related reasons regardless of an applicant's race, color, religion, sex, sexual orientation, gender identity, age, national origin, disability, marital status, genetic information, protected veteran status, or any other status protected by law.

Signature of Applicant: _____ **Date:** _____/_____/_____

CHILD / ADULT ABUSE DISCLOSURE

In accordance with RCW 43.43.830-845, and because employees and volunteers of Family Health Centers will or may have unsupervised access to children under sixteen years of age, developmentally disabled persons or vulnerable adults, you as an applicant are required by law to disclose to Family Health Centers the following matters.

If you answer yes to any of the following questions please specify in the line directly below.

	Yes	No
Have you been convicted of any crime against children or other persons?		
Have you been convicted of crimes relating to financial exploitation if the victim was a vulnerable adult?		
Have you been convicted of crimes related to drugs as defined in RCW 43.43.830?		
Have you been found by a court in a domestic relations preceding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor?		
Have you been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult?		
Have you been found by a court in a protection proceeding under chapter 74.34 RCW, to have abused or financially exploited a vulnerable adult?		

I declare under penalty of perjury of law that the foregoing statement is true and correct.

Signed: _____ Date:_____

_____

Printed name

Voluntary Self-Identification of “Protected” Veteran Status

Why Are You Being Asked to Complete This Form?

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA). This Act requires Government contractors to take affirmative action to employ and advance in employment protected veterans. We are requesting that you inform us if you are a veteran covered by VEVRAA, the completion of this form is completely voluntary and confidential.

For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor’s Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How Do You Know If You Are a Veteran Protected by VEVRAA?

VEVRAA covers several categories of veterans from World War II, the Korean conflict, the Vietnam era, and the Persian Gulf War.

If you believe you belong to any of the categories of protected veterans please indicate by checking the appropriate box below.

[ ] I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED BELOW
[ ] I AM NOT A PROTECTED VETERAN
[ ] I DO NOT WISH TO ANSWER