

Employment Application

Cowlitz Family Health Center considers all applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status. Applicants that require reasonable accommodations for the application and/or interview process should notify our Human Resource Department at HR@cfamhc.org or 360-425-9210.

Applicant Information – Fill out completely

Position applied for: _____ **Date:** _____

Location(s) applied for:	<input type="checkbox"/> Administration	<input type="checkbox"/> Women, Infants, Children (WIC)	<input type="checkbox"/> Woodland Clinic
	<input type="checkbox"/> 12 th Avenue Clinic	<input type="checkbox"/> First Steps (MSS)	<input type="checkbox"/> Castle Rock Clinic
	<input type="checkbox"/> Longview Dental	<input type="checkbox"/> Kelso Clinic	<input type="checkbox"/> Toutle River Campus
	<input type="checkbox"/> Broadway Campus	<input type="checkbox"/> Grade Street Campus	<input type="checkbox"/> Wahkiakum Clinic
<input type="checkbox"/> Float	<input type="checkbox"/> 14 th Avenue Clinic	<input type="checkbox"/> Phoenix House	<input type="checkbox"/> North Beach Clinic

How did you hear about this position?

<input type="checkbox"/> Current Employee:	<input type="checkbox"/> Family Health Center Website
<input type="checkbox"/> Previous Employee:	<input type="checkbox"/> WorkSource Location:
<input type="checkbox"/> Newspaper:	<input type="checkbox"/> Other:

Name: Last _____ First _____ M.I. _____

Address: Street _____ Apt _____

City _____ State _____ ZIP Code _____

Home Phone: _____ Cell Phone: _____ Email: _____

Are you under the age of 18?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, can you provide required proof of your eligibility to work for Family Health Center?	<input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------------	---	--	---

Are you a citizen of the United States?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, are you able to provide proof of identity and legal right to work in the US prior to employment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---	---	---

Have you filled out an application here before?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when?
---	---	---------------

Have you ever worked for Family Health Center?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when?
--	---	---------------

Are you currently employed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, may we contact your present employer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
-----------------------------	---	---	---

Are you current on "lay-off" status and subject to recall?	<input type="checkbox"/> YES <input type="checkbox"/> NO	On what date would you be available to begin working?
--	---	---

If required for a position, do you have a valid Driver's License? YES NO

Availability

Please check the days and time frames that you are available to work

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Mornings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employment Application

Education									
High School:					Address:				
Degree:					Did you graduate? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Undergraduate School:					Address:				
Degree:					Date Degree Awarded:				
Graduate School:					Address:				
Degree:					Date Degree Awarded:				
Other (Please Specify):					Address:				
Degree:					Date Degree Awarded:				
Technology Proficiency									
Please rate your proficiency level in the following programs									
	Word	Excel	Outlook	Power Point	Health Pro	Wisdom	Internet	EPIC	Other
Never Used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beginner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advanced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language Skills									
Please indicate any foreign languages you can speak, read, and/or write.									
	Speak			Read			Write		
Fluent									
Good									
Fair									
Additional Skills and Training									
Summarize special job-related skills and training acquired from employment or other experience. List professional, trade, or business activities and offices/licenses/certifications held.									
WA Medical / Dental Certification / License Number and Expiration date:									

Employment Application

Employment History – Fill out completely		
Employer:		Employer Phone:
Supervisor Name:		Supervisor Phone:
May we contact your previous supervisor for a reference? <input type="checkbox"/> YES <input type="checkbox"/> NO		Supervisor Email:
Employer Address:		
Job Title:		
Responsibilities:		
Reason you are leaving:	Date From:	Date To:
Employer:		Employer Phone:
Supervisor Name:		Supervisor Phone:
May we contact your previous supervisor for a reference? <input type="checkbox"/> YES <input type="checkbox"/> NO		Supervisor Email:
Employer Address:		
Job Title:		
Responsibilities:		
Reason for leaving:	Date From:	Date To:
Employer:		Employer Phone:
Supervisor Name:		Supervisor Phone:
May we contact your previous supervisor for a reference? <input type="checkbox"/> YES <input type="checkbox"/> NO		Supervisor Email:
Employer Address:		
Job Title:		
Responsibilities:		
Reason for leaving:	Date From:	Date To:
Employer:		Employer Phone:
Supervisor Name:		Supervisor Phone:
May we contact your previous supervisor for a reference? <input type="checkbox"/> YES <input type="checkbox"/> NO		Supervisor Email:
Employer Address:		
Job Title:		
Responsibilities:		
Reason for leaving:	Date From:	Date To:

Employment Application

Disclaimer and Signature

I certify that answers given herein are true and complete to the best of my knowledge. 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 one year. 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 time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is 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 and/or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

I hereby understand and acknowledge that if selected, I will be required to provide proof of my identity and legal right to work in the United States prior to commencement of my employment with Family Health Center. I also understand and acknowledge that all new employees must provide documents establishing identity and employment eligibility within three (3) business days of beginning work, as required by the Immigration Reform and Control Act of 1986. It is further understood that employees hired for fewer than three (3) business days must provide such documentation when they begin work. Failure to comply with these requirements will result in termination.

I authorize my former employers to release information to Family Health Center for the purpose of determining my suitability for the position for which I have applied, and I release all parties from any liabilities arising there from. Family Health Center is holding the original of this release and the information supplied will be held in strict confidence. I also understand a criminal background verification screening will be performed.

Printed Name:

Signature:

Date:

Incomplete applications may not be considered. Please fill out all sections as applicable.