Employment Application

The 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:

- ☐ Administration
- ☐ 12th Avenue Clinic
- ☐ Longview Dental
- ☐ Broadway Campus
- ☐ 14th Avenue Clinic
- ☐ Women, Infants, Children (WIC)
- ☐ First Steps (MSS)
- ☐ Kelso Clinic
- ☐ Grade Street Campus
- ☐ Phoenix House
- ☐ Woodland Clinic
- ☐ Castle Rock Clinic
- ☐ Toutle River Campus
- ☐ Wahkiakum Clinic
- ☐ North Beach Clinic
- ☐ Float

How did you hear about this position?

- ☐ Current Employee:
- ☐ Previous Employee:
- ☐ Newspaper:
- ☐ Family Health Center Website
- ☐ WorkSource Location:
- ☐ 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?	☐YES ☐NO	If yes, can you provide required proof of your eligibility to work for Family Health Center?	☐YES ☐NO
Are you a citizen of the United States?	☐YES ☐NO	If no, are you able to provide proof of identity and legal right to work in the US prior to employment?	☐YES ☐NO
Have you filled out an application here before?	☐YES ☐NO	If yes, when?	
Have you ever worked for Family Health Center?	☐YES ☐NO	If yes, when?	
Are you currently employed?	☐YES ☐NO	If yes, may we contact your present employer?	☐YES ☐NO
Are you current on "lay-off" status and subject to recall?	☐YES ☐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	☐	☐	☐	☐	☐	☐	☐
Afternoons	☐	☐	☐	☐	☐	☐	☐
Evenings	☐	☐	☐	☐	☐	☐	☐
Nights	☐	☐	☐	☐	☐	☐	☐

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Education	
High School:	Address:
Degree:	Did you graduate? ☐YES ☐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	☐	☐	☐	☐	☐	☐	☐	☐	☐
Beginner	☐	☐	☐	☐	☐	☐	☐	☐	☐
Intermediate	☐	☐	☐	☐	☐	☐	☐	☐	☐
Advanced	☐	☐	☐	☐	☐	☐	☐	☐	☐

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:

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Employment History – Fill out completely			
Employer:		Employer Phone:	
Supervisor Name:		Supervisor Phone:	
May we contact your previous supervisor for a reference?	☐YES ☐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?	☐YES ☐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?	☐YES ☐NO	Supervisor Email:	
Employer Address:			
Job Title:			
Responsibilities:			

Disclaimer and Signature		
Reason for leaving:	Date From:	Date To:

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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.