

**1401 Bailey Avenue**

**Needles, CA 92363**

**(760) 326-7100**

**PLEASE READ CAREFULLY. COMPLETE ALL QUESTIONS. PRINT CLEARLY IN INK.**

|  |
| --- |
| **PERSONAL** |
| TODAY’S DATE: | LAST NAME FIRST MIDDLE: SOCIAL SECURITY NUMBER |
| HOME STREET APT. CITY STATE ZIP CODEADDRESS: |
| HOME PHONE( )  | MESSAGE PHONE( ) | ARE YOU 18 OR OLDER: 🞏 YES 🞏 NOIF HIRED, YOU WILL BE REQUIRED TO SUBMIT PROOF OF AGE |
| NAME OF PERSON THROUGH WHOM YOU MAY BE CONTACTED FOR MESSAGE PURPOSES:ADDRESS: PHONE: |
| IF HIRED, CAN YOU FURNISH PROOF THAT YOU ARE LEGALLY PERMITTED TO WORK IN THE UNITED STATES:🞏 YES 🞏 NO |
| WHAT OTHER NAME HAVE YOU BEEN EMPLOYED UNDER IF DIFFERENT FROM PRESENT NAME? |
| NAMES OF RELATIVES EMPLOYED BY THIS FACILITY: | DEPARTMENT: |
| HOW DID YOU LEARN OF THIS JOB OPENING? | HAVE YOU PREVIOUSLY BEEN EMPLOYED BY COMMUNITY HEALTHCARE PARTNER INC.?🞏 YES 🞏 NOIF YES, WHEN?WHEN:  |
| **EDUCATIONAL RECORD** |
| HIGH SCHOOL | LOCATION | CIRCLE LAST GRADE COMPLETED9 10 11 12 | DIPLOMA? |
| COLLEGE | LOCATION | 1 2 3 4 | DEGREE/MAJOR |
| COLLEGE | LOCATION | 1 2 3 4 | DEGREE/MAJOR |
| OTHER EDUCATION, SPECIAL COURSES, OR ACADEMIC HONORS |
| COLLEGES IN WHICH YOU ARE CURRENTLY ENROLLED: |
| **PROFESSIONAL LICENSES/CERTIFICATION** |
| TYPE | NUMBER | STATE ISSUED | DATE ISSUED | EXPIRES ON | *OFFICE USE ONLY**CONFIRMED* |
| TYPE | NUMBER | STATE ISSUED | DATE ISSUED | EXPIRES ON | *OFFICE USE ONLY**CONFIRMED* |
| LISTED ANY PROFESSIONAL ORGANIZATION OF WHICH YOU ARE A MEMBER (You may omit any which indicates, sex, religion, national origin, ancestry, handicap or disability, race, age, sexual orientation, marital status or Veteran’s status): |
| **U.S. MILITARY EXPERIENCE** |
| BRANCH | INITIAL RANK | FINAL RANK |
| SERVICE SCHOOLS ATTENDED: |
| SPECIALTY (Nature of Duties): |
| **SKILLS** |
| TYPING SPEED: (Last Date Tested) | SHORTHAND SPEED : (Last Date Tested) | 10 KEY ADD, MACH. BY TOUCH🞏 YES 🞏 NO | PBX (Type Board) | MEDICAL TERMINOLOGY?🞏 YES 🞏 NO |
| LIST OTHER KNOWLEDGE OR SKILLS YOU POSSESS OR EQUIPMENT YOU CAN OPERATE: |

|  |
| --- |
| **JOB INTEREST** |
| FIRST CHOICE | SECOND CHOICE | DATE AVAILABLE | SALARY DESIRED: |
| HOURS & SHIFTAVAILABLE | FULL TIME YES  NO | PART TIME YES  NO | ON CALL YES  NO | DAYS YES  NO | EVENINGS YES  NO | NIGHTS YES  NO | WEEKENDS YES  NO |
| **EMPLOYMENT HISTORY****MOST RECENT EMPLOYER FIRST – EXPLAIN ANY LAPSES IN EMPLOYMENT BETWEEN JOBS** |
| PRESENT COMPANY MAY WE CONTACT?  YES  NO | PHONE NUMBER |
| ADDRESS |  FULL  PART AVERAGETIME TIME HOURS WEEK LY |
| JOB TITLE: IMMEDIATE SUPERVISOR | EMPLOYED |
| NATURE OF DUTIES: | FROM:MO: YR | TO:MO: YR: |
| REASON FOR LEAVING (Also indicate resigned, discharged, etc) | EXPLAIN TIME LAPSE:  |

|  |  |
| --- | --- |
| PRESENT COMPANY MAY WE CONTACT?  YES  NO | PHONE NUMBER |
| ADDRESS |  FULL  PART AVERAGETIME TIME HOURS WEEK LY |
| JOB TITLE: IMMEDIATE SUPERVISOR | EMPLOYED |
| NATURE OF DUTIES: | FROM:MO: YR | TO:MO: YR: |
| REASON FOR LEAVING (Also indicate resigned, discharged, etc) | EXPLAIN TIME LAPSE:  |

|  |  |
| --- | --- |
| PRESENT COMPANY MAY WE CONTACT?  YES  NO | PHONE NUMBER |
| ADDRESS |  FULL  PART AVERAGETIME TIME HOURS WEEK LY |
| JOB TITLE: IMMEDIATE SUPERVISOR | EMPLOYED |
| NATURE OF DUTIES: | FROM:MO: YR | TO:MO: YR: |
| REASON FOR LEAVING (Also indicate resigned, discharged, etc) | EXPLAIN TIME LAPSE:  |

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and I agree to have any of the statements checked by the Hospital unless I have indicated to the contrary. I authorize the references listed above to provide the Hospital any and all information concerning my previous employment and any pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to the Hospital as well as from the use or disclosure of such information by the Hospital or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or my omission of information on this application may result in my failure to receive an offer or, if I am hired, in my dismissal from employment.

In consideration of my employment, I agree to conform to the rules and standards of the Hospital and agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, either at my option or at the option of the Hospital. I understand that no employee or representative of the Hospital other than the president of the parent company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing. Furthermore the president of the parent company may not alter the at-will nature of the employment relationship unless he/she does so specifically and in writing. I also understand that all offers for employment are conditioned on the provision of satisfactory proof of an applicant’s identity and legal right to work in the U.S.

I understand that any offer of employment with the Hospital will be conditioned on completing a satisfactory background check, pre-employment medical examination, pre- employment drug and alcohol test. A purpose of the medical examination is to determine whether I am able to perform the essential functions of the job I am offered with or without reasonable accommodation, to identify any reasonable accommodation if such is warranted, and to ensure that my performance of the essential functions does not present a direct threat to my health and safety or the health and safety of others. I agree to undergo such a pre-employment medical examination and drug and alcohol test. If hired by the Hospital. I further agree to undergo any periodic medical examinations, which are permitted or required by law.

The Hospital and C.H.P., Inc. comply with Federal and State laws which prohibit discrimination on the basis of race, color, age, sex, religion, national origin, ancestry, disability, or handicapped Veteran status, medical condition (as defined by California Law), sexual orientation, marital status and Political Affiliation.

Applicants Signature Date

**EEO GOVERNMENT REPORT DATA COLLECTION**

APPLICANTS FOR EMPLOYMENT

THIS INFORMATION REQUESTED ON THIS FORM IS REQUIRED FOR FEDERAL GOVERNMENT REPORTING REGULATIONS. THIS INFORMATION IS KEPT **SEPARATE** FROM EMPLOYMENT APPLICATIONS AND WILL NOT AFFECT YOUR CANDIDACY FOR EMPLOYMENT.

Social Security Number:

|  |  |
| --- | --- |
|  | APPLICANTS NAME: (LAST, FIRST, MI) |
|  | EEO RACE CODE (PLEASE CHECK BOX WHICH DESIGNATES YOUR RACE) WHITE  BLACK  HISPANIC  ASIAN OR PACIFIC ISLANDER  AMERICAN INDIAN/ALASKAN NATIVE |
|  | DISABILITY STATUS: (PLEASE CHECK APPROPRIATE BOX) YES  NODEFINITION: ANY PERSON WHO HAS A PHYSICAL OR MENTAL IMPAIRMENT THAT SUBSTANTIALLY LIMITS ONE OR MORE MAJOR LIFE ACTIVITIES HAS A RECORD OF SUCH IMPAIRMENTS OR IS REGARDED AS HAVING SUCH IMPAIRMENTS, ACCOMMODATION REQUIRED |
|  | VETERAN STATUS: (PLEASE CHECK APPROPRIATE BOX) VIETNAM ERA VETERANS: Is a person who served on active duty for a period of more than 180 days, any part of which occurred between 8/5/61 to 5/7/74 and has any discharge other than dishonorable. DISABLED VIETNAM VETERAN: 30% or more V.A. certified disability incurred or aggravated on duty between 8/5/61 to 5/7/74. DISABLED VETERAN: (NOT VIETNAM) 30% or more V.A. certified disability incurred or aggravated in the line of duty before 8/5/64 or after5/7/74. |
|  | ARE YOU OVER FORTY (40), BUT UNDER THE AGE OF SEVENTY (70)  YES  NO |
|  | PLEASE STATE THE POSITION YOU ARE APPLYING FOR: |
|  | WHAT SOURCE PROMPTED YOU TO APPLY? (EMPLOYEE REFERRAL, NEWSPAPER ADVERTISEMENT, STATE JOBSERVICE OR OTHER)IF ADVERTISEMENT, PLEASE GIVE NAME OF PUBLICATION: IF EMPLOYEE REFERRAL, PLEASE GIVE PERSON(S) NAME: |

IT IS THE POLICY OF COMMUNITY HEALTHCARE PARTNER INC TO TREAT QUALIFIED DISABLED INDIVIDUALS, DISABLED VETERANS AND VETERANS OF THE VIETNAM ERA WITHOUT DISCRIMINATION AND TO FULFILL ITS COMMITMENT TO EQUAL EMPLOYMENT OPPORTUNITY AND THE PROVISIONS OF SECTION 503 OF THE REHABILITATION ACT OF 1973 AND SECTION 402 OF THE VETERAN’S READJUSTMENT ASSISTANCE ACT OF 1974. BOTH ACTS REQUIRE FEDERAL CONTRACTORS TO MAINTAIN AFFIRMATIVE ACTION PROGRAMS FOR APPLICANTS AND EMPLOYEES COVERED BY THESE ACTS. THEY ALSO REQUIRE THAT ALL APPLICANTS BE AFFORDED THE OPPORTUNITY TO VOLUNTARILY IDENTIFY THEMSELVES AS BEING DISABLED INDIVIDUALS, DISABLED VETERANS AND/OR VETERANS OF THE VIETNAM ERA IN ORDER THAT APPLICANTS AND/OR EMPLOYEES MAY DERIVE BENEFITS UNDER THEIR PROVISIONS.

 I HAVE READ THE ABOVE STATEMENT AND VOLUNTARILY PROVIDED THE REQUESTED INFORMATION TO BE USED FOR THE PURPOSE STATED.

 I HAVE READ THE ABOVE STATEMENT AND DECLINE THE INVITATION TO PROVIDE THE REQUESTED INFORMATION.

DATE SIGNATURE