



Working Together to Improve Lives in Our Communities
An Equal Opportunity Employer

Each question should be fully and accurately answered. No action can be taken on this application until all questions have been answered. Use blank paper if you do not have enough room on this application. **PLEASE PRINT**, except for signature on last page of application. All information given will be available only to persons who have a “need to know” or as required by law. The Health Center will make reasonable accommodation in the application process, if needed.

Date of application: _____

Name: _____ Social Security Number: _____
Last First Middle

Address: _____

Telephone: () _____ () _____ () _____
No. Street City State Zip Code

Day Evening Cellular

Position(s) applied for: _____ Date available: _____

How did you learn about this job? () Advertisement () Employment Agency () Friend () Relative () Other _____

Are you interested in: () Full-time () Part-time () Temporary

Are you under 18 years of age? ()Yes ()No If yes, indicate age at last birthday: _____

Have you ever filed an application with us before? ()Yes ()No If yes, give dates: _____

Have you ever been employed with us before? ()Yes ()No If yes, give dates: _____

Do any of your friends or relatives work here? ()Yes ()No
If yes, state name and relationship: _____

Are you eligible to work in the United States? ()Yes ()No Do you speak more than one language? ()Yes ()No

Have you been convicted of a crime in the past ten (10) years excluding misdemeanors and summary offenses?
()Yes ()No If yes, when? _____

For Driving Job Only: Do you have a valid driver’s license? ()Yes ()No
License Number and State Issued: _____

EDUCATION (Circle last year completed)	SCHOOL NAME	MAJOR/ Year Completed	DEGREE
Elementary & Jr. High 5 6 7 8	_____	_____	_____
High School 9 10 11 12	_____	_____	_____
College 1 2 3 4	_____	_____	_____
Other job-related education	_____	_____	_____

Professional Idaho License Number of Registration: _____ Verified By: _____

Other States Registered In: _____

EMPLOYMENT HISTORY:

List present position first. Include pertinent Armed Forces Experience.

1. Employer: _____ Telephone: _____

Address: _____ Present Job Title: _____

Dates: From _____ To _____ Salary: _____

Supervisor: _____ Reason for leaving: _____

Duties: _____

May we contact your current employer? ()Yes ()No

2. Employer: _____ Telephone: _____

Address: _____ Present Job Title: _____

Dates: From _____ To _____ Salary: _____

Supervisor: _____ Reason for leaving: _____

Duties: _____

3. Employer: _____ Telephone: _____

Address: _____ Present Job Title: _____

Dates: From _____ To _____ Salary: _____

Supervisor: _____ Reason for leaving: _____

Duties: _____

4. Employer: _____ Telephone: _____

Address: _____ Present Job Title: _____

Dates: From _____ To _____ Salary: _____

Supervisor: _____ Reason for leaving: _____

Duties: _____

Summary of other related work experience: _____

Describe any specialized training, skills and extra-curricular activities:

List professional, trade, business or civic activities and offices held:

Other Qualifications (Summarize special job-related skills and qualifications acquired from employment or other experience.)

Specialized Skills (Please List):

REFERENCES: (Do not include family members)

Name:	Telephone	Number of Years Known:	Occupation
_____	() _____	_____	_____
_____	() _____	_____	_____
_____	() _____	_____	_____

PLEASE READ CAREFULLY BEFORE SIGNING:

Adams County Health Center Inc. (ACHC) is an equal opportunity employer and considers all applicants on the basis of job qualifications. Your application will be given every consideration, but our receipt of it does not guarantee that you will be employed. If you have questions, ACHC personnel will be happy to assist you.

Should I become an employee, I agree to abide by the policies and procedures as set out by Adams County Health Center Inc. I understand that this application is not intended to be a contract for employment.

I certify that all statements made by me on this application are true, complete and correct to the best of my knowledge. I hereby grant permission to Adams County Health Center Inc. and its personnel to confirm by personal inquiry or otherwise, the information I have given in the employment process is current and correct. I understand that any willful misrepresentation of facts given in this process may be grounds for rejection of this application or dismissal if employed.

I understand that if I am employed, such employment is for no definite period of time and that Adams County Health Center Inc. can change wages, benefits, policies, and working conditions at any time.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS:

Signature of Applicant

Date Signed

Basic Personal Computer Skills Assessment

The purpose of this assessment is to help us determine needs for basic computer training in the practice.

Name: _____ Date: _____

	No	Yes (Home)	Yes (Work)
1. Do you currently use a Computer (PC/MAC, laptop, or other mobile device?)			
2. Do you use the Internet?			
3. Do you use E-mail? (i.e. Microsoft Outlook)			
4. Do you use any Microsoft Office products? (Word, Excel, etc.)			

5. Do you know how to double-click and right-click a mouse?

- No
- Yes

6. Mark the box that best describes your typing skills:

- Have never typed
- Use the "hunt and peck" method
- Type 15-25 WPM
- Type 25-40 WPM
- Type greater than 40 WPM

7. If prior experience working in healthcare, have you ever used an Electronic Health Record or electronic scheduling system?

- No
- Yes
- N/A