

Family Health Centers

OF SOUTHWEST FLORIDA, INC.

APPLICATION FOR EMPLOYMENT

It is important that you answer all questions on this application fully and truthfully, as failure to do so may delay consideration for employment or result in loss of employment opportunities. If an item does not apply to you, write NA (not applicable). This application will remain on active file for six months from today's date

Equal Opportunity Employer • Drug-Free / Smoke-Free Workplace

Please answer every question. USE INK.

PRINT

Today's Date ____/____/____

NAME _____
(FIRST) (MIDDLE) (LAST)

BUSINESS PHONE () _____

ADDRESS _____
(NUMBER) (STREET)

HOME PHONE () _____

(CITY) (STATE) (ZIP CODE)

FROM HERE ON, PLEASE WRITE IN YOUR NORMAL HANDWRITING

Type of Employment Desired: Full-Time Part-Time If part-time, hours available _____ Temporary

Position Applied For: First Choice: _____ Second Choice: _____

If hired, when could you be available to start work? _____ Date ____/____/____ Comments: _____

Work assignments are made based on the needs of the patient. Assignments may change and include work evenings and on weekends.

Are you willing to meet these requirements? Yes No

Have you previously applied for work at Family Health Centers before? Yes No If yes, give date _____ Location _____

Are you under age 18? Yes No If yes, what is your birthdate? ____/____/____

Have you previously been employed by Family Health Centers of Southwest Florida, Inc.? Yes No If yes, provide dates of employment, location and name of supervisor: _____

Do you currently have relatives employed by Family Health Centers? Yes No If yes, provide names, relationships to you and positions. _____

Can you submit verification of your legal right to operate a motor vehicle in this state? Yes No

Have you ever been convicted of a crime, pleaded no to contendre, or have had adjudication withheld, or are there any currently pending charges against you? Yes No

If yes, please describe all relevant details, including the date and nature, and any other information you believe is appropriate to a determination of your fitness for employment in the position for which you are applying. (Note: Answering yes to the above is not an automatic bar to employment. We will consider the nature of the offense, the date of the offense, rehabilitation program and the relationship between the offense and the position for which you are applying before making a decision.)

MILITARY SERVICE RECORD

Have you ever served in the Armed Forces of the United States? Yes No Branch of service _____

Date of entry into service _____ Rank of entry _____ Date of discharge ____/____/____

Military training received? _____

Types of duties performed _____

EMPLOYMENT HISTORY

THIS SECTION MUST BE COMPLETED REGARDLESS OF WHETHER OR NOT A RESUME IS ATTACHED. Beginning with your **PRESENT** or most recent employment, list in REVERSE ORDER, ALL periods of employment. Each time you changed jobs or your title changed should be listed as a separate period. Be sure to describe your military experience, if any. Describe, **IN DETAIL**, your specific duties beginning with your primary duties. (Attach additional sheets if necessary.)

Are you presently employed? Yes No May we contact your present employer? Yes No

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|--|------|-------|------|--------------|--------------------------------|--------------------|--------------------|---------------|--|
| 1 Employer | | | | | Address | | | | |
| Your Official Job Title | | | | | Supervisor's Name | | | Phone Number | |
| FROM | | TO | | Total Months | number of hours per week _____ | Beginning Salary | | Ending Salary | |
| Month | Year | Month | Year | | | \$ _____ per _____ | \$ _____ per _____ | | |
| Reason for leaving or desiring to leave: | | | | | | | | | |
| Describe your duties in detail: | | | | | | | | | |
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| 2 Employer | | | | | Address | | | | |
| Your Official Job Title | | | | | Supervisor's Name | | | Phone Number | |
| FROM | | TO | | Total Months | number of hours per week _____ | Beginning Salary | | Ending Salary | |
| Month | Year | Month | Year | | | \$ _____ per _____ | \$ _____ per _____ | | |
| Reason for leaving | | | | | | | | | |
| Describe your duties in detail: | | | | | | | | | |
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|---------------------------------|------|-------|------|--------------|--------------------------------|--------------------|--------------------|---------------|--|
| 3 Employer | | | | | Address | | | | |
| Your Official Job Title | | | | | Supervisor's Name | | | Phone Number | |
| FROM | | TO | | Total Months | number of hours per week _____ | Beginning Salary | | Ending Salary | |
| Month | Year | Month | Year | | | \$ _____ per _____ | \$ _____ per _____ | | |
| Reason for leaving | | | | | | | | | |
| Describe your duties in detail: | | | | | | | | | |
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For reference purposes, please indicate if you were employed under another name by any of the above employers. If so, indicate name. _____

Name two (2) persons in your field who know you, and whom we have your permission to contact immediately for Professional/Technical references. Preferably, these should be individuals with whom you have worked.

| NAME | EMPLOYER | BUSINESS PHONE | RELATIONSHIP |
|------|----------|----------------|--------------|
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GENERAL INFORMATION

Use the space below to describe your interest in Family Health Centers and the skills and aptitudes that you feel qualify you for a position with us. (You may wish to include civic and community activities, professional societies (excluding unions) in which you participated, special training or skills such as typing, accounting and the like.)

This space is provided for any additional information which you feel is important in considering you for the job for which you have applied.

APPLICANT'S CERTIFICATION & AGREEMENT

Please read before signing. If you have any questions regarding this statement, please ask them of the person who provided you with this application.

I certify that the answers given by me to the questions and statements on this application are true and correct without important omissions of any kind whatsoever. I understand that all information which I provided in this application is subject to independent verification on a routine basis as part of the hiring process. I understand that if employed, falsified statements, answers or omissions shall be considered sufficient cause for discharge, even if discovered at a later date. I authorize the hospitals, companies, schools or persons named to give any information regarding my employment, together with any information they may have regarding me, whether or not it is in their records. I hereby release said hospitals, companies, schools or persons from all liability for any damage for issuing this information. In addition, if accepted for employment, I hereby agree to abide by the rules and policies of Family Health Centers. I further understand that I must submit proof of my eligibility to work in the United States upon hire (green card, driver's license, birth certificate, and social security card). I also agree upon termination of my employment to return any property issued to me or allow the value of the same to be deducted from my wages. This application is not a contract of employment and that in consideration of my employment, I agree that any consideration and employment can be terminated at any time at the option of Family Health Centers or myself. As a condition of employment, I understand that Family Health Centers has a drug-free workplace and that I will comply with all aspects of that policy. I further understand that any offer of employment is contingent upon the results of a pre-employment drug test.

Signed: _____ Date: _____