

**APPLICATION FOR EMPLOYMENT
SHAWNEE FAMILY HEALTH CENTER**

Human Resources Office

P.O. Box 1507

Portsmouth, OH 45662

Phone: (740) 354-7702 Fax: (740) 353-1662

The Shawnee Family Health Center (SFHC) is committed to providing equal employment opportunities to all prospective and current employees on the basis of individual qualifications, experience and SFHC need. Discrimination based on race, age, sex, religion, national origin, disability, color, ancestry, military status, sexual orientation, gender identity, genetic information, or other protected class will not be tolerated. Applicable state and federal laws, in addition to rules and regulations governing fair employment practices, will be followed.

All applicants identified for employment with the SFHC will undergo (pre-employment/post-offer) testing for the presence of illegal drugs as a condition of employment. Any employment offer will be contingent upon satisfactory completion of a drug test. Because of requirements imposed by the Ohio MHAS, certain positions at SFHC require a physical examination following an offer of employment for such positions with annual physicals thereafter. A failure to receive a satisfactory fitness for duty report from the examining physician, may result in withdrawal of the offer of employment, or discharge. You may elect not to apply for these positions and no post offer physical examination will be required and you will be considered for all other available positions for which you qualify without further inquiry.

Submission of this application form does not indicate that there are any position vacancies, nor does it in any way obligate the SFHC. Failure to complete the application in its entirety may be cause for exclusion of employment consideration. Falsification of information on the application may result in exclusion of employment consideration or immediate discharge from employment.

PERSONAL INFORMATION

Full Name (Last, First, Middle): _____

Email Address: _____

Social Security Number: _____

Are you 21 years of age or older? Yes No

Telephone: Home () _____ Cell () _____ Have you ever worked here before? Yes No

Address: _____
Street/P.O. Box City State Zip Code County of Residence

Are you legally eligible to work in the U.S.? Yes No If no, indicate your visa status: _____

(Note: All prospective employees must submit proof of identity and eligibility for employment in the U.S.)

Do you have relatives working here? Yes No If yes, who? _____

Do you possess a valid drivers license? Yes No License #: _____ State: _____ Exp Date: _____

POSITION APPLYING FOR: _____ DATE YOU ARE AVAILABLE FOR WORK: _____

1. _____ Salary Expected: _____

2. _____ Salary Expected: _____

3. _____ Salary Expected: _____

Are you willing to work weekends, on-call, and/or holidays as SCHEDULED? Yes No

Please indicate employment you would accept: Full-Time Part-Time Temporary

If Part-Time, indicate days and hours available for work: _____

EDUCATION INFORMATION:

High School Education *You may be required to submit a copy of your diploma or GED certificate*

School Name: _____
Address: City: _____ State: _____
Did you Graduate: YES NO if no, have you passed a GED test? YES NO

Undergraduate Education *You may be required to submit a transcript or obtain an official copy of degree*

School Name: _____
Address: City: _____ State: _____ Country: _____
Years Attended: _____
Degree Earned: _____

Graduate Education *You may be required to submit a transcript or obtain an official copy of degree*

School Name: _____
Address: City: _____ State: _____ Country: _____
Years Attended: _____
Degree Earned: _____

PROFESSIONAL LICENSES (if applicable):						
State:	License #:	Type:	Issue Date:	Expiration Date:	Currently practicing?	Ever been suspended or revoked?
					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

MILITARY SERVICE: Branch: _____ Dates: (From) _____ (To) _____

Military
Education/Training/Experience: _____
Job Title/Duties: _____
Reason for Leaving: _____

PROFESSIONAL AND EMPLOYMENT REFERENCES (do not list relatives or former supervisors):

List three individuals who have knowledge of your qualifications and fitness for the position for which you are applying and who may be contacted during the recruiting process.

NAME	JOB TITLE/COMPANY	ADDRESS	DAYTIME PHONE #
1. _____			
2. _____			
3. _____			

WORK HISTORY

LIST BELOW ALL PRESENT AND PAST EMPLOYMENT, BEGINNING WITH YOUR MOST RECENT

1. EMPLOYER:		ADDRESS:	PHONE NUMBER:
DATE OF EMPLOYMENT:	STARTING SALARY:	SALARY ON LEAVING:	
DATE LEFT:	STARTING POSITION:		
	POSITION ON LEAVING:		
NAME/TITLE OF SUPERVISOR:			
REASON FOR LEAVING:			
DESCRIPTION OF DUTIES:			
2. EMPLOYER:		ADDRESS:	PHONE NUMBER:
DATE OF EMPLOYMENT:	STARTING SALARY:	SALARY ON LEAVING:	
DATE LEFT:	STARTING POSITION:		
	POSITION ON LEAVING:		
NAME/TITLE OF SUPERVISOR:			
REASON FOR LEAVING:			
DESCRIPTION OF DUTIES:			
3. EMPLOYER:		ADDRESS:	PHONE NUMBER:
DATE OF EMPLOYMENT:	STARTING SALARY:	SALARY ON LEAVING:	
DATE LEFT:	STARTING POSITION:		
	POSITION ON LEAVING:		
NAME/TITLE OF SUPERVISOR:			
REASON FOR LEAVING:			
DESCRIPTION OF DUTIES:			
4. EMPLOYER:		ADDRESS:	PHONE NUMBER:
DATE OF EMPLOYMENT:	STARTING SALARY:	SALARY ON LEAVING:	
DATE LEFT:	STARTING POSITION:		
	POSITION ON LEAVING:		
NAME/TITLE OF SUPERVISOR:			
REASON FOR LEAVING:			
DESCRIPTION OF DUTIES:			

Have you had any employment other than listed above? YES NO May we contact the employers listed above? YES NO
 If no, indicate by number which one(s) you do not wish us to contact: 1 2 3 4
 Reason(s):

In order for the family health center to verify your work and educational records, it is important for us to know if any of your records would be under another name. If so, please explain:

Have you ever been convicted of a felony? YES NO (Conviction will not necessarily disqualify an applicant for employment.) If so, describe in full (include dates, locations, types and dispositions):

IF YOU ARE APPLYING FOR A CLERICAL POSITION, PLEASE COMPLETE THE FOLLOWING:

Medical terminology Yes No Medical transcription Yes No

Computer skills Yes No Keyboarding Yes wpm: _____ No

List computer software skills: _____

Receptionist/switchboard skills: _____

Please provide any additional information you consider important but which is not requested in the application:

HOW WERE YOU REFERRED TO THE FAMILY HEALTH CENTER?

- CLASSIFIED ADVERTISEMENT AGENCY / WEBSITE SFHC EMPLOYEE OTHER

PLEASE READ CAREFULLY BEFORE SIGNING: I certify that the information on this application for employment is true and complete to the best of my knowledge. I understand that any misleading or incorrect statements may render this application void and would be sufficient cause for termination in the event of employment. I understand that prior to final acceptance for employment, I may be required to pass a finger printing background check, as well as medical tests, including drug testing, given at the discretion of SFHC. Should I accept employment with SFHC, Inc., I hereby agree that it would be with the understanding that I will abide by the policies and procedures of the Agency.

As an applicant for a position with SFHC, Inc., I hereby authorize SFHC to conduct an investigation of my past, I further authorize all current and/or past employers to release any information, including investigations which are not of record, to SFHC. I release all persons who disclose such information from any liability. I understand that any offer of employment is contingent upon a completed background check.

As an applicant I give my consent to undergo a drug test and to the collection of a urine sample for designated testing for the purpose of detecting the presence of narcotics and other drugs, as well as signs of abuse of legal drugs. I consent to the release of any medical records related to the drug test to SFHC. I agree to not file or pursue any complaints, claims or legal actions of any kind against SFHC or any of its employees, representatives, or agents arising out of their activities or actions performed in connection with drug testing.

I understand that employment at this Agency is AT WILL which means that either I or Shawnee Family Health Center can terminate the employment relationship at any time, with or without prior notice, and for any reason not prohibited by law. All employment is continued on that basis . I understand that no supervisor, manager or director of this Agency, other than the Chief Executive Officer, has any authority to alter the foregoing.

As specified in the Immigration and Reform Control Act of 1986, if I am offered employment, I am aware that I will be required to prove my identity and verify my eligibility to work in the United States.

SIGNATURE OF APPLICANT

Date