HI-DESERT FAMILY HEALTH CLINICS
MORONGO BASIN HEALTHCARE DISTRICT

APPLICATION FOR EMPLOYMENT

Administrative Offices | 58383 29 Palms Highway, Suite 101 | Yucca Valley, CA 92284 | 760-366-1548 | hidesertclinics.org

Hi-Desert Family Health Clinics afford equal employment opportunity regardless of sex, age, race, color, religious creed, national origin, ancestry, marital status, physical or mental disability, or sexual orientation. All areas of the application must be filled out completely and accurately. Please fill in the required information directly on the application and do not indicate "see resume." If you have any questions about completing the application, it is important to please ask the Hi-Desert Family Health Clinic representative who has been assisting you.

PERSONAL DATA

Date ____________________

Name ____________________ ____________________ ________
Last Name First Name Initial

Present Address ____
Street Number and Name

____ ( ) ____________________
City, State, Zip Code Area Code Telephone Number

Mailing Address if different from above:

____
Street Number and Name City, State, Zip Code

Other names under which you have worked ________________________________

Are you over 18 years of age? ❒Yes ❒No If under 18 can you, after employment, submit a work permit? ❒Yes ❒No

Can you, after employment, submit verification of your legal right to work in the U.S.? ❒ Yes ❒ No

Can you, after employment, submit proof of age? ❒ Yes ❒ No

Have you ever been convicted of a crime (misdemeanor or felony)? ❒ Yes ❒ No *(Conviction may not necessarily disqualify an applicant from employment).* If yes, please list all convictions, giving dates, location and disposition of your case(s).

____

____

Have you been convicted of a crime as defined in 42 U.S.C. 1320a-7b(f)? ❒ Yes ❒ No

If yes, please explain: ____

Alternative contact person:

____
Name Address Telephone

ALL APPLICANTS ARE SUBJECT TO PRE-EMPLOYMENT DRUG SCREENING PROCEDURES

POSITION DESIRED

Position(s) applied for ____________________ ____________________
First Choice Second Choice

Specify: ❒ Full-Time ❒ Part-Time ❒ On-Call ❒ Regular ❒ Temporary Days & Hours:________________

Shift preferred: ❒ Days ❒ Evenings ❒ Nights

Will you work weekends? ❒ Yes ❒ No Will you rotate shifts? ❒ Yes ❒ No

Are you able to perform the essential functions of the position for which you are applying with or without accommodation? ❒Yes ❒No

Have you ever applied for employment at HDFHC? ❒ Yes ❒ No If yes, month/year ____________

Were you previously employed by HDFHC? ❒ Yes ❒ No Note: related employees may not work in the same dept/same shift

If an offer is extended, when would you be available for work? ____________________

How did you become aware of the position for which you are applying? Please give individual or source information:

____

EDUCATION AND TRAINING

Name of school and address	Did you graduate?	Course Major	Diploma/Degree
	❐ Yes ❐ No		
	❐ Yes ❐ No		
	❐ Yes ❐ No		

Professional license/certification number	Type of License	Place of Issue	Expiration Date

Please list job related organizations, clubs, associations to which you belong. (You may omit those which indicate race, religious creed, color, etc.)

What personal, technical or professional skills do you bring to us which you feel will benefit the health center?

List three persons willing to provide professional and/or character references. Do not list relatives.

Name and occupation	Street, City, State, Zip	Phone Numbers
		Hm:
		Wk:
		Hm:
		Wk:
		Hm:
		Wk:

GOALS AND INTERESTS

Please tell us about your goals, interests, or any comments you may have relative to this application.

EMPLOYMENT HISTORY

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

List below your work experience for the previous 10 years, beginning with the most recent. You must provide phone numbers for employers. Give reasons for gaps in employment.

From	To	Name and Address of Employer		Job Title and Duties
Mo/Yr	Mo/Yr	Name:		
		Address:		
Earnings		City:	State: Zip:	
Starting	Ending	Ph. ( )	Supervisor:	
$	$	Number Supervised:	Reason for Leaving:	

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Mo/Yr	Mo/Yr	Name:		
		Address:		
Earnings		City:	State: Zip:	
Starting	Ending	Ph. ( )	Supervisor:	
$	$	Number Supervised:	Reason for Leaving:	

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PLEASE READ CAREFULLY

Initial each paragraph and sign below by checking the signature box

________ Initial I certify that I have answered all questions truthfully and have not withheld any information relative to my application. I understand that any falsification, misrepresentation, or omission, as well as any misleading statements or omissions of the application information, attachments, and supporting documents generally will result in denial of employment or immediate termination, if discovered after hire.

________ Initial I authorize Hi-Desert Family Health Clinics to thoroughly investigate my references, work record, education and other matters related to my suitability for employment, and further authorize the references I have listed to disclose to the company and all letters, reports, and other information related to my work records, without giving me prior notice of such disclosure. In addition, I release Hi-Desert Family Health Clinics, my former employers and all other persons, corporations, partnerships and associations for any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

________ Initial If hired, I recognize the rules and policies of Hi-Desert Family Health Clinics; I understand that my employment and compensation can be terminated at any time, with or without cause, and with or without notice, at the option of Hi-Desert Family Health Clinics or myself. I understand that the administration of Hi-Desert Family Health Clinics has the authority to create any other terms of employment and/or to enter into any employment contract that all such contracts must be in writing and signed by both parties. However, I also understand that unless otherwise stated in an employment contract, the company may change, withdraw and interpret other policies (including wages, hours and working conditions) as it deems appropriate.

________ Initial I understand and acknowledge that I will be required to submit to a physical examination, including drug test. Additionally, I hereby authorize the release of the results of such an examiniation to Hi-Desert Family Health Clinics for their use in evaluating my suitability for employment. Further, I release the examining facility and Hi-Desert Family Health Clinics from any and all liability, and from any damage that may result from the release of such information.

________ Initial I also understand that all offers of employment are conditionied on the provision of satisfactory proof of an applicant's identity and legal authority to work in the United States, as well as the satisfactory completion of a post-offer medical examination.

________ Initial My signature below indicates that I have read and understand the importance of supplying accurate information on the application. I am also aware of the possibility of an offer of employment being withdrawn if any of the information is not correct.

Date ____________________ Signature ____

Printed Name ____

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