

## Application for Employment

600 Orondo Avenue, Suite 1, Wenatchee, WA  
Phone: 509.662.6000 Fax: 509.664.4590

[www.cvch.org](http://www.cvch.org)

*An Equal Opportunity Employer*

Referral Source:  Advertisement  Relative  Government Employment Agency  
 Walk-in  CVCH Website  Private Employment Agency  
 Employee \_\_\_\_\_  Other \_\_\_\_\_

### PLEASE PRINT OR TYPE

Position Applied For: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Previous Names: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Drivers License # \_\_\_\_\_ State \_\_\_\_\_ E-Mail: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Cell Message

If necessary, the best time to reach you at home is: \_\_\_\_\_

Have you filed an application here before?  Yes  No When? \_\_\_\_\_ For which position? \_\_\_\_\_

Have you been previously employed at Columbia Valley Community Health?  Yes  No

If yes, give dates: From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you have any relatives employed here?  Yes  No If yes, indicate name(s) and relationship to you.  
\_\_\_\_\_

If you are under 18, can you furnish a work permit?  Yes  No

Are you legally eligible to work in the United States?  Yes  No

Type of employment desired:  Full Time  Part Time  Temporary  On-call/Pool

Are you on a lay-off and subject to recall?  Yes  No Will you relocate if required?  Yes  No

Check Site Preference:  Chelan  Wenatchee  Both

Have you ever been convicted of, or plead guilty to, a felony (in the last 7 years)?  Yes  No

(A "yes" answer to this question will not necessarily bar the applicant from employment.) If yes, explain fully:  
\_\_\_\_\_  
\_\_\_\_\_

Are you able to perform the essential functions of the position(s) for which you are applying with or without reasonable accommodations?

Yes, without accommodations

Yes, with accommodations

No

If necessary, please describe what type(s) of reasonable accommodations are necessary to perform the essential functions of the position: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Employment History

**List most recent employer first.** Include at least past five (5) years and account for any time gaps in your employment history, including any military service. (Attach additional sheet or resume if desired.) Please complete this section even if you are attaching a resume – **“See Resume” is not sufficient.**

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Phone: (\_\_\_\_) \_\_\_\_\_ Dates Employed (mo/yr) From: \_\_\_\_\_ To: \_\_\_\_\_

My supervisor: \_\_\_\_\_ May we contact for reference?  Yes  No  Later

Job title/duties: \_\_\_\_\_

Starting Salary: \_\_\_\_\_ per hour \_\_\_\_\_ per month Finishing Salary: \_\_\_\_\_ per hour \_\_\_\_\_ per month

Your reason for leaving: \_\_\_\_\_

~~~~~

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Phone: (\_\_\_\_) \_\_\_\_\_ Dates Employed (mo/yr) From: \_\_\_\_\_ To: \_\_\_\_\_

My supervisor: \_\_\_\_\_ May we contact for reference?  Yes  No  Later

Job title/duties: \_\_\_\_\_

Starting Salary: \_\_\_\_\_ per hour \_\_\_\_\_ per month Finishing Salary: \_\_\_\_\_ per hour \_\_\_\_\_ per month

Your reason for leaving: \_\_\_\_\_

~~~~~

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Phone: (\_\_\_\_) \_\_\_\_\_ Dates Employed (mo/yr) From: \_\_\_\_\_ To: \_\_\_\_\_

My supervisor: \_\_\_\_\_ May we contact for reference?  Yes  No  Later

Job title/duties: \_\_\_\_\_

Starting Salary: \_\_\_\_\_ per hour \_\_\_\_\_ per month Finishing Salary: \_\_\_\_\_ per hour \_\_\_\_\_ per month

Your reason for leaving: \_\_\_\_\_

## SKILLS OR SPECIAL TRAINING

List training and/or experience which may qualify you for the position(s) desired:

Mark "T" if you have **training** in the skill, "E" if you have **experience** in the skill, and "B" if you have **both**.

<u>BUSINESS</u>	<u>GENERAL</u>	<u>PATIENT CARE</u>
____ Typing _____ WPM	____ Floor Care (Manual)	____ Sterile Technique
____ Computers	____ Floor Care (Machines)	____ Vital Signs
____ Word _____	____ Maintenance (General)	____ Charting
____ Excel _____	____ Maintenance (Craft)	____ Pediatric
____ Access _____	____ Electrical _____	____ Obstetrics
____ Outlook _____	____ Dry-Wall _____	____ Gynecology
____ Data Entry	____ Plumbing _____	____ Geriatric
____ Ten-Key _____ SPM	____ Building _____	____ Orthopedic
____ Bookkeeping/Accounting	____ Electronics _____	____ Oncology
____ Transcription	____ Small Power Tools	____ Psychiatry
____ PBX/Reception		____ Dentistry
____ Insurance Billing		____ Pharmacy
____ Medical Terminology		

Other: \_\_\_\_\_ Other: \_\_\_\_\_ Other: \_\_\_\_\_

Professional Title (RN, HC, etc) \_\_\_\_\_ License # \_\_\_\_\_ State \_\_\_\_\_

Licensure, Registration, Certification (i.e.—CPA, Registered Counselor, LCSW, LICSW, LMHC, CNA, MD, DDS, DMD, RDH, RN, RD, PharmD):

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_

List any additional information you would like us to consider:

\_\_\_\_\_

List any foreign language(s) and check the one that best describes your skill level.

Language	Read/Write/Speak	Read/Write	Read/Speak	Read Only	Speak Only
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you a certified interpreter?  Yes  No Date certified: \_\_\_\_\_ Type: \_\_\_\_\_

## EDUCATION – List full name of schools attended.

High School: \_\_\_\_\_ Graduate?  Yes  No or GED?  Yes  No

College: \_\_\_\_\_ Graduate?  Yes  No Year: \_\_\_\_\_ Degree: \_\_\_\_\_

College: \_\_\_\_\_ Graduate?  Yes  No Year: \_\_\_\_\_ Degree: \_\_\_\_\_

Other: \_\_\_\_\_

**REFERENCES:** List name and telephone number of three **professional** references **not** related to you.  
**Previous supervisors or managers preferred.**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email (Preferred): \_\_\_\_\_ Fax \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email (Preferred): \_\_\_\_\_ Fax \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

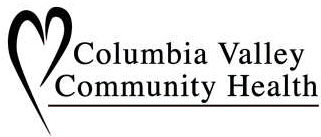
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email (Preferred): \_\_\_\_\_ Fax \_\_\_\_\_

I certify that the information set forth in this Application for Employment is true and complete to the best of my knowledge. I understand that, if employed, falsified statements on this application shall be considered sufficient cause for my dismissal. I understand that my employment shall be contingent upon proof of identity and verification of eligibility for employment in the United States in accordance with the Immigration Reform and Control Act of 1986. I further understand that my employment is contingent upon the checking of references furnished by me, and give the Employer the right to check and investigate such references. I consent to and authorize Columbia Valley Community Health Center and its personnel to request any information concerning my previous employment record as indicated on this Application for Employment. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such job related information.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*“It is the mission of Columbia Valley Community Health to provide access to improved health and wellness with compassion and respect for all.”*



# Voluntary Affirmative Action Information

(Completion of Information Below is Voluntary)

In an effort to comply with requirements regarding government recordkeeping, reporting and other legal obligations, we ask that you complete this applicant data survey. This information is used to satisfy the Affirmative Action requirements of section 503 of the Rehabilitation Act or necessitated by another federal law or regulation. Your cooperation is appreciated.

Please be advised that your survey is not a part of your official application for employment. It is considered confidential information that will not be used in any hiring decision. We consider applicants for all positions without regard to race, color, religion, sex, sexual orientation, national origin, age, disability, veteran status or any other legally protected status.

Position(s) applied for \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Referral Source:**

- Advertisement
- Walk-in
- Employee \_\_\_\_\_
- Relative
- Internet/Website
- Government Employment Agency
- Private Employment Agency
- Other \_\_\_\_\_

Applicant's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip Code

**As required, we comply with government regulations including Affirmative Action obligations.**

Gender:  Male  Female

**Check which of the following ethnic groups you consider yourself to belong:**

- Hispanic or Latino
  - American Indian/Alaskan Native\*
  - Two or more races\*
  - Black or African American\*
  - Native Hawaiian or other Pacific Islander\*
  - Caucasian\*
  - Asian\*
- \*Not Hispanic or Latino*

**SPECIAL NOTICE TO VIETNAM ERA VETERANS, DISABLED VETERANS AND INDIVIDUALS WITH PHYSICAL OR MENTAL HANDICAPS OR DISABILITIES:**

Government contractors subject to the Vietnam Era Veterans Readjustment Act of 1974 and the Rehabilitation Act of 1973 are required to take affirmative action to employ and advance in employment qualified disabled veterans and veterans of the Vietnam Era, and qualified handicapped individuals.

You are invited to volunteer this information, if you qualify, to assist in proper placement and determining reasonable accommodation. This information will be considered confidential, and refusal to provide this information will not adversely affect your consideration for employment.

**IF YOU SO WISH TO BE IDENTIFIED, PLEASE CHECK IF ANY OF THE FOLLOWING ARE APPLICABLE:**

- Vietnam Era Veteran
- Disabled Veteran
- Individual with a Disability