WEST OAKLAND HEALTH

APPLICATION FOR EMPLOYMENT

We are committed to a policy of Equal Opportunity and will not discriminate on any legally recognized basis, including but not limited to race, age, color, sex, marital status, national origin, citizenship, ancestry, physical or mental disability, veteran status, or any other legally protected basis. **This document must be completed in its entirety before an offer of employment can be authorized. Please indicate non-applicable (N/A) for those areas that do not apply to you**; do not leave sections/questions blank. Applicants who submit incomplete applications will not be considered for employment with West Oakland Health.

Date: _____

PERSONAL BACKGROUND

Name: _____
Last First Middle

Present Address: _____
Number Street City State Zip

Phone: (___)_____E-mail:_____

Position Applying For **(One Application Per Position)**: _____

Department/Program: _____

Date Available To Start: _____

Are you currently employed? ❒Yes ❒No

If so, may we contact your present employer? ❒Yes ❒No

Are you related to anyone currently employed with West Oakland Health? ❒Yes ❒No

Name of Employee: _____ Relationship: _____

Have you ever applied to this company before? ❒Yes ❒No

If so, when? _____ What position? _____

U.S. Military Service: ❒Yes ❒No
Rank: _____

If you are under 18, do you have a work permit? ❒Yes ❒No

Are you able, at the time of employment, to submit verification of your legal right to work in the U.S.? Verification and completion of the I-9 form must be completed no later than three (3) business days after date of hire ❒Yes ❒No

EDUCATIONAL BACKGROUND

EDUCATIONAL BACKGROUND	NAME OF SCHOOL CITY, STATE	CIRCLE HIGHEST GRADE COMPLETED AND DATES ATTENDED	MAJOR AREA OF STUDY	CERTIFICATE OR DIPLOMA RECEIVED (YES/NO)
High School		9 10 11 12 / GED		
College/University				
Graduate School				
Trade / Professional / Vocational Training				

Please list any specialized skills below *(i.e. computer programming, specialized tools or machines used, or equipment operation)*.

Please list any clerical skills you possess or knowledge of any machines below (i.e. typing, 10-key, word processing, medical terminology, Electronic Health Records, etc.).

LANGUAGE PROFICIENCY (OTHER THAN ENGLISH)

	Read	Write	Speak
	☐	☐	☐
	☐	☐	☐
American Sign Language	SIGN	☐ YES	☐ NO

LICENSE / CERTIFICATION / REGISTRATION

Do you have a current professional license, certificate or registration? ❒Yes ❒No

IF YES INDICATE TYPE	NUMBER	EXP. DATE	STATE WHERE ISSUED
IF YES INDICATE TYPE	NUMBER	EXP. DATE	STATE WHERE ISSUED
Are there any current restrictions of any nature on your license registration/certification or on your right to practice your profession, occupation or ability to provide health care services? ❒Yes ❒No		IF YES EXPLAIN	

WORK EXPERIENCE

Please list your work experience starting with your present or most recently held job. You may include in such history any verifiable work performed on a volunteer / internship bases.

CURRENT EMPLOYMENT

From:	**To:**	**Employer Name:**	**Phone:**
Position Title:		**Employer Address:**	
Name and title of Supervisor:		**Duties and Responsibilities of Position:**	
Reason for Leaving:			

PREVIOUS EMPLOYMENT

From:	**To:**	**Employer Name:**	**Phone:**
Position Title:		**Employer Address:**	
Name and title of Supervisor:		**Duties and Responsibilities of Position:**	
Reason for Leaving:			

From:	**To:**	**Employer Name:**	**Phone:**
Position Title:		**Employer Address:**	
Name and title of Supervisor:		**Duties and Responsibilities of Position:**	
Reason for Leaving:			

From:	**To:**	**Employer Name:**	**Phone:**
Position Title:		**Employer Address:**	
Name and title of Supervisor:		**Duties and Responsibilities of Position:**	
Reason for Leaving:			

REFERENCES

Please give the names of three (3) people, **NOT RELATED TO YOU;** who have known you at least three (3) years. One (1) Personal and two (2) Professionals

	Name	Occupation	E-mail Address	Telephone	Years Known
1.					

2.					
3.					

DRIVING RECORD (complete if you are applying for a position requiring a driver's license)

(If driving is a requirement of the position for which you are applying, continued employment is contingent on your maintaining a valid driver's license, and upon your being a driver in good standing for insurance purposes.)

Do you have a current driver's license? ❒Yes ❒No	If Yes, indicate driver's license number:	State Where Issued:
Are there any current restrictions on your driver's license? ❒Yes ❒No	If YES, indicate restrictions:	
Have you been found guilty of a moving violation in the past five (5) years? ❒Yes ❒No	If YES, indicate: Violation: Date: Violation: Date:	

PLEASE READ CAREFULLY

APPLICANT'S STATEMENT

In signing this application, I certify that all of the foregoing information is a complete and accurate statement of the facts and I further understand that if any misrepresentation, omission, or falsification is discovered, it will constitute grounds for dismissal.

I hereby authorize investigation of all statements contained in this application. Further, I give West Oakland Health permission to contact schools, previous employers, references, and others, and hereby release all parties from any liability in connection with the provision and use of such information.

I attest to the fact that if I accept a position with West Oakland Health, that I will not use illicit drugs, or abuse alcohol or other illegal drugs. I also understand that as a condition of employment a physical examination and drug-free status is required. I further understand that continued employment may be based on the successful passing of job-related physical examinations.

I understand and agree that, if employed by West Oakland Health I will abide by its rules and regulations, which I understand are subject to change. I further understand that my employment with West Oakland Health shall be introductory for a period of ninety (90) days and that at anytime during the introductory period or thereafter, my employment with West Oakland Health is for no definite period and may be terminated by either party at any time.

Applicant Signature: _____ Date: _____

AFFIRMATIVE ACTION QUESTIONNAIRE

We are an affirmative action (Equal Employment Opportunity) government contractor. In compliance with government regulations, we are **required** to record the number of applicants by age and gender. We ask that you indicate your gender, race or national origin, and date of birth, in the fields indicated below**. DO NOT WRITE YOUR NAME**. This information will not be kept with your application and will be used only in accordance with federal and state regulations. **YOU ARE NOT REQUIRED TO PROVIDE THIS INFORMATION**. Your application for employment will be considered in the same manner whether or not you fill out this form. This questionnaire will be separated for the application and will not be used in any employment decisions.

POSITION APPLYING FOR: _____

GENDER

❒ Male ❒ Female

NATIONAL ORIGIN / RACE

❒ **American Indian or Alaskan Native**
Persons having origins in any of the tribal peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

❒ **Asian**
Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent. This includes China, Japan, and Korea.

❒ **Black**
Persons having origins in any of the black racial groups of Africa.

❒ **Hispanic**
Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

❒ **Pacific Islanders**
Persons having origins in the Pacific Islands, such as Samoa.

❒ **White**
Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

❒ **Other** _____
Please Specify

DATE OF BIRTH: _____