



APPLICATION FOR EMPLOYMENT

To Applicant: We appreciate your interest in our organization. A clear understanding of your background and work history will aid in determining the position that best meets your qualifications. Migrant Health Service Inc. is an equal opportunity employer. Employment in all job classifications are without regard to race, color, creed, sex, age, national origin, religion, disability, military status, marital status, status with regard to public assistance, sexual orientation, or any other classification protected by applicable state or federal laws.

PERSONAL

Name	Position You Are Applying For/Location
Address	Rate of Pay Expected: \$ Hour
City, State, Zip	Phone Number(s) Home () Work ()
Driver's License Number:	State Issued In: Expiration Date:
Email address:	Date Available:

Are you a Military Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates of Active Service From To	Type of Discharge:
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PROFESSIONAL

License Type:	State	Date Issued: Expiration Date:	Number
License Type:	State	Date Issued: Expiration Date:	Number
License Type:	State	Date Issued: Expiration Date:	Number
Has your License or Professional Status ever been suspended or revoked:		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain:

EDUCATION

Type	Name of School	Address	Did You Graduate?	Degree Received
High School			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Business Schools Vocational Correspondence			<input type="checkbox"/> Yes <input type="checkbox"/> No	
College or University			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate School			<input type="checkbox"/> Yes <input type="checkbox"/> No	

EMPLOYMENT HISTORY

Present or Last Employer:	Your Title:	Last Salary:	
Address:	Duties:	Date Began:	Date Left
Supervisor:	Phone Number:	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Leaving:
Previous Employer:	Your Title:	Last Salary:	
Address:	Duties:	Date Began:	Date Left
Supervisor:	Phone Number:	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Leaving:
Previous Employer:	Your Title:	Last Salary:	
Address:	Duties:	Date Began:	Date Left
Supervisor:	Phone Number:	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Leaving:

Explain gaps in your employment history:

For Reference Purposes: Is any of your educational history listed under another name(s)? Yes No

If so, please list: _____

REFERENCES WE MAY CONTACT

Do Not List Relatives or Personal Friends.		
NAME	COMPLETE ADDRESS	OCCUPATION/TELEPHONE
Last _____ First _____	Street/Box # _____ City _____ State _____ Zip Code _____	Occupation _____ _____ Telephone () _____
Last _____ First _____	Street/Box # _____ City _____ State _____ Zip Code _____	Occupation _____ _____ Telephone () _____
Last _____ First _____	Street/Box # _____ City _____ State _____ Zip Code _____	Occupation _____ _____ Telephone () _____

GENERAL INFORMATION

How were you referred? <input type="checkbox"/> Web Site _____ <input type="checkbox"/> Newspaper (Please Identify) _____ <input type="checkbox"/> Career Fair (Please Specify) _____	<input type="checkbox"/> Employer/Friend/Relative _____ <input type="checkbox"/> Walk In <input type="checkbox"/> Other (Specify) _____
Have you been previously employed by Migrant Health Service Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates employed and positions held:	
Have you ever been convicted, pleaded guilty or no contest to a crime other than a minor traffic conviction? <input type="checkbox"/> Yes <input type="checkbox"/> No An answer of "yes" will not necessarily disqualify you from employment.	
Have you ever been fired or asked to resign your employment rather than being fired? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please explain, including reason, employer and dates: 	
Have you previously, currently or expect in the future any health conditions that may affect your ability to perform your job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SMOKING, DRUG FREE WORKPLACE AND DRESS CODE	
Our policy is to promote and provide a safe and healthy environment for our patients, employees, volunteers and visitors. Therefore, we do not allow the use of any tobacco products within our facility, we prohibit the use of illegal drugs, and additionally we have a dress code policy.	
If employed, will you uphold the use of tobacco products policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If employed, will you uphold the drug free workplace policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If employed, will you uphold the dress code policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT'S STATEMENT
<p>I hereby give Migrant Health Service Inc. the right to investigate my past employment, education and activities. I release from all liability all persons, companies and corporations who supply such information. I indemnify Migrant Health Service Inc. against liability that might result from such an investigation. I understand that any false answer, statement or omission I might make in this application or in any other required document shall be considered sufficient cause to deny employment or for discharge if already employed. I verify that I am eligible to work in the United States.</p> <p>I also understand that nothing contained in this application or in the granting of an interview is intended to create an employment contract between Migrant Health Service Inc. and myself for employment or for any benefit. I have received no promise regarding employment, and I understand that no such guarantee is binding on Migrant Health Service Inc. If an employment relationship is established, I understand that all employment with Migrant Health Service Inc. is "at will". This means that either Migrant Health Service Inc. or I may terminate the employment relationship at any time for any lawful reason.</p> <p>If hired at Migrant Health Service Inc., prior to my first day of work I will be required to verify that I am either a U.S. Citizen or a legal resident foreign national.</p> <p><input type="checkbox"/> I agree to the terms and conditions listed above.</p>

COMPLIANCE PROGRAM QUESTIONNAIRE

1. Have you ever been convicted of a crime which is listed as grounds for mandatory or permissive exclusion from any Federal or State healthcare program pursuant to 42 U.S.C. & 1320a-7(a)-(b)(3) (whether you were actually excluded or not)? (For purposes of this question, "convicted" has the meaning set forth in 42 U.S.C. & 1320(a-7(i) and includes any judgment of conviction that has been entered against you, even if there is an appeal pending or the judgment has been expunged; any finding of guilt by a federal, state or local court; any plea or guilty or solo contender; or any entry into a first offender; deferred adjudication or other program whereby a judgment of conviction has been withheld).

Yes No (If Yes, please explain) _____

2. Have you ever been excluded, suspended or debarred from; or otherwise sanctioned by the Medicare or Medicaid programs or any other federally-funded health care program?

Yes No (If Yes, please explain) _____

3. Do you, or any member of your immediate family, or household, have a direct or indirect ownership or controlling interest of 5% or more in any health care or related business? (For purposes of this question, "immediate family member" has the meaning given in 42 U.S.C. & 1320a-7(i) and include your: spouse; natural or adoptive parent, child, or sibling; step parent, stepchild, stepbrother, or stepsister; father, mother, daughter, son, brother, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. (Include provider numbers for each)

Yes No (If Yes, please explain) _____

4. Have any of the entities in question #3 above been excluded, suspended or debarred from or otherwise sanctioned by Medicare, Medicaid or any other federally-funded health care program?

Yes No (If Yes, please explain) _____

I certify that the information provided in this application is complete and accurate to the best of my knowledge. Falsification of any information will result in the immediate rejection of this application and termination from employment if discovered post hire.

Name: _____ **Date:** _____

FOR OFFICE USE ONLY - DO NOT WRITE BELOW LINE

Interview by/Location: _____ Date: _____ Offer? Yes No
Accepted? Yes No Employment Start Date: _____ Starting Rate of Pay _____
Position: _____ Health Center/Location _____
Attend Training? Yes No Has Vehicle? Yes No
Willing to travel to other Health Center Locations? Yes No
Spanish/English: Excellent Good Fair Poor Not Applicable

APPLICANT TRACKING RECORD

To All Applicants:

We are requesting that you voluntarily provide the following information. The information will assist us in monitoring our Equal Opportunity and Affirmative Action recruitment and hiring efforts. Failure to provide this information will not affect your consideration for employment. This applicant tracking record will be kept confidential and will be kept separate from your personnel file.

Please type or print clearly.

Date: _____

Name (Last, First, MI): _____

Address (Street, City, State, Zip): _____

Position(s) applying for: _____

1. **Sex:** Male Female

2. **Race/Ethnic Group:**
(Check One)

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintain cultural identification through tribal affiliation or community recognition.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

3. **Disability:** Do you have a physical or mental impairment which substantially limits one or more major life activities?

No Yes If yes, please describe:

4. **Veteran Status:**

- Non-veteran
- Veteran
- Vietnam Veteran
- Disabled Veteran
- Disabled Vietnam Veteran

5. **Referral Source:**

(How did you learn about this job?)

- | | |
|--|--|
| <input type="checkbox"/> Career Fair | <input type="checkbox"/> Newspaper Ad |
| <input type="checkbox"/> Employment Agency | <input type="checkbox"/> School |
| <input type="checkbox"/> Employee Referral | <input type="checkbox"/> State Employment Agency |
| <input type="checkbox"/> Internet – Classified Ads | <input type="checkbox"/> Other (Please specify): |
| <input type="checkbox"/> MHSI Website | |