

Employment Application

Please attach a copy of your most recent resume.

Date of Application: _____

Contact Information

| | |
|---|------------------------|
| Name (first / middle / last): | Position Applying For: |
| Street Address: | Home / Cell Phone: |
| City / State / Zip: | |
| Are you authorized to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Have you ever worked for Community Health Center of the Black Hills (<i>formerly</i> known as Rapid City Community Health) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when _____ | |

Education

| | |
|---------------------|--|
| High School: | Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Address: | Degree: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| College: | Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Address: | Degree: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Trade/Other: | Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Address: | Degree: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Availability

Full-Time Part-Time On-Call (PRN) Temporary

Date available to start _____ Hours available to work _____

Emergency Information

In case of emergency, contact:

| | |
|-------------|-----------------------|
| Name: | Relationship to Self: |
| Work Phone: | Home/Cell Phone: |

Skills, Interests & Education

| |
|---|
| Please summarize your previous experience (if any): |
| Special trainings, certifications: |

Employment History

| | |
|-----------------------------|---|
| <u>Employer:</u> | Position: |
| Street Address: | Phone: |
| City/State/Zip: | From: To: Reason for Leaving: May we contact your previous supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Supervisor | |
| Summary of responsibilities | |

| | |
|-----------------------------|---|
| <u>Employer:</u> | Position: |
| Street Address: | Phone: |
| City/State/Zip: | From: To: Reason for Leaving: May we contact your previous supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Supervisor | |
| Summary of responsibilities | |

| | |
|------------------|--|
| <u>Employer:</u> | Position: |
| Street Address: | Phone: |
| City/State/Zip: | From: To: |

| | |
|-----------------------------|---|
| | Reason for Leaving: May we contact your previous supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Supervisor | |
| Summary of responsibilities | |

Military Service: Did you serve on active duty? Yes No
 If yes, Branch: _____ From: _____ To: _____ Type of Discharge: _____

Referred/Learned of position: _____

Have you ever been convicted of a crime other than a misdemeanor traffic violation? Yes No

If yes, state the nature of the crime: _____

References *Please list 3 Professional references of people unrelated to you*

| | |
|----------|-----------|
| Name: | Position: |
| Address: | Phone: |
| Name: | Position: |
| Address: | Phone: |
| Name: | Position: |
| Address: | Phone: |

I specifically authorize the Community Health Center of the Black Hills and/or its representatives to consult with any third party who may have information bearing on my education, professional qualifications, credentials, clinical competence, character or any other matter as well as to inspect or obtain any and all communications, reports (including but not limited to credit reports) records, statements, documents, recommendations or disclosures of said third parties that may be material to such questions. I authorize the release of my credit bureau files.

I authorize the said third parties to release said information to Community Health Center of the Black Hills and/or its authorized representative upon request. I hereby release from any liability, and all individuals and institutions or organizations that, in good faith and without malice concerning my

professional competence, ethics, character, education, training licensing and other qualifications, provide information to Community Health Center of the Black Hills and/or its agents.

I certify that the information on this application and its supporting documents are true and complete to the best of my knowledge and understand and agree that failure to fully complete the form, or misrepresentation or omission of facts, represents grounds for elimination from consideration for employment, or termination after employment if discovered at a later date. I authorize the employer to investigate and verify all statements contained in this application and supporting materials.

I understand that the Community Health Center of the Black Hills is an equal opportunity employer and does not discriminate on the basis of age, gender, race, sexual preference, religion, veteran status, or disability. Grievances concerning possible discrimination may be made to the Human Resources Department.

I authorize the Community Health Center of the Black Hills to verify my competence through the National Provider Data Bank and release the clinic from liability for verification from this query.

Signature: _____

Date: _____