



# St. Croix Regional Family Health Center

## APPLICATION FOR EMPLOYMENT

### WE ARE AN EQUAL OPPORTUNITY EMPLOYER

SCRFHC does not discriminate in hiring, promotion, retention, or termination on the basis of race, color, national origin, religion, age, sex, sexual orientation, disability, veteran status, genetic predisposition, or any other characteristic protected under local, state or federal law.

Name \_\_\_\_\_  
Last First M.I.

Mailing Address \_\_\_\_\_

Email Address \_\_\_\_\_

Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Position(s) Applied For \_\_\_\_\_

How did you hear of the position? \_\_\_\_\_

## Education

Schools	Name/Location	Graduated? Y/N Length of program	Major Courses	Diploma/Degree/ Certification
High School				
College				
Business or Trade School				
Other Licenses or Certifications				

# Employment History

Please list your complete employment history. List present or most recent employer first. Use an additional page, if necessary.

<b>Employer</b>	Employed (mo./Yr.)  From:  To:	Address/City/State	Hours per week	Reason for leaving
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Type of work performed:

Name of Supervisor and contact information:

<b>Employer</b>	Employed (mo./Yr.)  From:  To:	Address/City/State	Hours per week	Reason for leaving
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Type of work performed:

Name of Supervisor

<b>Employer</b>	Employed (mo./Yr.)  From:  To:	Address/City/State	Hours per week	Reason for leaving
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Type of work performed:

Name of Supervisor

Are you presently employed? Yes  No  If so, may we contact your present employer? Yes  No

If you served in the United States Armed Forces, briefly list the dates, rank, and skills acquired:

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## Personal Information

Are you able to perform the essential duties of the position you are applying for with or without reasonable accommodation Yes  No

Are you legally authorized to work in the U.S.? Yes  No

*Note: you will be required to furnish documents to verify your eligibility for employment in accordance with the Immigration Reform and Control Act and your employment is contingent upon furnishing such documents.*

Are you at least 18 years of age? Yes  No

Please list any unique qualifications: \_\_\_\_\_

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Please list any special office/software skills: \_\_\_\_\_

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Please list any other skills:

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If hired, when would you be available? \_\_\_\_\_

What are your salary requirements? \_\_\_\_\_

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## Certifications, Registrations and Licenses

Certification, Registration or License Type	Document Number	State	Date Issued	Exp. Date	Temporary/ Permanent
					<input type="checkbox"/> T <input type="checkbox"/> P
					<input type="checkbox"/> T <input type="checkbox"/> P
					<input type="checkbox"/> T <input type="checkbox"/> P
					<input type="checkbox"/> T <input type="checkbox"/> P

## References (work references are preferred)

NAME	HOW THEY KNOW YOU	EMAIL ADDRESS	PHONE NUMBER

I certify that the answers given by me to the foregoing questions and statements are true and correct to the best of my knowledge without consequential omissions of any kind. I agree that St. Croix Regional Family Health Center shall not be held liable in any respect if my employment is rejected or subsequently terminated because of false statements, answers or omissions made by me in this application. I understand that any misleading or incorrect statements may render this application void, and if employed, may lead to employment termination.

I also voluntarily and knowingly authorize the companies, schools or persons named above to give any information requested regarding my former employment, character and qualifications. I hereby voluntarily and knowingly fully release and discharge, absolve, indemnify, and hold harmless said companies, schools or persons from any and all liability for any damages for issuing this information, except for the malicious and willful disclosure of derogatory facts concerning my employment made for the express purpose of preventing me from obtaining employment, which the party disclosing such facts knows to be untrue.

In consideration of my employment, I agree to conform to the rules and regulations of this organization. My employment and compensation can be terminated with or without cause and with or without notice, at any time, at the option of either my employer or me, unless I have a written contract stating otherwise.

Signature \_\_\_\_\_ Date \_\_\_\_\_