424 Hahlo Houston TX, 77020 Phone No (713) 674-332 Fax No (713) 343-5496 www.vecinohealthcenters.org

EMPLOYMENT APPLICATION

It is the policy of Vecino Health Centers to provide equal opportunity for all applicants for employment regardless of political affiliation, race, color, national origin, age, sex, religious creed or disability. Applicants may request any reasonable accommodation(s) to participate in the application process.

PLEASE PRINT CLEARLY (If any information is missing or incorrect your application may be rejected.)

Name (Last)	**(First)**	**(Middle)**	**Date Of Application**

Home Address	**City**	**State**	**Zip Code**

Home Number: **Alternate Number:**	**Social Security No**

Have you ever been known by another name? ☐ **Yes** ☐ **No** **If yes, please indicate:**

Position Applying for	**Date available for employment?**	**Salary Required**	**Location Preference**

Are you available to work? ☐ **Full Time** ☐ **Part Time** ☐ **Weekends**	**Please check which days you are available to work?** ☐ **Sunday** ☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday**

- **Are you currently employed?** ☐ **Yes** ☐ **No**
- **Are you legally eligible for employment in the United States?** ☐ **Yes** ☐ **No**
  Proof of employment authorization will be required upon employment.
- **Have you ever been employed by Vecino Health Centers?** ☐**Yes** ☐**No**
  If yes, please indicate date of employment ______________________Department ____________________
- **Do you have any relatives who are employed by Vecino Health Centers?** ☐ **Yes** ☐ **No**
  If yes, please complete: Name_____________________________Relationship: ___________________
  Department Employed: _________________________________Location: ______________________
- Are you willing to work in an organization where there is no smoking throughout the facility at any time? ☐ **Yes** ☐ **No**
- **If the job requires, do you have the appropriate valid driver's license?** ☐ **Yes** ☐ **No**
  If yes, please indicate: DL#: _______________________Type: _______________State Issued: ______________

Have you ever been convicted of or plead guilty, no contest, or received deferred adjudication for any criminal offense (include misdemeanors and felonies)? Answering "yes" will not automatically bar you from employment, if "yes", please indicate the information requested below. If you need additional space, please attach separate sheet. ☐ YES ☐ **NO**

CHARGE	DATE	CITY/STATE	DISPOSITION

PROFESSIONAL SPECIALIZATION CERTIFICATION

Are you certified by a professional board or association? ☐ **Yes** ☐ **No** If yes, please answer the following:

Name of Board or Association ____

Type of Certification ______________________________ Issued ___/___/___Expiration Date ___/___/__

MILITARY SERVICE

Have you served in the Military? ☐ **Yes** ☐ **No** If yes, please answer the following:

____ ______________________
Branch Rank

____ ______________________
Dates Type of Discharge

CONTINUING EDUCATION

Please attach a list of the continuing education programs that you have attended or presented for the period since last license renewal.

CPR ☐**Basic Life Support** ☐ **Advanced Life Support** ☐ **Instructor**

OTHER CERTIFICATION ______________________________ ______________________
Type of certification Date of Certification

Questions #1-3 for <u>providers and support professionals</u> ONLY

1. Are you currently taking controlled substances by prescription or otherwise? ☐ **Yes** ☐ **No**

"Currently" means recently enough so that the use of the substance may have an ongoing impact on one's functioning, or within the past two years.

"Controlled Substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the licensed transcriber's direction, as well as those used illegally.

"Ability to provide health care services" is to be construed to include the following:

a. The cognitive capacity to make appropriate assessments and judgments and learn and keep abreast of health care services developments; and
b. The ability to communicate those judgments and health care information to patients and other health care providers with or without the use of aides or devices, such as voice amplifiers; and
c. The physical capability to perform health care services tasks such as checking vital signs and assigned portions of the physical examination procedures and tasks that may fall within your scope of practice, with or without the use of aides or devices, such as corrective lenses or hearing aids.

If you answered, "yes" to question 1, please answer a and b below.

a. Does your use of controlled substances in any way impair or limit your ability to provide health care services with reasonable skill and safety? ☐ **Yes** ☐ **No**
b. Are you currently participating in a professionally supervised program that monitors you in order to assure that you are not illegally utilizing the controlled substances? ☐ **Yes** ☐ **No**

2. Do you have a medical condition that would require special accommodations for you to provide health care services with reasonable skill and safety? ☐ **Yes** ☐ **No**

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV/AIDS, tuberculosis, drug addiction and alcoholism.

If you answered "yes" to question 2, please answer a & b below.

a. Are any limitations that may be related to your medical condition ameliorated by current ongoing treatment or participation in a monitoring program? ☐ **Yes** ☐ **No**
b. Are any limitations that may be related to your medical condition overcome by the manner in which you have chosen to provide health care services? ☐ **Yes** ☐ **No**

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? ☐ **Yes** ☐ **No**

<u>If you answered "Yes" to any of the above, please attach explanation and related documents.</u>

REFERRAL SOURCE

☐ Job Line ☐ WorkInTexas.com ☐ Walk in ☐ Job Fair ☐ Internet Ad

☐ Employee Referral: ________________________ ☐ Other: ____________________________

EDUCATION AND TRAINING

	High School	College	Graduate School	Business/Trade School
Name of School				
Location of School				
Circle Highest Year Complete	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Degree Obtained				
Graduation Date				
Major/Minor				

EXPERIENCE

Any Special Training/Skills/Qualifications:	Do you know any foreign language? ☐ **Yes** ☐ **No** If yes, please specify:

EMPLOYMENT HISTORY

Please complete and do not indicate "Refer to Resume". A complete employment application is required with or without a resume. List all current and former employment for the last 10 years, beginning with the most recent. Include self employment, volunteer experience and periods of unemployment. If you need additional space, please attach separate sheet.

Employer	Dates of Employment From: Month/Year	To: Month / Year	Work Performed/Job Duties
Address / City & State / Zip Code			
Employer's Telephone Number(s)	Starting Salary	Ending Salary	Reason for leaving
Position Job Title	Supervisors Name		

Employer	**Dates of Employment** From: Month/Year	To: Month / Year	Work Performed/Job Duties
Address / City & State / Zip Code			
Employer's Telephone Number(s)	Starting Salary	Ending Salary	Reason for leaving
Position Job Title	Supervisor Name		

Employer	Dates of Employment From: Month/Year	To: Month / Year	Work Performed/Job Duties
Address / City & State / Zip Code			
Employer's Telephone Number(s)	Starting Salary	Ending Salary	Reason for leaving
Position Job Title	Supervisor Name		

REFERENCES (Professional recommendations and/or Past Employment references only)		
NAME	ADDRESS	TELEPHONE

PERIODS OF UNEMPLOYMENT (Please account for all periods of unemployment)		
Dates From: Month/Year	To: Month/Year	Explanation

APPLICANT'S STATEMENT (PLEASE READ)

I certify that the foregoing information is true and correct to the best of my knowledge, and I understand that any misrepresentation or willful omission of the facts shall be cause for rejection of the application or termination of employment. I hereby authorize Vecino Health Centers to conduct verification of employment history, criminal background check, personal references, driving or police record inquiries to determine my acceptability for employment. I hereby understand and acknowledge that Vecino Health Centers makes no commitment of employment to the applicant by acceptance of this application. I further certify that should I become employed and subsequently terminated, I voluntarily agree that all debts owed by me to Vecino Health Centers may be withheld from my final paycheck(s). I agree to observe all rules, regulations and policies of Vecino Health Centers.

X ______________________________ ______________________________
SIGNATURE OF APPLICANT DATE

FOR PERSONNEL USE ONLY		
Interviewer:	Hire Date:	Department:
Comments:		