

# SENECA HEALTHCARE DISTRICT



Human Resources Department  
130 Brentwood Drive, PO Box 737  
Chester, California 96020  
Phone: (530) 258-2159  
Fax: (530) 258-2068  
*An Equal Opportunity Employer*

## EMPLOYMENT APPLICATION

**Please Print Clearly**

DATE: \_\_\_\_\_

Name: \_\_\_\_\_

Last

First

Middle

Home phone: (\_\_\_\_\_) \_\_\_\_\_ Business phone: (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Mailing Address:

Street #/PO Box

City

State

Zip

Home Address:

Street #/PO Box

City

State

Zip

Permanent Address (if different from above):

Street #/PO Box

City

State

Zip

## EMPLOYMENT DESIRED

Position(s) applying for: \_\_\_\_\_

Are you applying for:

Regular full-time work?

Yes \_\_\_\_ No \_\_\_\_

Regular part-time work?

Yes \_\_\_\_ No \_\_\_\_

Short hour or per diem work?

Yes \_\_\_\_ No \_\_\_\_

Temporary work, e.g., summer or holiday work?

Yes \_\_\_\_ No \_\_\_\_

What days/hours are you available for work: \_\_\_\_\_

If applying for temporary work, during what period of time will you be available: \_\_\_\_\_

Are you available for work on weekends? Yes \_\_\_\_ No \_\_\_\_

Would you be available to work overtime, when necessary? Yes \_\_\_\_ No \_\_\_\_

If hired, on what date can you start work? \_\_\_\_\_

Salary desired: \_\_\_\_\_



**PERSONAL INFORMATION**

Have you ever applied or worked for Seneca Healthcare District before? Yes \_\_\_ No \_\_\_

If yes, when and in what position? \_\_\_\_\_

Do you have any friends or relatives working for Seneca Healthcare District? Yes \_\_\_ No \_\_\_

If yes, state name and relationship: \_\_\_\_\_

Why are you applying for work at Seneca Healthcare District?

\_\_\_\_\_  
\_\_\_\_\_

If hired, would you have a reliable means of transportation to and from work? Yes \_\_\_ No \_\_\_

Are you at least 18 years old? Yes \_\_\_ No \_\_\_  
*(If under 18, hire is subject to verification that you are of minimum legal age)*

If hired, can you present evidence of your U.S. citizenship or proof of your legal right to live and work in this country? Yes \_\_\_ No \_\_\_

Are you able to perform the essential functions of the position(s) for which you are applying, either with or without reasonable accommodations? Yes \_\_\_ No \_\_\_

If no, describe the functions that can not be performed:

\_\_\_\_\_  
\_\_\_\_\_

(Note: SHD complies with the ADA and considers reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. Hire may be subject to passing a medical examination and to skill and agility tests.)

Have you ever been convicted of a criminal offense (felony or serious misdemeanor)? Convictions for marijuana related offenses that are more than two years old need not be listed. Yes \_\_\_ No \_\_\_

Have you ever been *\*convicted* of any of the following federal crimes as defined in 42 U.S.C. § 1320a-7(i) or been subject to an exclusion action:

*\*A conviction includes a court judgment of conviction, a finding of guilt against you by a court, an accepted plea of guilty or “nols contendere” by you, or your participation in a first offender, deferred adjudication, or other arrangement or program where the judgment of conviction has been withheld.*

*Convictions are not an absolute bar to employment. Each case will be evaluated on its own merits.*

- 1. Crimes relating to the delivery of an item or service under a health care program? Yes \_\_\_ No \_\_\_
- 2. Crimes of patient abuse or neglect? Yes \_\_\_ No \_\_\_
- 3. Felonies or misdemeanor crimes of fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct that occurred after the enactment of the HIPAA in 1996 in connection with a health care program? Yes \_\_\_ No \_\_\_



4. Felonies or misdemeanor crimes relating to the manufacture, distribution, prescription, or dispensing of a controlled substance? Yes \_\_\_\_ No \_\_\_\_
5. Crimes relating to the obstruction of an investigation of any of the afore mentioned crimes? Yes \_\_\_\_ No \_\_\_\_

If yes to any of the above, state nature of the offense(s), crime(s), and/or exclusion(s), when and where convicted, and disposition of the case:

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(Note: No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The nature of the offense, the date of the offense, the surrounding circumstances, and the relevance of the offense to the position(s) applied for may, however be considered.)

Are you currently employed? Yes \_\_\_\_ No \_\_\_\_

If so, may we contact your current employer? Yes \_\_\_\_ No \_\_\_\_

**EDUCATION, TRAINING, AND EXPERIENCE**

SCHOOL	NAME/ADDRESS	YEARS COMPLETED	GRADUATE		DEGREE OR DIPLOMA
			YES	NO	
High School					
College/ University					
Graduate School					
Vocational/ Business					
Health Care					

Some of our patients do not speak English. Do you speak, write, or understand any foreign language? Yes \_\_\_\_ No \_\_\_\_

If yes, which language(s): \_\_\_\_\_

Do you have any other experience, training, qualifications, or skills which you feel make you especially suited for work at Seneca Healthcare District? If yes, please explain:

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Name of Employer: \_\_\_\_\_

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

Type of Business: \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Employment Dates: \_\_\_\_\_ to \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

May we contact this employer for a reference? Yes \_\_\_\_ No \_\_\_\_

Your Position Title: Duties:
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Weekly pay: Starting \$ \_\_\_\_\_ Ending \$ \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

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

Type of Business: \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Employment Dates: \_\_\_\_\_ to \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

May we contact this employer for a reference? Yes \_\_\_\_ No \_\_\_\_

Your Position Title: Duties:
---------------------------------

Weekly pay: Starting \$ \_\_\_\_\_ Ending \$ \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_



Name of Employer: \_\_\_\_\_

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

Type of Business: \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Employment Dates: \_\_\_\_\_ to \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

May we contact this employer for a reference? Yes \_\_\_\_ No \_\_\_\_

Your Position Title: Duties:
---------------------------------

Weekly pay: Starting \$ \_\_\_\_\_ Ending \$ \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

\_\_\_\_\_

Name of Employer: \_\_\_\_\_

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

Type of Business: \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Employment Dates: \_\_\_\_\_ to \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

May we contact this employer for a reference? Yes \_\_\_\_ No \_\_\_\_

Your Position Title: Duties:
---------------------------------

Weekly pay: Starting \$ \_\_\_\_\_ Ending \$ \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

\_\_\_\_\_



**MILITARY SERVICE**

Have you obtained any special skills or abilities as the result of service in the military? Yes \_\_\_\_ No \_\_\_\_

If so, describe those skills/abilities:

**REFERENCES**

List three persons not related to you who have knowledge of your work performance within the last three years.

Name: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

Years acquainted: \_\_\_\_\_

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Name: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

Years acquainted: \_\_\_\_\_

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Name: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

Years acquainted: \_\_\_\_\_

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## VOLUNTARY SELF-IDENTIFICATION FORM

Equal Employment Opportunity Employers are required by the Federal Government to provide statistical information about applicants and employees to demonstrate that we meet equal opportunity requirements. Your completion of this form is voluntary and would be greatly appreciated.

This information will be kept separate and confidential and will not be considered in any employment decisions.

POSITION APPLIED FOR: \_\_\_\_\_

DATE: \_\_\_\_\_ SEX:  M  F

- AMERICAN INDIAN OR ALASKAN NATIVE (All persons having origins in any of the original peoples of North America).
- ASIAN OR PACIFIC ISLANDER (Persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands).
- BLACK (African descent and Jamaican and West Indian).
- HISPANIC (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin).
- CAUCASIAN
- OTHER (Please specify) \_\_\_\_\_

YES  NO Do you believe you are a handicapped person subject to the benefits of the Rehabilitation Act of 1973?

SOURCE OF REFERRAL

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Please Read Carefully, Initial Each Paragraph, and Sign Below**

\_\_\_\_\_ I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

\_\_\_\_\_ I hereby authorize Seneca Healthcare District to thoroughly investigate my references, work record, education, and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to Seneca Healthcare District any and all letters, reports, and other information related to my work records without giving me prior notice of such disclosure. In addition, I hereby release Seneca Healthcare District, my former employers, and all other persons, corporations, partnerships, and associations from any and all claims, demands, or liabilities arising out of or in any way related to such investigation or disclosure.

\_\_\_\_\_ I understand that nothing contained in the application or conveyed during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and Seneca Healthcare District. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, at the option of either myself or Seneca Healthcare District and that no promises or representations contrary to the foregoing are binding on Seneca Healthcare District unless otherwise provided in an applicable collective bargaining agreement or memorandum of understanding.

\_\_\_\_\_ I understand that all offers of employment are conditioned on the provision of satisfactory proof of my identity and legal authority to work in the U.S.

\_\_\_\_\_ I understand that offers of employment are conditioned on Seneca Healthcare District's receipt of satisfactory responses to reference requests, the satisfactory completion of a post-offer medical examination, and the completion of a Consumer Report to include a criminal background check.

Date: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

Name: \_\_\_\_\_

(Please Print)

