

PLEASE PRINT ALL INFORMATION  
REQUESTED EXCEPT SIGNATURE



# La Casa Family Health Center Employment Application Form

Please mail completed application to:  
La Casa Family Health Center  
Attn: Human Resources Director  
PO Box 843  
Portales NM 88130

FOR OFFICE USE ONLY:  
Date Received: \_\_\_\_\_  
Reviewed by: \_\_\_\_\_

PLEASE COMPLETE PAGE 1-5

Application Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First Suffix Middle Initial

Present Address \_\_\_\_\_  
Street City State Zip

How long at current address \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_

Are you under 18 \_\_\_\_ YES \_\_\_\_ NO, if "YES" can you provide proof of your eligibility to work? \_\_\_\_ YES \_\_\_\_ NO

Are you currently authorized to work in the United States? \_\_\_\_ YES \_\_\_\_ NO Proof of eligibility will be required, if hired.

Position applied for \_\_\_\_\_ Wage Desired (if applicable) \_\_\_\_\_

How many hours can you work weekly? \_\_\_\_\_ When are you available to start work? \_\_\_\_\_

Employment desired  FULL-TIME ONLY  PART-TIME ONLY  FULL- or PART-TIME

Are you related to a Board Member or current employee?  YES  NO If yes, who? \_\_\_\_\_

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete Mailing Address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. or Trade School				
Professional School				

Have you ever been convicted of a crime which is substantially related to the functions or qualifications of the job for which you are applying?  NO  YES A Conviction record will not necessarily disqualify you from employment.

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) and type(s) of rehabilitation.

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

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### APPLICATION FOR EMPLOYMENT

Do you have a driver's license?  YES  NO

What is your means of transportation to work? \_\_\_\_\_

Driver's license # \_\_\_\_\_ State of Issue \_\_\_\_\_  Operator  Commercial (CDL)

Expiration date \_\_\_\_\_

Have you had any accidents during the past three years? How many? \_\_\_\_\_

Have you had any moving violations during the past three years? How many? \_\_\_\_\_

Typing	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ WPM	10-Key	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other _____ Skills _____
Personal Computer	<input type="checkbox"/> YES <input type="checkbox"/> NO		Word Processing	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ WPM

Please list two references other than relatives.

Name \_\_\_\_\_

Name \_\_\_\_\_

Position \_\_\_\_\_

Position \_\_\_\_\_

Company \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

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Please use this space to elaborate on any background, experience, or qualifications that you believe should be considered in evaluating your qualifications for employment. You may include volunteer experience, licenses, certificates or previous training. Please omit any information that would disclose your race, gender, age, marital status, ethnic origin, religious or political affiliations, or disability.

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What foreign language(s) can you:

SPEAK \_\_\_\_\_

WRITE \_\_\_\_\_

READ \_\_\_\_\_

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## APPLICATION FOR EMPLOYMENT

### MILITARY

Have you ever been in the armed forces?    YES    NO      If yes, what branch of service? \_\_\_\_\_  
 Specialty \_\_\_\_\_      Date Entered \_\_\_\_\_      Discharge Date \_\_\_\_\_

### Work Experience

Please list your work experience for the past five years beginning with your most recent job held. If you were self-employed, give business name. Attach additional sheets if necessary.

Name of employer Address City, State, Zip Phone number	Name of supervisor	Employment dates	Pay or Salary
		From	Start
		To	Final
Job Title			
Reason for leaving (be specific)			
List the jobs you hold, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

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May we contact your present employer?       YES     NO

After reviewing the attached job description, please indicate if you are able to perform the essential functions of the job for which you have applied \_\_\_\_ Yes \_\_\_\_ No. If you answered "No", please identify those job functions that you cannot perform. If a reasonable accommodation is required to enable you to perform the job properly and safely, please describe:

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PLEASE READ CAREFULLY

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### APPLICATION FORM WAIVER

As indication that you have read and understood each sentence, please write your initials in the spaces provided below.

In exchange for the consideration of my job application by La Casa Family Health Center, I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relations, either in the position applied for or any other position, and regardless of the contents or employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time of time, or other La Casa Family Health Center practices, shall serve to create an actual or implied contract or employment, \_\_\_\_\_ or to confer any right to remain an employee La Casa Family Health Center, or otherwise to change in any respect the employment-at-will relations between it and the undersigned, \_\_\_\_\_ and that relationship cannot be altered except by a written instrument signed by the Chief Executive Officer of La Casa Family Health Center. \_\_\_\_\_ Both the undersigned and La Casa Family Health Center may end the employment relationship at any time, without specified notice or reason. \_\_\_\_\_ If employed, I understand that La Casa Family Health Center may unilaterally without specified notice or reason. \_\_\_\_\_ If employed, I understand that La Casa Family Health Center may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits. \_\_\_\_\_

I authorize investigation of all statements contained in this application. \_\_\_\_\_ I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. \_\_\_\_\_ I hereby give La Casa Family Health Center permission to contact schools, all previous employers (unless otherwise indicated), references, and others, and hereby release La Casa Family Health Center from any liability as a result of such contact. \_\_\_\_\_

I understand that, in connection with the routine processing of your employment application, La Casa Family Health Center will require a pre-employment drug screen. \_\_\_\_\_

I understand that, in connection with the routine processing of your employment application, La Casa Family Health Center will conduct a background check. \_\_\_\_\_

I also understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete an I-9 Form in this regard. \_\_\_\_\_

I further understand that my employment with La Casa Family Health Center shall be probationary for a period of one hundred and eighty (180) days, and further that at any time during the probationary period or thereafter, my employment relationship with La Casa Family Health Center is terminable at will for any reason by either party. \_\_\_\_\_

Signature of applicant \_\_\_\_\_ Date: \_\_\_\_\_

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La Casa Family Health Center is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, gender, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with La Casa Family Health Center depends solely on your qualifications.

Thank you for completing this application form and for your interests in La Casa Family Health Center.