



an affiliate of Salinas Valley Memorial Healthcare System

Application for Employment
Central Coast Community Health Care, Inc. and Affiliates
Human Resources Department
P.O. Box 2480 • Monterey, CA 93942
(831) 648-4213 • Fax: (831) 648-4207
E-mail: hr@ccvna.com • Website: www.ccvna.com

Form with fields: Last Name, First Name, Middle Initial, Application Date, Current Address (#, Street, P.O. Box), Home Phone, City, State & Zip Code, Cellular Phone, Position Desired, Referred By, Social Security #

Form with questions: Have you worked for the following companies (If yes, state date you left) and What days and hours are you available to work? Includes checkboxes for Yes/No and Full Time/Part Time/Per diem.

CITIZENSHIP section: Do you have the legal right to work in the job for which you are applying? Pursuant to the Immigration Reform and Control Act of 1986, all applicants, upon being made an offer of employment, must produce documents...

LANGUAGE section: List languages you speak, read and/or write other than English: (optional). Includes columns for Language and checkboxes for Speak, Read, Write.

Are you 18 or older? [] Yes [] No

Have you, since the age of 18, ever been convicted of a felony? [] Yes [] No
If yes, explain and give date. Note: A conviction will not necessarily bar you from employment.

Empty lines for additional information or notes.

EXPERIENCE		GIVE A COMPLETE RECORD OF ALL EMPLOYMENT AND REASONS FOR PERIODS UNEMPLOYED DURING THE PAST TEN YEARS. ATTACH EXTRA PAGE IF NECESSARY. (COMPLETE EVEN IF RESUME IS ATTACHED).		
LAST EMPLOYMENT FIRST		Employer's Name, Address, Telephone Number	Title and Summary of Duties	Reason for Leaving
From	To			
		Employer No. & Street City, State, Zip	Supervisor Phone	
		Employer No. & Street City, State, Zip	Supervisor Phone	
		Employer No. & Street City, State, Zip	Supervisor Phone	
		Employer No. & Street City, State, Zip	Supervisor Phone	
		Employer No. & Street City, State, Zip	Supervisor Phone	
		Employer No. & Street City, State, Zip	Supervisor Phone	
May we contact your present employer for a reference?		List office machines you can use: <input type="checkbox"/> Not applicable		Typing Speed WPM____ Shorthand Speed WPM____
<input type="checkbox"/> Yes <input type="checkbox"/> No		Please list other equipment you can operate: <input type="checkbox"/> Not applicable		

Affidavit, I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever. I agree that my employer shall not be liable in any respect if my employment is terminated because of the falsity of statements, answers or omissions made by me in this application. I authorize employers, companies, schools or persons to give any information regarding my employment, together with any information they may have regarding me whether or not it is in their records. I hereby release said employers, companies, schools or persons from all liability for any damage, both legal and otherwise, for issuing this information. I understand that the agency is committed to providing a safe, efficient and productive workplace. All offers of employment are conditioned upon successful completion of the pre-employment health screening. In addition, if accepted for employment, I hereby agree to abide by the rules and policies of my employer. I affirm that everything is true and correct, and I acknowledge that I can be terminated at anytime if any information I supply is false. I affirm that I have a genuine intent to seek employment and no other purpose in applying for a job with the agency.

Further, I understand that any employment is not for a stated period of time and may be terminated with or without cause, at any time, at the option of either myself or my employer with the decision of the president being final.

Applicant Signature

Date

We are an equal opportunity employer. Federal and State laws, and our personnel policies prohibit discrimination in employment because of race, color, creed, age, sex, sexual orientation, marital status, national origin, physical or mental impairment, or medical condition.

Applicant - Please do not write below this line

Interview by

Date

To be completed by applicant if hired: I affirm that the above terms set forth my complete and final understanding as to that upon which I have agreed to be employed at the Central Coast Community Health Care and its affiliates.

Employee Signature

Date

Employment Reference Request

Central Coast Community Health Care, Inc. and Affiliates
Human Resources
P.O. Box 2480, Monterey, CA 93942
(831) 648-4213, Fax (831) 648-4207

I, (print name) _____, authorize the company or individual listed below to furnish information regarding my employment history and performance to Central Coast Community Health Care, Inc and Affiliates (CCCHC). I hereby release all individuals and companies listed below from all liability for damage whatsoever that may be incurred as a result of furnishing such information.

Applicant Signature _____ Date _____ Social Security Number _____

Contact Name: _____ Phone #: _____

Title: _____ Company: _____

Address: _____

For use by Employment Reference or CCCHC Human Resources only

The applicant listed above has given your name or organization as an employment reference. Your cooperation in completing the information below is appreciated. All information provided is confidential. Please return the reference sheet by mail or fax to the location indicated above.

Dates of Employment _____ Position _____

Please circle the number that best represents your appraisal of the applicant in the areas listed:

	Outstanding	Above Average	Average	Poor
Professional skills	1	2	3	4
People skills	1	2	3	4
Attendance	1	2	3	4
Reliability	1	2	3	4

Reason for leaving: _____

Eligible for Rehire: Yes ___ No ___ If no, please explain _____

Comments: _____

Signature : _____ Printed Name: _____

Title: _____ Date: _____

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EEOC Questionnaire

The following statistical information is required for compliance with federal laws assuring equal employment opportunity. Your submission of the information is voluntary. The information you provide on this form will not be used to determine your eligibility or qualification for employment. It will remain in a confidential file separate from your employment application.

Please select one EEO Code only:

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

White (Not Hispanic or Latino)

A person having origins in any of the peoples of Europe, the Middle East, or North Africa.

Black or African American (Not Hispanic or Latino)

A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)

A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands

Asian (Not Hispanic or Latino)

A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

American Indian or Alaska Native (Not Hispanic or Latino)

A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Two or More Races (Not Hispanic or Latino)

All persons who identify with more than one of the above five races.

Signature: _____

Date: _____

Printed name: _____