APPLICATION FOR EMPLOYMENT
NUESTRA CLINICA DEL VALLE, INC.

Equal Opportunity Employer/Provider

P.O. BOX 1689 PHARR, TX 78577
(956) 787-8915 Fax: (956) 787-2021

Name: _____ POSITION APPLYING FOR:

Address: _____ _____

City: _____ State: _____ Zip: _____ SALARY DESIRED:

Telephone: ( ) _____ _____

Email: _____

The information you provide in this application will assist us in determining your current or potential abilities to provide the best service for our organization. Resumes and/or letters of recommendation may be attached. In compliance with federal law, all persons hired will be required to verify identity and eligibility to work in the United States and to complete the required employment eligibility verification document form upon hire.

Are you authorized to work in the U.S.? Yes ___ No ___ Date Available: _____

Driver's License (Required) Full-time: _____ Part-time: _____

State Issued _____ DL# _____ Exp. _____ Hours Desired: _____

Do you have transportation? Yes ___ No ___ Bilingual: Yes _____ No _____

Are you willing to travel? Yes ___ No ___ Languages: _____

EDUCATIONAL INFORMATION: (List schools attended – academic/business/vocational/technical)

Name and Location	Academic Major/Minor	Number of Years	Graduate Yes / No	Degree/ Certificate

How did you learn about this job vacancy? [ ] NCDV Website [ ] School [ ] Workforce commission
[ ] Newspaper Advertisement [ ] Other _____

SPECIAL SKILLS AND QUALIFICATIONS Summarize special skills and qualifications relevant to position desired.

_____

_____

Typing: _____ WPM Office Equipment: _____

Medical Equipment: _____

Have you ever been a member of the Armed Services of the U.S.? Yes: _____ No: _____

LICENSES OR CERTIFICATES:

Profession/Specialty: _____ License Number: _____

Granted by: _____ Expiration Date: _____

EMPLOYMENT RECORD:

Current or most recent employer: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Position: _____ Salary: _____
Dates Employed: From: _____ To: _____
Duties Performed: _____

_____
Reason for leaving: _____
May we contact this employer: Yes___ No___ Immediate Supervisor: _____

Next Previous Employer: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Position: _____ Salary: _____
Dates Employed: From: _____ To: _____
Duties Performed: _____

_____
Reason for leaving: _____
May we contact this employer: Yes___ No___ Immediate Supervisor: _____

Are you related to any of Nuestra Clinica Del Valle Board Members? Yes _____ No _____
If yes, how are you related? _____

Do you have any relatives working with Nuestra Clinica Del Valle? Yes _____ No _____
If yes, names? _____

Have you ever been convicted of any crime (not including traffic violations)? Yes _____No _____
If yes, when, where, and disposition of offense? _____

Have you been employed at a Community Health Center? Yes _____ No _____
If yes, dates, location, position held? _____

Emergency Contact:

Name: _____ Phone: _____

Address: _____

CHARACTER REFERENCES: (NO RELATION)

NAME	OCCUPATION	ADDRESS & TELEPHONE
1.		
2		
3.		

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE OF APPLICANT DATE

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I have applied for employment with Nuestra Clinica Del Valle and give the agency permission to make inquiries of references and former employers concerning my performance and general character. I hereby authorize the party receiving this form to give full and complete information as may be requested by Nuestra Clinica Del Valle. I hereby release all persons and agencies whatsoever from all liability for any damages incurred by me through the furnishing of such information.

SIGNATURE OF APPLICANT _____ DATE _____

APPLICANT'S NAME PRINTED _____ SOCIAL SECURITY NUMBER _____