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:	F	POSITION AF	PPLYING FOR	₹:	
Address:				Internation Y	
City: State: Zip:		SALARY DESIRED:			
Telephone: ()	<u> </u>				
Email:					
The information you provide in this application will assist us in for our organization. Resumes and/or letters of recommendation required to verify identity and eligibility to work in the United document form upon hire.	may be attached. In con	pliance with	federal law, all	persons hired v	
Are you authorized to work in the U.S.? Yes No	Date Avail	Date Available:			
Driver's License (Required)	Full-time:	Full-time: Part-time:			
State Issued DL# Exp	Hours Des	Hours Desired:			
Do you have transportation? Yes No	Bilingual:	Bilingual: Yes No			
Are you willing to travel? Yes No	Languages	Languages:			
EDUCATIONAL INFORMATION, (1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	lo attandadd	: a /h : : : : - : - /	vacational 4-	ohnioo1)	
EDUCATIONAL INFORMATION: (List schoo	Academic Academ	Number	Graduate	Degree/	
Name and Location	Major/Minor	of Years	Yes / No	Certificate	
How did you learn about this job vacancy? [] NCDV We					
	r Advertisement [
SPECIAL SKILLS AND QUALIFICATIONS Sumi	marize special skills an	d qualificatio	ns relevant to	position desire	
Typing: WPM Office Equipment:			- 11		
Medical Equipment:					
Have you ever been a member of the Armed Services of the	e U.S.? Yes:	No:	-		
LICENSES OR CERTIFICATES:					
	pecialty: License Number:				
Granted by:	nted by: Expiration Date:				

EMPLOYMENT RECORD:

Current or most recent employer: Address:		State:	Zip:
Phone:	Position:	Sala	ry:
Dates Employed: From:	To:		
Outies Performed:			
Reason for leaving:			
May we contact this employer: Yes_	No Immediate Supervisor	r:	
Next Previous Employer:			
Address:	City:		
Phone:	Position:	Sala	ry:
Dates Employed: From: Duties Performed:	To:		
	· · · · · · · · · · · · · · · · · · ·		
Reason for leaving: May we contact this employer: Yes_	No Immediate Superviso	r·	
may we contact and employer. Tob_	1\0 Infinediate Super vise.	••	
Are you related to any of Nuestra Clinica Del Valle Board Members? If yes, how are you related?		Yes	No
Do you have any relatives working with If yes, names?	n Nuestra Clinica Del Valle?		No
Have you ever been convicted of any cr	rime (not including traffic violations)? Yes	No
If yes, when, where, and disposition of offense? Have you been employed at a Community Health Center? If yes, dates, location, position held?		Yes	No
Emergency Contact:			
Name:	Phone:		
Address:			
CHARACTER REFERENCES: (I			
NAME	OCCUPATION	ADDRES	SS & TELEPHONE
1.			
2			24 No. 24 PM
3.			
CERTIFY THAT THE INFORMAT		HIS APPLICATION	ON IS ACCURATE
RUE TO THE BEST OF MY KNOW	WLEDGE AND BELIEF.		
SIGNIATURE OF A DRIVE A NIT		DATE	
SIGNATURE OF APPLICANT		DATE	

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I have applied for employment with Nuestra Clinica del Valle, Inc., and give the agency permission to conduct criminal background checks and 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, Inc. 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
AFFLICANT S NAME FRINTED	SOCIAL SECURIT NUMBER