



**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

**APPLICATION FOR EMPLOYMENT  
NUESTRA CLINICA DEL VALLE, INC.**

Equal Opportunity Employer/Provider



**NUESTRA CLINICA DEL VALLE**

P.O. BOX 1689 PHARR, TX 78577

(956)787-8915 Fax: (956)787-2021

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