

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

P.O. BOX 1689
PHARR, TEXAS 78577
956-787-8915

Equal Opportunity Employer/Provider

Name: _____	POSITION APPLYING FOR: _____
Address: _____	_____
City: _____ State: _____ Zip: _____	SALARY DESIRED: _____
Telephone: _____	_____

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.

Social Sec. No. _____	Date Available: _____
U.S. Citizen: Yes _____ No _____	Full-time: _____ Part-time: _____
If no, present legal status _____	Hours Desired: _____
Do you have transportation? Yes _____ No _____	Bilingual: Yes _____ No _____
Drivers License? Yes _____ No _____	Languages: _____
Type: _____ Number: _____	_____
Are you willing to travel? Yes _____ No _____	

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? Newspaper advertisement School
 Newspaper internet Other _____
 Workforce commission

Additional Training/Skills relevant to position desired:

TYPING: _____ WPM OFFICE EQUIPMENT: _____

MEDICAL EQUIPMENT: _____ OTHER: _____

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

Licenses or Certificates:

Profession: _____ Specialty: _____

License Number: _____ Expiration Date: _____

Granted by: _____

EMPLOYMENT RECORD:

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

Reason for leaving: _____
May we contact this employer: Yes: _____ No _____

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

Reason for leaving: _____
May we contact this employer: Yes: _____ No _____

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? _____

In case of 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