

**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: \_\_\_\_\_

<b>EDUCATIONAL INFORMATION:</b> (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, 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.

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SIGNATURE OF APPLICANT

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DATE

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APPLICANT'S NAME PRINTED

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SOCIAL SECURITY NUMBER

[www.nuestraclinicadelvalle.org](http://www.nuestraclinicadelvalle.org)