AMPLA HEALTH



935 Market Street, Yuba City, CA 95991 (530) 674-4261 ~ FAX (530) 674-4164

HR MANUAL

**APPLICATION FOR EMPLOYMENT**

***(PLEASE PRINT CLEARLY or TYPE)***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Full Legal Name: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Mailing Address | | | | | | | | | | | | | | | | | | | | | |  | | | City | | | | | | | | | | | | | | |  | | State | | |  | | | Zip | |
|  | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | |  | |  | | |  | | |  | | |
| Permanent Address ***(if different)*** | | | | | | | | | | | | | | | | | | | | | |  | | | City | | | | | | | | | | | | | | |  | | State | | |  | | | Zip | |
|  | | | | | | | | | | |  | |  | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | | |
| Residence Telephone | | | | | | | | | | |  | | Message/Cell Telephone | | | | | | | | | | | | | | |  | Email address | | | | | | | | | | | | | | | | | | | | |
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| Position(s) Applying For | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Days/Hours Available: ***(Check all that apply)*** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full time | | | Part time | | | Per Diem (on-call) | | | | | | | | | Saturdays | | | | | | | | | | | Sundays | | | | | | | Holidays | | | | Overtime | | | | | | | | | Evenings | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M |  | | | | | | T | | |  | | | | | | | | W | | | | | | |  | | | | | | | | | | Sun | | |  | | | | | | | | | | |  |
| Th |  | | | | | | F | | |  | | | | | | | | Sat | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | |
| Select locations willing to travel to: | | | | | | | | |  | | | | | | |  | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | |
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| Arbuckle | | Chico | | | Colusa | | Gridley | | | | | Hamilton City | | | | | | Lindhurst | | | | | | | | | Los Molinos | | | | Orland | | | | | Oroville | | | | | | Richland | | | | | | Yuba City | |
| Date Available: | | | |  | | | | | | | | | | | | | | | | | | | | | | | Salary Desired: | | | | | | |  | | | | | | | | | | | | | | | |
| How did you learn of the position? | | | | | | | | Print Ad  Online Ad  Other | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Are you related to any Ampla Health Board or Staff Member? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please give name of person(s) and how related: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you previously applied or worked for Ampla Health? | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please give date(s) and location(s): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have reliable transportation to and from work? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have automobile insurance as required by California law? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **EDUCATION:** | |  | |  |  |
| **(please print clearly)** | **High School** | | **College/University** | | **Graduate/Professional/**  **Other** |
| School Name |  | |  | |  |
| Highest Grade Completed |  | |  | |  |
| Graduated | Yes  No | |  | |  |
| Diploma/Degree/  Certificate Earned |  | |  | |  |
| Major |  | | | | |

**RECORD OF EMPLOYMENT:**

Please list the names of your previous employers in chronological order with present or last employer listed first. *Be sure to account for all periods of time including military service and any period of unemployment.* **If self-employed, give first name and supply business references.** (Attach extra sheets if necessary.)

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| **Present/Last Employer** | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | | | | |
| City: | |  | | | | | | | | | | | | | | | State: | |  | | Zip: | |  |
| Telephone: | | | ( |  | | | | ) |  | | - | |  | Dates Employed From: | | | |  | | to: | |  | |
| Title: |  | | | | | | | | | | | | | Supervisor: | |  | | | | | | | |
| Responsibilities: | | | | |  | | | | | | | | | | | | | | | | | | |
| Reason for Leaving: | | | | | | |  | | | | | | | | | | | | | | | | |
| May we contact? | | | | | | Yes | | | | No | | If not, Reason: | | |  | | | | | | | | |

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| **Present/Last Employer** | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | |
| City: | |  | | | | | | | | | | | State: | |  | | Zip: | |  |
| Telephone: | | | ( |  | | | ) |  | - |  | Dates Employed From: | | |  | | to: | |  | |
| Title: |  | | | | | | | | | | Supervisor: |  | | | | | | | |
| Responsibilities: | | | | |  | | | | | | | | | | | | | | |
| Reason for Leaving: | | | | | |  | | | | | | | | | | | | | |

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| **Present/Last Employer** | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | |
| City: | |  | | | | | | | | | | | State: | |  | | Zip: | |  |
| Telephone: | | | ( |  | | | ) |  | - |  | Dates Employed From: | | |  | | to: | |  | |
| Title: |  | | | | | | | | | | Supervisor: |  | | | | | | | |
| Responsibilities: | | | | |  | | | | | | | | | | | | | | |
| Reason for Leaving: | | | | | |  | | | | | | | | | | | | | |

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| **Present/Last Employer** | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | |
| City: | |  | | | | | | | | | | | State: | |  | | Zip: | |  |
| Telephone: | | | ( |  | | | ) |  | - |  | Dates Employed From: | | |  | | to: | |  | |
| Title: |  | | | | | | | | | | Supervisor: |  | | | | | | | |
| Responsibilities: | | | | |  | | | | | | | | | | | | | | |
| Reason for Leaving: | | | | | |  | | | | | | | | | | | | | |

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| Have you ever been terminated or asked to resign from any job?  Yes  No If yes, explain the | | | |
| circumstances: |  | | |
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| Please explain fully any gaps in your employment history: | | |  |
|  | | | |
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| If laid off or fired, give reason (s): | |  | |
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| Have you ever used another name: Yes  No *Is any additional information relative to change of name, use of an assumed name or nickname necessary to enable a check on your work and education report? If Yes, please explain:* |
|  |
| Are you over 18 years of age:  Yes  No |
| Are you able to provide proof of your right to be employed in the United States of America*:*  Yes  No |

|  |  |
| --- | --- |
| Foreign Language (List all that apply): | |
| Speak |  |
| Read |  |
| Write |  |
|  |  |
| Skills: |  |
|  | |
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| **Equal Employment Opportunity Data** | | |
| This form will assist Ampla Health and its commitment to Equal Employment Opportunity. Completion of this form is entirely **voluntary**, and all information will remain confidential and will not affect your application for employment. | | |
|  | **Gender:**  Male  Female |  |
|  |  |  |
| **Ethnic Group:** | |  |
|  | Hispanic or Latino | A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origins regardless of race. |
|  | White ***(Not Hispanic or Latino)*** | A person having origins in any of the original people of Europe, North America or North Africa. |
|  | Black or African American ***(Not Hispanic or Latino)*** | A person having origins of any of the black racial groups of Africa. |
|  | Native Hawaiian or other Pacific Islander ***(Not Hispanic or Latino)*** | A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands. |
|  | Asian ***(Not Hispanic or Latino)*** | A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Laos, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam. |
|  | American Indian or Alaskan Native ***(Not Hispanic or Latino)*** | A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. |
|  | Two or More Races ***(Not Hispanic or Latino)*** | All persons who identify with more than two of the above races. |
|  |  |  |
| **Veteran Status:** | |  |
|  | Not a veteran  Recently separated veteran  Vietnam era veteran | |
| **Approximate years served:** | |  |
| 1960-1969  1970-1979  1980-1989  1990-1999  2000-2009  2010-2012  Currently Active | | |
|  |  | |
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| DISABLED – A person with a disability is an individual who: (1) has a physical or mental impairment or medical condition that limits one or more life activities, such as walking, speaking, breathing, performing manual tasks, seeing, hearing, learning, caring for oneself or working; (2) has a record or history of such impairment or medical condition; or (3) is regarded as having such an impairment or medical condition. The reporting of a disability is strictly **VOLUNTARY** | | |
|  |  | |

**Completion of the above Race/Ethnic Identification is OPTIONAL and State Law prohibits use of this information for anything other than statistical purposes.**

**THIS APPLICATION WILL BE CONSIDERED ACTIVE FOR A MAXIMUM OF SIX MONTHS. IF YOU WISH TO BE CONSIDERED FOR EMPLOYMENT AFTER THAT TIME, YOU MUST REAPPLY. PLEASE READ AND SIGN THE FOLLOWING.**

**APPLICANT’S STATEMENT & AGREEMENT:**

In the event of my employment to a position with Ampla Health, I will comply with all rules and regulations of Ampla Health. I understand that any offer of employment may be contingent upon the passing of a physical examination and a test for the presence of alcohol and/or narcotics in my system, performed by a medical provider selected by Ampla Health.

I understand that Ampla Health may investigate my driving record and my criminal record and that an investigative consumer report may be prepared whereby information is obtained through personal interviews with my neighbors, friends, personal references, and others with whom I am acquainted. This inquiry includes information as to my character, general reputation, personal characteristics, and mode of living. I understand that I have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. I further understand that Ampla Health may contact my previous employers, and I authorize those employers to disclose to Ampla Health all records and information pertinent to my employment with them. Employee authorizes the release of any information regarding employment and with respect to any information released pursuant to this Authorization, waives any claim against a former employer, their agents, employees or representatives. It is understood that the Applicant is not waiving any other actions and/or rights that they may have against prior employers other than as it pertains to the specific release of information authorized by this application.

***I authorize the persons named herein as references to provide Ampla Health with any pertinent information they may have regarding myself.***

I hereby state that all the information that I provided on this application or any other documents filled out in connection with my employment, and in any interview is true and correct. I understand that if I am employed and any such information is later found out to be false in any respect, I may be dismissed. I understand if selected for hire, it will be necessary for me to provide satisfactory evidence of my identity and legal authority to work in the United States, and that federal immigration laws require me to complete a Form I-9 in this regard.

If hired, I agree as follows: My employment and compensation is terminable at will, is for no definite period, and my employment and compensation may be terminated at any time, without cause at the option of either Ampla Health or myself. No implied, oral, or written agreements contrary to the express language of this agreement are valid unless they are in writing signed by the President/CEO. No supervisor or representative of Ampla Health, other than the President/CEO of Ampla Health has any authority to make any agreements contrary to the foregoing. This agreement is the entire agreement between Ampla Health and the employee regarding the right of Ampla Health or employee to terminate employment without good cause, and this agreement takes the place of all prior and contemporaneous agreements, representations, and understandings of the employee and Ampla Health.

**Ampla Health is an equal opportunity employer. Ampla Health does not discriminate in employment and no question on this application is used for the purpose of limiting or excluding any applicant’s consideration for employment on a basis prohibited by local, state or federal law.**

**I hereby acknowledge that I have read the above statements, understand the same, and agree with all the above.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Date |  | **Applicant’s Signature** |

Notification/Release of Information

**The purpose of this form is to notify you that a Consumer Report and/or an Investigative Consumer Report will be conducted on you in the course of consideration for employment. I hereby authorize your company or any agent of your company to contact any and all corporations, former employers, and credit agencies, educational institutions, law enforcement agencies, city, state, county, and federal courts and military services to release information about my employment, education, consumer credit history, driving record, criminal record, and general public records history to the person or company with which this form has been filed. This releases the aforesaid parties from any liability and responsibility for collecting the above information. This release shall remain in effect for the length of my employment. I understand I have the right to obtain a free copy of this consumer report if; (1) Any adverse action/decision is made based on the information in the consumer report, & (2) If the request is being made in writing within 60 days of the adverse action. If any Investigative consumer Report is conducted, I will be notified in writing within three days from request of said report. I believe to the best of my knowledge that all information I have provided is accurate true and correct and that I fully understand the terms of this release.**

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| Name (Last) | |  | | | | | | | (First) | | |  | | | | | | | | | | | (Middle) | | | | | |  | | | | | | | |
| List all other legal names used in the last 7 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| \* | | | |  | | | | | | | | | | | \* | | | | | | | | | | |  | | | | | | | | | | |
| Drivers License # | | | | |  | | | | | State | |  | | | | Phone # (Day) | | | | | | | | ( | |  | | | ) |  | | | - | |  | |
| Professional License Held | | | | | | |  | | | | | | | State | | | | |  | | | Lic. # | | | |  | | | | | | | | | | |
| Signature | | |  | | | | | | | | | | |  | | | | Today’s Date | | | | | | | |  | | | | | | | | | | |
| Current Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City |  | | | | | | | | | | State | |  | | | | Zip | | |  | | | | | from | |  | | | | to | | |  | | |
| List all other addresses you have lived in the last 7 years. Use additional form if necessary. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address | | | | | | | | City | | | | | | | State | | | | | | Zip | | | | Dates | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | |  | | | | | |  | | | | from | | |  | | | | to | | | |  |
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**TO BE FILLED OUT BY COMPANY REQUESTING INFORMATION:**

# Company Requesting Information: Ampla Health Return Fax # (530) 674-4164 1

Name Of Person To Return Info To: **Human Resources Department** Voice # **(530) 674-4261 1**

Information Requested**:**  Criminal History  Civil History  Social Security Verification  Driving Record  Education/Degree Verification

Reference Check  National Wants & Warrants  Professional License Verification  Previous Employer Verification  O.I.G Name Search

**Disclaimer:**

While the information contained in the reports provided has been obtained from public records data sources deemed reliable, its accuracy cannot be guaranteed due to potential human error in the actual recording of the record. Since this information is not owned by Pre-employ.com, Inc., and since public records data on any one individual, group of individuals, company, or companies can be contained in more than one repository Pre-employ.com, Inc., can only rely on its accuracy from the public records data sources presently available at the time of the search. This information is furnished for your exclusive use and accepted by you without any liability on the part of Pre-employ.com, Inc. it’s sources, officer’s agents or employees. Furthermore you agree to indemnify Pre-employ.com, Inc., its sources, agents, and employees of any liability for the use of this information and shall agree that the right to obtain and the purpose for this information, for your exclusive use, is fully within the appropriate law or laws which apply to the permissible purpose of retrieving background information on an individual’s criminal record history, credit history and/or workers compensation claim history.