Date Application Received: _____


***Del Puerto Health Care District is an equal opportunity employer.***

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. (Not all prohibited bases apply to all programs.) To file a complaint of discrimination write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800)795-3272, or (202) 720-6382 (TDD).

**Instructions:** **Complete all sections of this application, or indicate not applicable (N/A) *even if attaching a resume*. If more space is needed, add additional pages.**

**Date:** _____

| APPLICANT INFORMATION | | | | | |
|---|---|---|---|---|---|
| Last Name | | First | | M.I. | |
| Other Names Used (if any) | | First | | M.I | |
| Street Address | | | | Unit # | |
| City | | State | | ZIP | |
| Home Phone | ( ) | Cell Phone | ( ) | | |
| e-Mail Address | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Position you are applying for: | | | | | | Desired Wages: | | |
| If hired, date available to start work: | | Indicate days & hours you are available | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| What type of employment are you seeking? | Full Time? | YES ☐ | NO ☐ | Temporary? | | YES ☐ | NO ☐ |
| | Part Time? | YES ☐ | NO ☐ | If yes, period of time available for temp work? | From: To: | | |
| Will you be available to work overtime? | | YES ☐ | NO ☐ | Comment, if any: | | | |
| Have you ever worked for Del Puerto Health Care District? | | YES ☐ | NO ☐ | If yes, indicate dates | | | |
| Do you have friends or family members working for Del Puerto Health Care District? | | YES ☐ | NO ☐ | If yes, name & relationship | | | |

| **PRE-SCREEN INFORMATION** | | |
|---|---|---|
| Are you at least 18 years old or older? | YES ☐ | NO ☐ |
| Can you provide proof that you authorized to work in the U.S.? | YES ☐ | NO ☐ |
| If hired, do you have a reliable means of transportation to and from work? | YES ☐ | NO ☐ |
| All applicants must submit to alcohol & drug testing and a pre-employment physical following an offer of employment but before beginning work. Are you willing to submit to pre-employment drug screening and a physical? | YES ☐ | NO ☐ |
| All applicants must submit to a pre-employment background check following an offer of employment but before beginning work. Are you willing to submit to a background check? | YES ☐ | NO ☐ |
| I have received and reviewed the job announcement for the position for which I am applying, I qualify for the skill experience, and language requirements, and I understand the essential duties and responsibilities outlined in the job announcement. | YES ☐ | NO ☐ |

| EDUCATION / TRAINING *If additional space is needed, please on reverse or add an additional page.* | | | |
|---|---|---|---|
| High School: | Address: | | |
| Did you graduate? | YES ☐ | NO ☐ | Degree: |
| College / University: | Address: | | |
| Did you graduate? | YES ☐ | NO ☐ | Degree: |
| Vocational /Business/EMT School: | Address: | | |
| Did you graduate? | YES ☐ | NO ☐ | Degree: |
| Vocational /Business/Paramedic School: | Address: | | |
| Did you graduate/complete training? | YES ☐ | NO ☐ | Degree / Certificate: |
| Health Care Training: | Address: | | |
| Did you graduate/complete training? | YES ☐ | NO ☐ | Degree / Certificate: |

| Many of our patients do not speak English. Do you speak, write, or understand any foreign language? Yes ____ No ____ | If yes, please indicate your level of competence in any other than English language: | |
|---|---|---|
| | Language 1: _____<br>1☐ = Understand but do not speak<br>2☐ = Casual conversation only<br>3☐ = Speak, read, write<br>4☐ Certified medical translator | Language 2: _____<br>1☐ = Understand but do not speak<br>2☐ = Casual conversation only<br>3☐ = Speak, read, write<br>4☐ Certified medical translator |
| Do you have any other experience, training, or skills which you feel make you especially suited for work at Del Puerto Health Care District?<br><br>If yes, please describe: | | |

CERTIFICATION (Complete this section if applying for a professional position.) Please provide copies.

| Paramedic | Emergency Medical Technician | Nurse Practitioner | Physician Assistant | LVN | Medical Assistant |
|---|---|---|---|---|---|
| Paramedic Certified | EMT Basic Certified | N/P License | P/A License | LVN License | M/A Certified |
| ACLS | Health Provider CPR | NPI | NPI | CPR | CPR |
| CPR | DMV Medical Certificate | DEA | DEA | | |
| DMV Medical Certificate | ICS 100 | Furnishings | Furnishings | | |
| ICS 100 | ICS 700 | CPR | CPR | | |
| ICS 700 | | | | | |
| 0PALS/PEP | | | | | |
| PHTLS/BTLS/ITLS | | | | | |
| Stanislaus County Accreditation | | | | | |

| Has your license / certification ever been revoked or suspended? | YES ☐ | NO ☐ |
|---|---|---|
| If yes, state reasons for revocation or suspension, date of revocation or suspension, and date of reinstatement. | | |

**Instructions:** **List the last five years of employment history, starting with the most current.**

| EMPLOYMENT HISTORY | *If additional space is needed, please add an additional page.* | |
|---|---|---|
| Company | | Phone |
| Address | | Supervisor |
| Job Title | Start Date: | End Date: |
| Responsibilities | | |
| Reason for Leaving: | | |
| May we contact your supervisor for a reference? | YES ☐ NO ☐ | |

| | | |
|---|---|---|
| Company | | Phone |
| Address | | Supervisor |
| Job Title | Start Date: | End Date: |
| Responsibilities | | |
| Reason for Leaving: | | |
| May we contact your supervisor for a reference? | YES ☐ NO ☐ | |

| | | |
|---|---|---|
| Company | | Phone |
| Address | | Supervisor |
| Job Title | Start Date: | End Date: |
| Responsibilities | | |
| Reason for Leaving: | | |
| May we contact your previous supervisor for a reference? | YES ☐ NO ☐ | |

| | | |
|---|---|---|
| Company | | Phone |
| Address | | Supervisor |
| Job Title | Start Date: | End Date: |
| Responsibilities | | |
| Reason for Leaving: | | |
| May we contact your previous supervisor for a reference? | YES ☐ NO ☐ | |

| REFERENCES | *Please list three professional references* | | |
|---|---|---|---|
| Full Name | | Relationship | |
| Company | | Phone | |
| email Address | | Years Known | |
| Full Name | | Relationship | |
| Company | | Phone | |
| emails Address | | Years Known | |
| Full Name | | Relationship | |
| Company | | Phone | |
| email Address | | Years Known | |

| PLEASE READ CAREFULLY, INITIAL EACH PARAGRAPH, AND SIGN BELOW | |
|---|---|
| _____ Initials | **Certification of Information**: I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment, and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery. |
| _____ Initials | **At Will Employment:** I understand that nothing contained in the application, or conveyed during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and the company, except where the policy conflicts with state law or CBA provisions. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, at the option of either myself or the company, and that no promises or representations contrary to the foregoing are binding on the company unless made in writing and signed by me and the Company's designated representative. |
| _____ Initials | **Equal Opportunity**: Del Puerto Health Care District is an equal opportunity employer. It is the policy of Del Puerto Health Care District to provide equal employment opportunities for all qualified persons without discrimination on the basis of race, color, religious creed, national origin, ancestry, age, sex, marital status, sexual orientation, gender, gender identity, gender expression, genetic information, medical condition, mental disability, physical disability, past, citizenship, current, or prospective service in the uniformed services, AIDS/HIV, Political activities or affiliations, status of a victim of domestic violence, assault, or stalking, or any other characteristic protected under applicable federal, state, or local law. |
| _____ Initials | **Verification of Eligibility to Work:** In compliance with Federal law, all persons hired will be required to verify identity and eligibility to work in the United States and will be required to complete the employment eligibility verification document form upon hire and provide appropriate forms of documentation as required by the U.S. Government. |
| _____ Initials | **Confirmation of Physical Ability to Perform:** I have reviewed the physical qualification assessment of the job for which I am applying. To the best of my knowledge, I am physically capable of safely performing the tasks identified. I understand that any omission or misrepresentation of material fact in this application may result in refusal or separation from employment. I understand that if I am employed by Del Puerto Health Care, I will be required to undergo a physician's physical assessment. |

_____ _____

Date Applicant's Signature

**AUTHORIZATION TO OBTAIN EMPLOYMENT AND REFERENCE INFORMATION AND/OR REVIEW PERSONNEL FILE OF EMPLOYEMENT APPLICANT**

Name of Applicant: _____

I hereby authorize**: Del Puerto Health Care District**

1. To conduct an employment reference check by asking references I identified, my former employer(s), coworkers and/or educators about my ability to perform my duties, interact with coworkers, management and the public, and any other aspect of my past or current employment.

2. To verify information, I have provided in my employment interview or on my job application; and;

3. To examine, inspect and/or copy any records reflecting my employment history, including records of my education, personnel history, supervisory or organizational files relating to my application for employment.

In signing below, I understand that the documents to be reviewed will contain information regarding my education and employment history and may include such items as payroll records, employment history, prior performance evaluations, attendance records, commendations, disciplinary actions, corrective actions, grievances or appeals and other material relating to my employment.

A photocopy of this authorization shall be as valid as the original.

Any information obtained through this authorization shall be kept confidential by the department performing this reference.

This authorization is valid for 90 calendar days from the date of signature.

_____ _____

Applicant's Signature Date

_____ _____

Signature of Individual(s) obtaining and reviewing information Date

**PRIVACY STATEMENT**

This information is requested by the State of California. The Information Practices Act of 1977 (California Civil Code Section 1798.17) and the Federal Privacy Act (5 USC 552a, sub-division (e)(3); require this notice be provided when collecting personal information from individuals. Information requested on this form, which includes the social security number is needed by human resource staff to identify applicants accurately. Furnishing the requested information on this form is mandatory. Failure to provide this information will prevent the hiring division/unit from obtaining crucial information needed during the hiring process and will affect the potential employee's chances for hire.

**NON AVAILABILITY**

IN THE CALENDAR BELOW, PLEASE IDENTIFY YOUR CURRENT SHIFT OR CLASS PATTERN(S), OR ANY OTHER REGULAR OBLIGATIONS THAT WOULD PREVENT YOU FROM WORKING OR PICKING UP VACANT SHIFTS AT PDA. FILL IN THE DATES , YOU ARE NOT AVAILABLE OVER A FOUR WEEK PERIOD (ONE MONTH):

## Dates/Hours Not Available to Work

| SUN. | MON. | TUES. | WED. | THURS. | FRI. | SAT. |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

I ACKNOWLEDGE THAT I AM OBLIGATED TO INFORM PATTERSON DISTRICT AMBULANCE OF ANY MATERIAL CHANGES TO MY WORK SCHEDULE, OR IF I TAKE ON ADDITIONAL EMPLOYMENT AFTER BEING HIRED AT PDA, OR ANYTHING THAT REDUCES MY AVAILABILITY TO WORK AT PDA.

Applicant _____ Date _____

## Equal Employment Opportunity Data

Application Date: _____

To be completed by applicant:

Completion of this form is entirely voluntary, and all information will remain confidential and will not affect your application for employment. We are required by law *to* collect this information for equal opportunity employment purposes, and it will not become part of your personnel record if you are hired by this company.

Name: _____

**Sex:** ☐ Male ☐ Female ☐ Choose not to

identify American Indian/Alaskan Native

☐ Asian

☐ Black or African-American

☐ Hispanic or Latino

☐ White (not Hispanic or Latino)

☐ Native Hawaiian or other Pacific Islander

☐ Two or more races

☐ Choose not to identify

Government contractors must take affirmative action to employ and advance certain qualified individuals subject to the Rehabilitation Act of 1973 and the Vietnam Era Veterans Readjustment Act of 1974. Completion of the following information is voluntary, and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodation, please check where applicable:

☐ Vietnam Era Veteran

☐ Disabled Veteran

☐ Individual with a Disability

☐ Choose not to identify