



CAMBRIA COMMUNITY HEALTHCARE DISTRICT

EMPLOYMENT APPLICATION

NAME: _____

SSN: _____

ADDRESS: _____

DL#: _____

HOME PH: _____

CELL PH: _____

WORK PH: _____

POSITION DESIRED: _____

FULL TIME

PART TIME

BACK UP

DATE AVAILABLE: _____

EDUCATION

LEVEL	SCHOOL NAME / LOCATION	YEAR GRAD	SUBJECTS / DEGREE / CERT.
HIGH SCHOOL			
COLLEGE			
OTHER SCHOOLS			

FORMER EMPLOYERS (LIST YOUR LAST 4 EMPLOYERS, STARTING WITH THE MOST RECENT FIRST)

DATE MONTH / YEAR	EMPLOYER NAME AND ADDRESS	POSITION	SALARY	REASON FOR LEAVING
FROM: TO:				
FROM: TO:				
FROM: TO:				
FROM: TO:				

REFERENCES

PLEASE LIST IN THE FOLLOWING BOX THREE PEOPLE NOT RELATED TO YOU AND WHOM YOU HAVE KNOWN FOR AT LEAST ONE YEAR.

NAME	ADDRESS	PHONE	YEARS KNOWN

EXPERIENCE

PLEASE DESCRIBE BELOW ANY SKILLS OR ADDITIONAL QUALIFICATIONS

GENERAL INFORMATION

DO YOU SPEAK ANY FOREIGN LANGUAGES? YES <input type="checkbox"/> NO <input type="checkbox"/>
HAVE YOU EVER WORKED FOR AN EMPLOYER WHO PROVIDED PUBLIC EMPLOYEE RETIREMENT (PERS) BENEFITS? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE NAME, ADDRESS, AND PHONE NUMBER
DO YOU HAVE ANY PHYSICAL LIMITATIONS OR DISABILITIES THAT COULD PREVENT YOU FROM PERFORMING THE DUTIES ASSOCIATED WITH THIS POSITION? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE EXPLAIN: _____

ADDITIONAL COMMENTS

IN CASE OF EMERGENCY, PLEASE NOTIFY:

_____ PHONE: _____

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT MISREPRESENTATION, FALSIFICATION OR OMISSION OF FACTS CALLED FOR IS CAUSE FOR DISMISSAL. FURTHER, I UNDERSTAND THAT THE USE OF THIS FORM DOES NOT INDICATE THERE ARE ANY POSITIONS OPEN AND DOES NOT IN ANY WAY OBLIGATE THIS AGENCY.

SIGNATURE: _____ **DATE:** _____

DO NOT WRITE BELOW THIS LINE

DATE OF HIRE: _____	POSITION: _____
STARTING PAY SCHEDULE: _____	AMOUNT: _____ EMPLOYEE NUMBER: _____
APPROVED: _____ ADMINISTRATOR	