If you wish to fill out this application using your computer you must download a free copy of Adobe Acrobat Reader, if you don't already have it installed. Download it by clicking anywhere within this box: https://get.adobe.com/reader/

Once you have Adobe Acrobat Reader installed, save this file to your computer, open it with Adobe Acrobat Reader, complete the form, save the document, and upload it when you submit the career form online.

Application for Employment

301 NP Ave.
Fargo, ND 58102
Phone: (701) 271-3344

715 11th St. N.
Suite 106B
Moorhead, MN 56560
(218) 299-7830

We appreciate your interest in our organization. In order that your application may be thoroughly evaluated, please answer the following questions completely and accurately.

Family HealthCare provides Equal Opportunity Employment for all individuals without regard to race, sex, color, religion, national origin, physical or mental handicap, sexual orientation, marital status, or age. We are proud to be a smoke free campus.

PERSONAL INFORMATION

Date of Application: Position Applied For:

Name:
(Last) *(First)* *(Middle Initial)*

Address:
(Street) *(City)* *(State)* *(Zip Code)*

Contact Information:
(Home) *(Alternate #)* *(Email)*

Are You Eligible To Work In The United States? ☐ YES ☐ NO

Have You Ever Applied For Employment Here? ☐ YES ☐ NO

If Yes:	Date of Application:	Position Applied For:	Employment Date: From: To:

NOT APPLICABLE FOR MN RESIDENTS

Have you ever been convicted of a crime or are you now under charges for any offense against the Law? You may omit: (1) charges that were dismissed or resulted in acquittal; (2) any conviction that has been set aside, vacated, annulled, expunged, or sealed; (3) any offense that was finally adjudicated in a juvenile court or juvenile delinquency proceeding; and (4) any charges that resulted only in a conviction of a non-criminal offense. ☐ YES ☐ NO

If Yes, Please Explain:

A conviction does not automatically exclude any applicant from employment and the employer would consider the nature and date of the offense and all other facts and circumstances.

Have you ever been fired from any job for any reason? ☐ YES ☐ NO If Yes, Please Explain:

Have you ever quit a job after being notified that you would be fired? ☐ YES ☐ NO

POSITION DESIRED

Position Applying for?	Work Preference: ☐ Full-time ☐ Part-time ☐ PRN	Salary Requirements:	Date Available:

Explain your reasons for seeking employment at Family HealthCare Center and any special abilities / qualifications you possess that pertain to the position.

PROFESSIONAL LICENSES /CERTIFICATIONS

License Type:	State Issued:	Number:	Expiration Date: / /
License Type:	State Issued:	Number:	Expiration Date: / /

Certification / Expiration:

☐ _____ ☐ CPR_____

☐ NRP_____ ☐ PALS_____

☐ ACLS_____ ☐ ATLS_____

☐ TNCC_____ ☐ NALS_____

Certification / Expiration:

☐ _____ ☐ ACLS/PALS Instructor_____

☐ AORN_____ ☐ CDE (Diabetes Educ.)_____

☐ RN, C (ANA)_____ ☐ Parish Nurse_____

☐ CPR Instructor_____

EDUCATION

Type of School	Name & Address of School	Number of Years Completed	Did You Graduate?	Type of Degree & # of Credits	Field of Study
High School			☐ YES ☐ NO		
Business / Vocational / Correspondence Schools			☐ YES ☐ NO		
College or University			☐ YES ☐ NO		
Graduate School			☐ YES ☐ NO		

EMPLOYMENT HISTORY *(Please list present or most recent employer first)*

Name of Employer:	Address:	
Position Title:	Supervisor: May We Contact: ☐ YES ☐ NO	Telephone: ( )
Last Salary: $ Per	Dates of Employment From: To:	Reason For Leaving:
Describe Duties / Responsibilities:		

Name of Employer:	Address:	
Position Title:	Supervisor: May We Contact: ☐ YES ☐ NO	Telephone: ( )
Last Salary: $ Per	Dates of Employment From: To:	Reason For Leaving:
Describe Duties / Responsibilities:		

Name of Employer:	Address:	
Position Title:	Supervisor: May We Contact: ☐ YES ☐ NO	Telephone: ( )
Last Salary: $ Per	Dates of Employment From: To:	Reason For Leaving:
Describe Duties / Responsibilities:		

REFERENCES

Give name, address and telephone number of references who are not related to you and are not previous employers.

Reference Type: ☐ Professional ☐ Personal

Name: ____________________

Address: ____________________

City, State & Zip: ____________________

Home/Business Phone: ____________________ Years Acquainted ________

Organization ____________________

Relationship: *(please circle one)* Sub-ordinate/Co-worker/Supervisor/Teacher Enter Relationship Type From List Here When Filling Out On A Device

Reference Type: ☐ Professional ☐ Personal

Name: ____________________

Address: ____________________

City, State & Zip: ____________________

Home/Business Phone: ____________________ Years Acquainted ________

Organization ____________________

Relationship: *(please circle one)* Sub-ordinate/Co-worker/Supervisor/Teacher Enter Relationship Type From List Here When Filling Out On A Device

Reference Type: ☐ Professional ☐ Personal

Name: ____________________

Address: ____________________

City, State & Zip: ____________________

Home/Business Phone: ____________________ Years Acquainted ________

Organization ____________________

Relationship: *(please circle one)* Sub-ordinate/Co-worker/Supervisor/Teacher Enter Relationship Type From List Here When Filling Out On A Device

♦ READ BEFORE SIGNING ♦

I certify, to the best of my knowledge, the information submitted is complete and correct. I understand that if accepted, Family HealthCare may terminate my volunteer or student/intern experience if I have made any false statements or misrepresentations in this application or during the screening process.

RELEASE: I hereby authorize Family HealthCare to investigate my past record and to ascertain any and all information which may concern my record and character, whether same is of record or not, and hereby authorize my past and present employers, references, educational institutions and all persons whomsoever may have relevant information to release such information to Family HealthCare. Further, I release these same individuals and institutions from any damage or liability because of furnishing said information.

SIGNATURE:____________________ DATE:____________________

VOLUNTARY EEOC INFORMATION

Family HealthCare is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, Family HealthCare invites you to voluntarily self-identify your race or ethnicity by checking the appropriate box below.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil-rights enforcement. When reported, data will not identify any specific individual.

Race and ethnic designations as used by the Equal Employment Opportunity Commission (EEOC) and on this self-identification form do not denote scientific definitions of anthropological origins.

PLEASE CHECK THE APPROPRIATE BOX:

- ☐ Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
- ☐ White (not Hispanic or Latino) – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- ☐ Black or African American (not Hispanic or Latino) – A person having origins in 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, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ American Indian or Alaska 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 one of the five races.

☐ Male ☐ Female

Name:_____ Date:_____