Your Community Physicians

Chinese Community Health Care Association
445 Grant Ave., Suite 300, San Francisco, CA 94108
Tel: (415) 216-0088 Fax: (415) 216-0092
www.cchca.com

Application of Employment

Date of This Application ___________________________

Chinese Community Health Care Association (CCHCA) is an equal opportunity employer, and CCHCA's hiring decision are based upon the abilities and qualifications of applicants. CCHCA's hiring and employment practices comply with Title VII of the 1964 Civil Rights Act and other applicable Federal or State statutes prohibiting discrimination based on race, sex, national origin, or religion. CCHCA's practices also comply with the Age Discrimination in Employment Act, which prohibits age discrimination against applicants and employees who are between the ages of 40 and 65. No program or activity administered by CCHCA which receives Federal financial assistance shall exclude from participation, deny benefits to or subject to discrimination, any individual solely by reason of his or her handicap.

THIS APPLICATION IS GOOD FOR SIX MONTHS, UPON TERMINATION OF SIX MONTHS, YOU MUST RE-APPLY.

ALL APPLICANTS MUST READ:

1. IF YOU ARE OFFERED EMPLOYMENT, A PHYSICAL EXAMINATION AT CCHCA'S EXPENSE MUST BE TAKEN AND SATISFACTORILY PASSED PRIOR TO THE TIME OF REPORTING FOR DUTY.
2. IF YOU ARE OFFERED EMPLOYEMNET AND ARE NOT A U.S. CITIZEN, YOU WILL BE REQUIRED TO GIVE CCHCA YOUR ALIEN REGISTRATION NUMBER AND EVIDENCE OF POSSESSION OF AN ALIEN REGISTRATION RECEIPT CARD OR OTHER DOCUMENTATION ISSUED BY THE U.S. IMMIGARATION AND NATURALIZATIONS SERVICE WHICH GRANTS GOVERNMENT AUTHORIZATION TO WORK.
3. APPLICANTS UNDER 18 YEARS OF AGE PLEASE NOT:
   IF YOU ARE OFFERED EMPLOYMENT, THE LAW REQUIRES YOU TO HAVE A WORK PERIMIT, AND YOU WILL BE REQUIRED TO SHOW CCHCA THAT YOU HAVE THE NEXESSARY PERMIT BEFORE YOU CAN BE ALLOWED TO REPORT FOR DUTY.

SOURCE OF REFERRAL	*FOR STATISTICAL USE ONLY, AND NOT USED FOR HIRING PURPOSES			
	☐ Self ☐ Newspaper	☐ State Employment Office ☐ Employment Agency	☐ Union ☐ School	☐ Employee (Name)___________ ☐ Other (Specify)
POSITION FOR WHICH YOU ARE APPLYING:				
YOU ARE APPLYING FOR A POSITION WHICH IS:	☐ Full Time	☐ Part Time	☐ Temporary	☐ Casual
DATES YOU ARE AVAILABLE FOR WORK:				

GENERAL INFORMATION

(Last Name)	(First Name)	(Middle)	Social Security Number
Address (Number & Street/City/State/ Zip Code)			Home Phone Number
DO YOU HAVE ANY RELATIVES CURRENTLY EMPLOYED BY CCHCA? IF "YES", PLEASE GIVE THE RELATIVE'S NAME:		☐ YES ☐ NO	
HAVE YOU PLEADED GUILTY OR BEEN CONVICTED OF A FELONY CRIME WITHIN THE PAST FIVE YEARS? (A "yes" answer does not automatically bar you from employment with CCHCA. CCHCA will consider the nature of the offense and its relationship to emplyment with CCHCA and the position for which you are applying in reaching a decision as to your employment application.) IF "YES", GIVE THE DETAILS OF THE OFFENSE(S):____ ____		☐ YES ☐ NO	

EDUCATION AND TRAINING

1. Education

• Only education and training which is relevant to and required for the position which you are seeking will be considered. The location of schools attended and dates of attendance are requested only for the purpose of facilitating any required verification of the information given below – such information will not be used for discriminatory purposes

a) HIGH SCHOOL: PLEASE CIRCLE THE NUMBER OF YEARS COMPLETED 1 2 3 4

HIGH SCHOOL DIPLOMA: ☐ YES ☐ NO IF "NO", DO YOU HAVE A GRADUATION EQUIVALENCY DIPLOMA? ☐ YES ☐ NO

b) COLLEGE: PLEASE CIRCLE THE NUMBER OF YEARS COMPLETED 1 2 3 4 DEGREE EARNED: ☐ YES ☐ NO

IF "YES", TYPE OF DEGREE___________________ MAJOR IN COLLEGE________________________________

COLLEGE(S) ATTENDED: Name Location Date Attended

____ ________________________ ___________________________________

____ ________________________ ___________________________________

c) GRADUATE SCHOOL(S):

____ ________________________ ___________________________________

____ ________________________ ___________________________________

d) TECHNICAL SCHOOL(S)

____ ________________________ ___________________________________

____ ________________________ ___________________________________

e) OTHER (BUSINESS, etc.)

____ ________________________ ___________________________________

____ ________________________ ___________________________________

2. SPECIAL SKILLS AND/OR TRAINING

a) OFFICE (Complete only if you are applying for a clerical or other position in which the following abilities would be applicable)

Accounting ☐ Adding Machine ☐ Calculator ☐ E. D. P. (Kind) _____________________________

Bookkeeping (Kind) __________________ Cashiering Credit & Collection Medical Terminology

PBX ☐ Shorthand Speed (WPM) __________ Typing Speeds (WPM): Medical_______ General_______ Dictaphone_______

b) NURSING (For nursing applicants only) • Please state the amount of time you have spent in each of the following:

Administrative ___________ I.C.U. _____________C.C.U. _____________Emergency ___________ Surgical ___________

Medical _______ Orthopedics _______ Operating Room _______ Recovery Room________ Other (Specify) ________

c) ADDITIONAL SKILLS OR TRAINING • Do you have any other special skills, training and/or education which you have mentions above, and which you believe are relevant to the position you are seeking? If so, please give details:

____

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d) PROFESSIONAL LICENSE(S) YOU POSSESS: Type Number State Expiration Date

____ _______________ _______ ___________________________________

____ _______________ _______ ___________________________________

EMPLOYMENT HISTORY

Please complete the following information for a period of at least the last ten years, starting with your present or most recent employment. You should include employment with public agencies, including the U.S. Government, Armed Services, etc.

Employer	Employed from Month/Year	To Month/Year	Position Title	
Street Address			Name Under Which You Worked If Different From That Shown on Page 1	
City / State / Zip Code	Last Supervisor's Name		Phone	May We Contact This Employer? ☐ Y ☐ N
Position Description			Reason For Leaving	

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AFFIDAVIT

- READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING – IF YOU HAVE ANY QUESTIONS REGARDING THESE STATEMENTS, PLEASE ASK FOR CLARIFICATION BEFORE SIGNING.

1. The facts set forth above in my application for employment are true and complete. I understand that if employed, any material false statements or omissions on this application shall be sufficient cause for dismissal.

2. I Authorize the Hospital to contact State Regulatory agencies regarding the status of any license I possess, my competency and performance, and other information relevant thereto.

3. I am aware that this application will only be kept on file for 6 months. Upon expiration of 6 months, I know that I must reapply if I wish to continue being considered for employment.

4. I understand that if employed, I will be on probation during my first ninety (90) days of employment with this Hospital and may be terminated for any reason at the discretion of the Hospital during this probationary period.

5. I further understand that the work schedules of this Hospital as permitted by the Fair Labor Standards Act use the 14-day pay period as a basis for computing overtime unless specific individual or collective agreements provide otherwise. (Time and one-half will be paid after 8 hours in one day and after 80 hours in the 14-day pay period.)

6. I also authorize the organizations, schools, or persons named above to give any information regarding my employment or education. I hereby release said organizations, schools, or persons from all liability for any damage for issuing this information.

- I VERIFY THAT I HAVE READ, UNDERSTOOD, AND CONSENT TO THE ABOVE.

Signature of Applicant____ Date_______________

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