651 E. Prescott Rd. Salina, KS 67401

APPLICATION FOR EMPLOYMENT

Position applied for: _____

Social Security #: ____-____-_____

Last Name: _____ First Name:_____ Middle_____ Phone: (___) -_____

Address: _____

City_____State_____Zip_____ E-Mail:_____

Are you legally eligible for employment in the United States? ☐ Yes ☐ No

(Under the Immigration Reform and Control Act of 1986, you will be required to provide documentation to certify your eligibility and identity, should you be employed.)

Employment Preference: ☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Other

Date Available: _____

Days Available: ☐Mon. ☐Tues. ☐Wed. ☐Thurs. ☐Fri. ☐Sat. ☐Sun.

Hours Available: ☐Day ☐Evening ☐Night ☐Rotating ☐Weekends

Specify Shift Hours (*if any*): _____

Salary Desired: _____

Do you have any relatives employed at SFHC? ☐Yes ☐No If yes, whom? _____

Have you ever filed an application with us? ☐Yes ☐No If yes, when? _____

May we contact your current employer? ☐Yes ☐No

May we contact your previous employer? ☐Yes ☐No If not, why? _____

RECORD OF EMPLOYMENT (Beginning with your most recent employer)

1.

Name of Employer:_____

Address:_____

Telephone: (___) -_____ Your Position:_____

Dates Employed (*mm/dd/yyyy*): From ____/____/_____ To ____/____/_____

Rate of Pay: Starting _____ Ending _____

Reason for Leaving:_____

Supervisor's Name and Title: _____

Your Duties:_____

Salina Family Healthcare Center does not discriminate on the basis of race, color, national origin, ethnic group identification, sex, age or mental ability.

Name of Employer:_____

Address:_____

Telephone: (___) -_____ Your Position:_____

Dates Employed (*mm/dd/yyyy*): From ____/____/_____ To ____/____/_____

Rate of Pay: Starting _____ Ending _____

Reason for Leaving:_____

Supervisor's Name and Title: _____

Your Duties:_____

Name of Employer:_____

Address:_____

Telephone: (___) -_____ Your Position:_____

Dates Employed (*mm/dd/yyyy*): From ____/____/_____ To ____/____/_____

Rate of Pay: Starting _____ Ending _____

Reason for Leaving:_____

Supervisor's Name and Title: _____

Your Duties:_____

EDUCATION

	Name	Major	Level Completed	Did you Graduate?	Degree
High School				☐ Yes ☐ No	
College			☐1 ☐2 ☐3 ☐4	☐ Yes ☐ No	
Graduate				☐ Yes ☐ No	
Other (*specify*)			☐1 ☐2 ☐3 ☐4	☐ Yes ☐ No	

TECHNICAL SKILLS

Microsoft Office Applications

Access Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

Word Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

Excel Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

Outlook Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

PowerPoint Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

Do you have experience with any of the following: Dentrix ☐ Yes ☐ No PDS Cortex ☐ Yes ☐ No

McKesson's Practice Partner ☐ Yes ☐ No

Employee Self-Service Portal ☐ Yes ☐ No If yes, do you have experience with any of the following: Electronic form completion ☐ Yes ☐ No Benefit enrollment ☐ Yes ☐ No Applicant tracking ☐ Yes ☐ No

Other Applications you have experience in: _____

Special Credentialing, Certifications or Professional Licensing: _____

Additional Skills or Qualifications: _____

_____

WORK REFERENCES

Name:	Name:
Company:	Company:
Address:	Address:
Phone:	Phone:

PERSONAL REFERENCES

Name:	Name:
Address:	Address:
Phone:	Phone:

Have you read and do you understand the duties and responsibilities of this position? ☐ Yes ☐ No

Is there any reason why you could not perform all the described duties associated with this position? ☐ Yes ☐ No

If yes, please explain:

_____

_____

I hereby certify that the information provided in this application along with its attachments, are true and complete. I also agree and understand that any falsification of information herein, regardless of time of discovery, may result in the forfeit of my employment with this organization. I understand that all information in this application is subject to verification and I consent to any criminal history background checks. I also authorize this organization to contact my references, educational institutions, or any other person or organization that may have information relevant to my employment. I further authorize the organization to rely upon and use as it sees fit, any information received from such contacts. Information contained on this application may be disseminated to other agencies, non-governmental organizations or systems on a need-to-know basis for good cause shown as determined by the agency head or designee.

Applicant Signature: _____ Date: _____

Salina Family Healthcare Center
A Federally Qualified Community Health Center
651 E. Prescott, Salina, KS 67401
Medical Center ~ (785) 825-7251
Dental Center ~ (785) 826-9017
Pharmacy ~ (785) 452-3900

VOLUNTARY SELF-IDENTIFICATION FORM

Salina Health Education Foundation is subject to certain government recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, we invite applicants and/or employees to voluntarily self-identify their race and ethnicity. Submission of this information is strictly voluntary and refusal to provide it will not subject you to any adverse treatment. If you do not self-identify, identification will be made visually.

The information will be kept confidential and will 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.

Thank you for your cooperation in providing this information. If you need assistance, please contact Human Resources.

GENDER:	☐ Male ☐ Female
ETHNICITY:	☐ ***Hispanic/Latino:*** A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin, regardless of race. ☐ ***Not Hispanic/Latino***
RACE:	☐ ***White:*** A person having origins in any of the original peoples of Europe, the Middle East or North America. ☐ ***Black or African American:*** A person having origins in any of the Black racial groups of Africa. ☐ ***Native-Hawaiian or other Pacific Islander:*** A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands. ☐ ***Asian:*** 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 Viet Nam. ☐ ***American Indian or Alaskan Native:*** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. ☐ ***Two or More Races (Not Hispanic or Latino):*** All persons who identify with more than one of the above races.
VETERAN STATUS:	☐ ***I am not a Veteran*** ☐ ***Veteran:*** As defined under one or more of the following: • served on active duty for a period of more than 180 days, and any part of which occurred between August 5, 1964 and May 7, 1975 and were discharged or released other than dishonorability; or, • was discharged or released from active duty for a service connected disability if any part of the active duty was performed between August 5, 1964 and May 7, 1975; or, • who served on active duty in the U.S. military, ground, naval, or air service during a war or in a campaign or expedition for which a campaign badge has been authorized (such as The Persian Gulf, El Salvador, Grenada, Lebanon, Panama, Southwest Asia, Haiti, Somalia & Bosnia); or • one who served on active duty in the U.S. military, ground, naval, or air service during the one year period beginning on the date of discharge or release from active duty (recently separated veteran).

☐ I have elected to **NOT** complete this voluntary form.

Print Name:_____ Social Security Number: _____

Signature:_____ Date: _____

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