# APPLICATION FOR EMPLOYMENT

**Sacred Circle Healthcare**
**660 S 200 E Suite 250**
**Phone:801-359-2256**
**Fax: 801-364-4392**

Position applied for:______________________________ Agency (if applicable):____________________

Social Security No:____________________________ *(Note: Your social security no. is optional. It may be required on other forms prior to employment but will not prohibit an employment consideration.)*

Name:________________________________________ Home Phone: (____)____________
Last First Middle

Address:______________________________________ Business Phone: (_____)____________

______________________________________________ E-mail:____________________
City State Zip

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. Salary Desired:________________

Hours Available: ☐ Day ☐ Evening ☐ Night ☐ Rotating ☐ Weekends Specify Shift Hours:______________

Do you have any relatives employed at our office? ☐ Yes ☐ No If yes, who?______________________

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

May we contact your current employer? ☐ Yes ☐ No May we contact your previous employer? ☐ Yes ☐ No

**RECORD OF EMPOYMENT (beginning with your most recent employer)**

| **1.** Name of Employer | | | | Address | Telephone # | Your Position |
|---|---|---|---|---|---|---|
| Dates Employed | | Rate of Pay | | Reason for Leaving: | Supervisor's Name & Title | |
| From: | To: | Starting: | Ending: | | | |
| MM/YY | MM/YY | | | | | |
| Your Duties: | | | | | | |

Provided by HCP

| **2.** Name of Employer | | Address | Telephone # | Your Position |
|---|---|---|---|---|
| Dates Employed | Rate of Pay | Reason for Leaving: | Supervisor's Name & Title | |
| From: To: MM/YY MM/YY | Starting: Ending: | | | |
| Your Duties: | | | | |

| **3.** Name of Employer | | Address | Telephone # | Your Position |
|---|---|---|---|---|
| Dates Employed | Rate of Pay | Reason for Leaving: | Supervisor's Name & Title | |
| From: To: MM/YY MM/YY | Starting: Ending: | | | |
| Your Duties: | | | | |

## EDUCATION

| Type | Name | Major | Last Year Completed | Did you Graduate? | Degree |
|---|---|---|---|---|---|
| High School | | | ☐1 ☐2 ☐3 ☐4 | ☐Yes ☐No | |
| College | | | ☐1 ☐2 ☐3 ☐4 | ☐Yes ☐No | |
| Graduate Studies | | | ☐1 ☐2 ☐3 ☐4 | ☐Yes ☐No | |
| Other (specify) | | | ☐1 ☐2 ☐3 ☐4 | ☐Yes ☐No | |

## TECHNICAL SKILLS

☐ Word Processor ☐ WPM ☐ Adding Machine ☐ Data Entry ☐ Personal Computer

☐ Software Skills:

Special Credentialing, Certifications, or Professional Licensing:

Additional Skills and Qualifications:

## WORK REFERENCES

| Name: | Name: |
|---|---|
| Company: | Company: |
| Address: | Address: |
| Phone: | Phone: |

## PERSONAL REFERENCES

| Name: | Name: |
|---|---|
| Address: | Address: |
| Phone: | Phone: |

Have you been convicted of a felony or misdemeanor, or presently have charges pending against you for a felony or misdemeanor?
☐Yes ☐ No If yes, please explain:________________________________

Have you ever been convicted of any type of billing fraud including Medicare, or Medicaid? ☐ Yes ☐ No

Have you ever been included on the Office of Inspector General's database of suspended persons? ☐ Yes ☐ No

Have you read and understand the duties and responsibilities for 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:______________________________________________________________________________

Are you an enrolled member of a federally recognized Tribe (CTGR or Other)? ☐ Yes ☐ No
If yes, please list your Tribal ID or C.I.B. No.:____________________________________________________________

**Sacred Circle Health Care/Confederated Tribes of the Goshute Reservation gives preference to qualified American Indian/Alaskan Native Applicants.**

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 forfeit my employment with this practice. I understand that all information on this application is subject to verification and I consent to any criminal history background checks. I also authorize this practice to contact my references, educational institutions, or any other person or organization that may have information relevant to my employment. I further authorize the practice 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: ________________