Application for Employment

Community Health Connection (CHC), is an equal opportunity employer and affords equal opportunity to all applicants for all positions without regard to race, color, religion, gender, national origin, age, disability, marital or veteran status or any other status protected under local, state or federal laws.

Date of application	Position desired:	Rate of pay:	☐ Per hour ☐ Annual

Last name	First name	Middle name

Full address (street, city, state, zip)	
Telephone number	Alternate phone number
Email address	

Are you legally eligible to work in the United States? ☐ Yes ☐ No	Do you require sponsorship for an employment visa? ☐ Yes ☐ No
Are you over 18 years of age? ☐ Yes ☐ No	If you are not over 18, can you provide proof of you eligibility to work? ☐ Yes ☐ No
Are you related to any CHC employees or any member of the Board of Directors? ☐ Yes ☐ No	Have you ever worked for CHC before? ☐ Yes ☐ No
If have worked for CHC before, please give the dates. From: To:	Have you ever been convicted, plead guilty, or nolo contendo to any crime in the last seven years? (a conviction will not automatically result in disqualification from employment) ☐ Yes ☐ No
If yes, please explain.	
Have you ever been fired or asked to resign from a job? ☐ Yes ☐ No	If yes, please explain.

EDUCATION

High school name and location		Did you receive a diploma? ☐ Yes ☐ No	Did you receive a GED? ☐ Yes ☐ No
College/Vocational school name	Location (City, State)	Number of years completed:	Major/Degree
College/Vocational school name	Location (City, State)	Number of years completed:	Major/Degree:

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LICENSES / CERTIFICATIONS

License / Certification	Organization	License/Certification #	Expiration Date

Additional skills/specialized training (*related to the position for which you are applying*):

MILITARY SERVICE

Were you in the US Armed Forces? ☐ Yes ☐ No	What branch?	How many years did you serve?
Dates of duty		
List duties in service, including special training.		

EMPLOYMENT HISTORY

Beginning with your most recent employer, list all positions within the last 10 years.

Company name	City/state		
Position held	Manager/Supervisor	Phone number	
Dates of employment From: To:	Ending salary	☐	Per hour
		☐	Annual
Responsibilities:			
Reason for leaving		May we contact? ☐ Yes ☐ No	

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Company name	City/state			
Position held	Manager/Supervisor	Phone number		
Dates of employment From: To:	Ending salary			Per hour
				Annual
Responsibilities:				
Reason for leaving			May we contact? ☐ Yes ☐ No	

Company name	City/state			
Position held	Manager/Supervisor	Phone number		
Dates of employment From: To:	Ending salary			Per hour
				Annual
Responsibilities:				
Reason for leaving			May we contact? ☐ Yes ☐ No	

Company name	City/state			
Position held	Manager/Supervisor	Phone number		
Dates of employment From: To:	Ending salary			Per hour
				Annual
Responsibilities:				
Reason for leaving			May we contact? ☐ Yes ☐ No	

Please provide and other information that you feel would help us in considering your application for employment.

Community Health Connection Medical Services

REFERENCES

Give name and telephone number of at least three references who are not related to you. Please include at least two professional references.

Name	Title	Phone number	Email address	Years known

For Professionally Licensed Applicants

Please answer the following questions and attach copies of documents listed below to receive full consideration for employment. Further information may be requested at time of interview.

1. Has your license to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily surrendered or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board? ☐ Yes ☐ No

2. Have you ever received a reprimand or been fined by any state licensing board? ☐ Yes ☐ No

3. Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? ☐ Yes ☐ No

4. Have you voluntarily surrendered, limited your privileges or not reapplied for privileges? ☐ Yes ☐ No

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ☐ Yes ☐ No

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? ☐ Yes ☐ No

7. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐ Yes ☐ No

8. Have any of your board certifications or eligibility ever been revoked? ☐ Yes ☐ No

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ☐ Yes ☐ No

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? ☐ Yes ☐ No

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? ☐ Yes ☐ No

12. Are you currently or have you ever been the subject of an investigation within the last ten years by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program? ☐ Yes ☐ No

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

14. Have you ever received sanctions from or been the subject of investigation within the last ten years by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No

15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? ☐ Yes ☐ No

16. Have you ever been investigated, sanctioned, reprimanded or cautioned within the last ten years by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation within the last ten years by a hospital or healthcare facility of any military agency? ☐ Yes ☐ No

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? ☐ Yes ☐ No

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? ☐ Yes ☐ No

19. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? ☐ Yes ☐ No

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?* ☐ Yes ☐ No

21. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? * ☐ Yes ☐ No

22. Have you ever been court-martialed for actions related to your duties as a medical professional?* ☐ Yes ☐ No

23. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the controlled Substances Act or other provision of Feral law." The term does include, however, the unlawful use of prescription controlled substances.) ☐ Yes ☐ No

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐ Yes ☐ No

25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? ☐ Yes ☐ No

26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? ☐ Yes ☐ No

**Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health organization or credentialing organization based upon all the relevant circumstances, including the nature of the crime.*

Please plan to bring with you at time of interview a copy of the following documents:
Professional Oklahoma License, CPR Certification, Curriculum Vitae, National Board Certification and Diploma

APPLICANT ACKNOWLEDGEMENT AND AUTHORIZATION
PLEASE READ CAREFULLY BEFORE SIGNING

I hereby certify that all of the information provided by me in this application (or any other accompanying or required documents) is correct, accurate and complete to the best of my knowledge. I understand that the falsification, misrepresentation or omission of any facts in said documents will be cause for denial of employment or immediate termination of employment regardless of the timing or circumstances of discovery.

Initials	Date

I hereby give Community Health Connection and its consumer reporting agency, Sentry Link, Pre-Hire, and/or ADP Screening and Selection Services, permission to contact appropriate parties, and hereby release employer and its agent from all liability as a result of such contact. I hereby consent to allow the consumer reporting agency to conduct a National Criminal History Check on me, and to report the results of such a check to Community Health Connection, Sentry Link, Pre-Hire, and ADP Screening and Selection Services

Date of Birth	Social Security Number
Other names used	Initials

I agree that Community Health Connection may, at its sole discretion, deny me employment. Community Health Connection reserves the right to rescind any offer of employment if information gained through pre-employment screens is considered unfavorable by Community Health Connection.

Initials	Date

Employment with Community Health Connection is at will, for no specified duration and may be terminated by either Community Health Connection or myself at any time, with or without cause or notice. I understand that none of the documents, policies, procedures, actions, statements of Community Health Connection or its representatives used during the employment process is deemed a contract of employment real or implied. I understand that no representative of Community Health Connection except the CEO has the authority to enter into any agreement guaranteeing any conditions of employment or any agreement contrary to the foregoing statements and that any such agreements must be made in writing and signed by the CEO of CHC.

I understand that this application is considered current for three months. If I wish to be considered for employment after this period I must fill out and submit a new application.

By signing below I acknowledge that I have read, understood and agree to the above statements.

Signature _____ Date _____

Name and phone number of person completing this form if other than applicant:

_____ _____

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Community Health Connection

Equal Employment Information Request

(Completion of Information Below is Voluntary)

Community Health Connection is an equal opportunity employer. We are requesting that you provide the following information, which will not be used in evaluating your application for employment, or in the case of incumbent employees, your performance evaluation. This section is voluntary, will be kept confidential, will not be kept with the application form, and will not be seen by the hiring supervisor. Refusal to provide the information will not affect your application for employment or consideration for any position with our organization.

Name: _____ Date: _____

Date of Birth: _____ Position(s) applied for: _____

Referral Source

☐ Advertisement ☐ Employee ☐ Web site ☐ School

☐ Recruiter/Agency ☐ Other _____

Name of source (if applicable): _____

Check one to indicate your status

☐ Male ☐ Female

Check one to indicate your Race or Ethnic Identity

☐	American Indian or Alaskan 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.
☐	Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent. This area includes, for example, Cambodia, China, Japan, Korea, Malaysia, the Philippine Islands, Thailand, and Vietnam.
☐	Black or African American – (not Hispanic or Latino) A person having origins in any of the black racial groups of Africa.
☐	Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture, regardless of race.
☐	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.
☐	White – (not Hispanic or Latino) A person having origins in any of the originals peoples of Europe, North Africa or the Middle East.
☐	Two or More Races (Not Hispanic or Latino) –A person who identifies with more than one of the above five races.

Check one or more to indicate your veteran status:

☐ Veteran ☐ Disabled Veteran ☐ Vietnam Era Veteran

Indicate if you have a disability that may affect your ability to perform the job for which you want to be considered:

☐ Yes, I have a disability ☐ No, I do not have a disability

☐ ***I do not wish to Self Identify***

Signature: _____ Date: _____

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