# Coalition of Health Services, Inc.

301 South Polk, Suite 740
Amarillo, Texas 79101
Phone #: 806.337.1700 Toll Free #: 888.892.2273 Fax #: 806.337.1700

## Application for Employment

Date: ____/____/________ Social Security Number: ____-____-____

Last Name: ________________ First Name ________________ Middle ________

Address: ______________________________________________
Street City State Zip Code

Home Phone Number: ________ Cell Number: ________ Email: ________________

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Job Applying for: ________________________ Date Available for Work: ____/____/____

Status Preferred: ☐ Full-Time ☐ Part-Time ☐ Relief / PRN ☐ Temporary ☐ Summer Only

Are you willing to work weekends? ☐ YES ☐ NO

What are your salary requirements? $ ____________ per ____________

Are you related to a Coalition of Health Services, Inc. manager or supervisor? ☐ YES ☐ No Who? ____________

Have you ever been employed by the Coalition of Health Services, Inc. or any affiliate of this organization? ☐ YES ☐ NO

When? ____/____/____ to ____/____/____ Under what name? ____________

How did you learn about this Position? ________________________

If hired, can you furnish proof of identification and authorization to work? ☐ YES ☐ NO Are you over 18? ☐ YES ☐ NO

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**FOR COALITION USE ONLY**
***DO NOT WRITE IN THIS AREA***

Employment Date: ____/____/____ Program: ____________

Title of Position: ________________ ☐ Re-Employed ☐ New Employee

☐ Full-Time ☐ Part-Time Temporary to what date? ____/____/____ No. Hrs./Pay Period ________

Orientation Date: ____/____/____ Base Pay Rate: $ ________ Final Pay Rate: $ ________

Exempt ☐ Non-Exempt Time allotted for meals: ☐ 30 min. ☐ 1 hour ☐ No meal

Name desired on badge: ________________________

**AUTHORIZATIONS:**

Program Manager: ________________ Executive Officer: ________________

References Checked: ☐ YES ☐ NO Data Entered / Date: ____/____/____

## EDUCATION

| SCHOOL | NAME AND LOCATION | YEARS COMPLETED | GED | DEGREE / DEPLOMA | MAJOR SUBJECT |
|---|---|---|---|---|---|
| High School | | Circle: 9 10 11 12 | ☐ YES ☐ NO | | |
| College or University | | Circle: 1 2 3 4 | | | |
| Vocational Technical or Post Graduate | | | | | |

**SPECIAL SKILLS RELATED TO WORK FOR WHICH YOU ARE APPLYING:**

Other languages spoken:

Use of personal Computer-Business Software (list)

☐ 10-Key Calculator ☐ Touch ☐ Sight Medical Terminology ☐ YES ☐ NO Typing Speed ________ WPM

**PROFESSIONAL /TECHNICAL LICENSES:** *Please list* *<u>all license numbers</u>* *in appropriate blanks:*

RN LVN

Other (specify) State Registered Expiration date / /

## YOUR APPLICATION WILL REMAIN ACTIVE FOR 30 DAYS AND ON FILE FOR 1 YEAR

### PLEASE READ CAREFULLY BEFORE SIGNING

I certify that, all the information provided by me in connection with my application, whether on this document or not, is true and complete, and that any misstatement, falsification, or omission of information shall result in a refusal to hire or if hired and later determined, termination. In being considered for employment with the Coalition of Health Services, Inc., I agree to the following conditions:

1) I understand that, if employed, my employment with the Coalition of Health Services, Inc. is for no definite period of time and that I may terminate my employment at any time without cause, and the Coalition of Health Services may terminate or modify the employment relationship at any time without prior notice or cause.
2) I understand that, if employed, I must comply with all policies and procedures established by the Coalition of Health Services, Inc. and that the Coalition of Health Services, Inc. has the right to make changes in policies and procedures at any time.
3) I understand that, if employed, I accept the responsibility of carrying out all duties in a manner consistent with the Christian mission and philosophy established by the Coalition of Health Services, Inc.

Date: / / Signature:

# EMPLOYMENT HISTORY

**THIS PORTION OF THE APPLICATION MUST BE COMPLETED EVEN IF SUPPLEMENTED BY A RESUME**

Start with your most recent work experience and list jobs you have held, including time spent in the military service or school. Cover full disposition of your time whether employed or not. Be sure to have correct addresses of previous employers. You may place additional information on a sheet and attach.

| Present / Last Employer | Telephone | Start Date | End date |
|---|---|---|---|
| Address | Your name when employed (for references purposes) | Start Salary | End Salary |
| Name of Supervisor | Title of your job | Hours Worked | May We contact |
| Job Duties | Reason for Leaving | | |
| Present / Last Employer | Telephone | Start Date | End date |
| Address | Your name when employed (for references purposes) | Start Salary | End Salary |
| Name of Supervisor | Title of your job | Hours Worked | May We contact |
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| Job Duties | Reason for Leaving | | |

Have you ever pled guilty to, been convicted of or received probation, deferred adjudication or pretrial diversion for any criminal offense, other than minor traffic citation?

YES NO If YES, please provide information on criminal offense, current status and expected date of completion.

# Coalition of Health Services, Inc.

The individual named below has applied for employment with the Coalition of Health Services, Inc. and has authorized a five year background investigation. We would appreciate your candid appraisal.

Name of Applicant: ______________________________ SS#: ____________________

Position Applied for: ______________________________________________

Reference 1:

Name of Company: ______________________________________________

Name of Reference: ____________________________ Current Phone#: ____________________

Comments: ______________________________________________

______________________________________________

Reference 2:

Name of Company: ______________________________________________

Name of Reference: ____________________________ Current Phone#: ____________________

Comments: ______________________________________________

______________________________________________

Reference 3:

Name of Company: ______________________________________________

Name of Reference: ____________________________ Current Phone#: ____________________

Comments: ______________________________________________

______________________________________________

Reference checked by: ____________________________ Date Checked: ____________________

I, the undersigned have made an application for employment with the Coalition of Health Service, Inc. I authorize you to give to the Coalition of Health Service, Inc. any and all information and opinion concerning my previous employment, education, or any other information you might have, personal or otherwise, with regard to any of the subjects covered herein, and in consideration of your furnishing this information to the Coalition of Health Service, Inc. on my behalf, I release you and agree to hold you harmless from all liability for damages (actual, consequential, or otherwise) which may result from furnishing such information to the Coalition of Health Service, Inc.

Signed: ______________________________________ Date: ____________________

# Coalition of Health Services, Inc.

## FOR COALITION USE ONLY

| Comments: | |
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Referrals:

| Date | Interviewer & Program | Position | Comments (include reasons for not interviewing) |
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| ADDITIONAL COMMENTS: | |
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