



**Family Health Centers, Inc.**  
**3310 Magnolia Street**  
**Orangeburg, SC 29115**  
**Ph. 803-531-6900**  
**Application For Employment**



**Please print or type all information.**

1. Title of Position Applying For		2. Location	3. Date of Application
4. Name: Last	First	Middle Initial	5. Maiden Name
6. Current Address: Number		Street	Apt. No.
7. Bus. Phone No:			
8. City	9. State	10. Zip Code	11. Home Phone No:
12. Education: (Circle the highest grade completed) 9 10 11 12 GED Associate's Bachelor's Master Ph.D.			
High School Name	Address:		City, State
College/Technical School Name:	Degree Earned and Year		City, State
College/Technical School Name:	Degree Earned and Year		City, State
13. General Skills: Computer Skills–List Software and years of experience:			0-1 yr 1-2 yrs 2+yrs
_____			( ) ( ) ( )
_____			( ) ( ) ( )
_____			( ) ( ) ( )

Professional License/Certificate (Other than Driver's License): \_\_\_\_\_

Additional Information: Attach additional pages if necessary.

14. Language other than English in which you are fluent: \_\_\_\_\_ ( ) Read ( ) Write ( ) Speak  
 Language other than English in which you are fluent: \_\_\_\_\_ ( ) Read ( ) Write ( ) Speak

15. May we contact you at work? \_\_\_Yes \_\_\_No If yes, work number and best time to call: \_\_\_\_\_

16. Have you submitted an application with Family Health Centers before? \_\_\_ Yes \_\_\_ No  
 If yes, give dates and position(s) applied for: \_\_\_\_\_

17. Do you have any relatives (by blood or marriage) working for Family Health Centers? \_\_\_ Yes \_\_\_ No  
 If yes, A. List Name(s), B. Relationship(s), and C. Location  
 A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_  
 A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_

18. Has your employment ever been involuntarily terminated or have you ever resigned to avoid discharge (for any reason except lack of work) within the past ten years? \_\_\_Yes \_\_\_ No  
 If yes, list name and address of employer and date and reason for discharge/resignation.  
 Name of Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
 State reason for discharge/resignation to avoid discharge: \_\_\_\_\_

19. Date available for work: \_\_\_\_\_ What is your desired salary range? \_\_\_\_\_

20. Type of employment desired: \_\_\_ Full Time \_\_\_ Part-time \_\_\_ Temporary \_\_\_ Volunteer  
 If Part-time – Hours Available \_\_\_\_\_

**Employment History:** This section **MUST BE COMPLETED** even if you are attaching a resume. Since every effort will be made to contact current and previous employers, correct telephone numbers are very important. Volunteer work or internships may also be included. Additional employment information may be attached.

**Current or Most Recent Employer:** \_\_\_\_\_ ( ) Full Time ( ) Part Time

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone number \_\_\_\_\_

Date employed: From \_\_\_\_\_ To \_\_\_\_\_  
Job Title \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

May we contact this supervisor? ( ) Yes ( ) No Salary: \$ \_\_\_\_\_ (Monthly)

Duties: \_\_\_\_\_

\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

**Second Most Recent Employer:** \_\_\_\_\_ ( ) Full Time ( ) Part Time

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone number \_\_\_\_\_

Date employed: From \_\_\_\_\_ To \_\_\_\_\_  
Job Title \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

May we contact this supervisor? ( ) Yes ( ) No Salary: \$ \_\_\_\_\_ (Monthly)

Duties: \_\_\_\_\_

\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

**Third Most Recent Employer:** \_\_\_\_\_ ( ) Full Time ( ) Part Time

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone number \_\_\_\_\_

Date employed: From \_\_\_\_\_ To \_\_\_\_\_  
Job Title \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

May we contact this supervisor? ( ) Yes ( ) No Salary: \$ \_\_\_\_\_ (Monthly)

Duties: \_\_\_\_\_

\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

**Fourth Most Recent Employer:** \_\_\_\_\_ ( ) Full Time ( ) Part Time

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone number \_\_\_\_\_

Date employed: From \_\_\_\_\_ To \_\_\_\_\_  
Job Title \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

May we contact this supervisor? ( ) Yes ( ) No Salary: \$ \_\_\_\_\_ (Monthly)

Duties: \_\_\_\_\_

\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

**FAMILY HEALTH CENTERS, INC. WILL CONDUCT DRUG SCREENS, CRIMINAL BACKGROUND CHECKS, AND PERSONAL AND EMPLOYER REFERENCE CHECKS FOR ALL APPLICANTS PRIOR TO EMPLOYMENT.**

If the job for which you are applying requires driving, please answer the following questions:

Driver's License # \_\_\_\_\_ Type \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_  
Endorsements \_\_\_\_\_ Restrictions \_\_\_\_\_  
Full Auto Insurance ( ) Yes ( ) No

Are you legally eligible for employment in this country? ( ) Yes ( ) No

Have you ever been convicted of a criminal offense? ( ) Yes ( ) No

Note: **Omit minor vehicle violations and any offense committed before your 17<sup>th</sup> birthday, which was finally adjudicated in juvenile court or under a youthful offender law. Conviction of a criminal offense is not a bar to employment in all cases. Each conviction is evaluated individually.**

If yes, please list charge(s) \_\_\_\_\_

Where Convicted	Date	Disposition Statue
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**Please give the names of three references, not relatives, who are familiar with your work.**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**PLEASE CAREFULLY READ AND SIGN BOTH OF THE FOLLOWING STATEMENTS**

**Certification of Applicant: I certify that the answers given by me to the forgoing questions and statements are true and correct without consequential omissions of any kind. I understand and agree that any misleading or incorrect statements or omissions may render this application void, and if employed, would be cause for termination, and Family Health Centers, Inc. shall not be liable in any respect for such action or termination. As an applicant with Family Health Centers, I understand that, if hired, I must comply with the employee Drug and Alcohol Policy and the Immigration Reform and Control Act of 1986, which requires proof of employment eligibility. Additionally, I agree to submit to a pre-employment drug screening test as required by Family Health Centers and understand that my application will be rejected if I fail to do so. If I have requested herein that my present employer not be contacted, an offer of employment may be conditioned upon acceptable information and verification from such employer before beginning work.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CERTIFICATION**

**By my signature, I authorize the Agents of Family Health Centers to conduct a background check pertaining to my suitability for employment which may include current and former employer job reference checks, criminal history check and medical evaluation. I hereby release said companies, schools or persons from all liability for any damage of issuing this information.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE USE THIS AREA TO ADD ANY ADDITIONAL INFORMATION/COMMENTS YOU MAY WANT TO INCLUDE ON LICENSES, CERTIFICATION OR OTHER JOBS HELD, THAT MEET THE EXPERIENCE REQUIREMENTS OF THE JOB YOU ARE APPLYING FOR.**

**PLEASE MAIL ALL COMPLETED AND SIGNED APPLICATIONS TO FAMILY HEALTH CENTERS, INC. ATTN: HUMAN RESOURCES, 3310 MAGNOLIA ST, OR P.O. BOX 1806 ORANGEBURG, SC 29115**

## EEOC DATA REPORTING FORM

The federal government requires that the following information be collected for statistical reporting as a part of the Affirmative Action Program. Refusal to answer will not result in adverse treatment of any applicant. **This information is not used in the employment process nor released in a manner which identifies the individual. This form will be removed prior to being forwarded to the hiring authority.**

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Last Name \_\_\_\_\_ (Maiden Name if applicable) \_\_\_\_\_

First Name \_\_\_\_\_ Middle \_\_\_\_\_

Position for which you are applying \_\_\_\_\_

Title

Sex (Check appropriate box) \_\_\_\_ Male \_\_\_\_ Female

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (required for SLED Check)

- Race (Check appropriate box)
1. \_\_\_\_ American Indian / Alaskan Native
  2. \_\_\_\_ Asian / Pacific Islanders
  3. \_\_\_\_ Black / Non Hispanic
  4. \_\_\_\_ Hispanic
  5. \_\_\_\_ White / Non Hispanic

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If handicapped or otherwise physically impaired, will you need reasonable accommodations to participate in the selection process (e.g., interview, written test, or job demonstration)? \_\_\_\_ Yes \_\_\_\_ No

If yes, please notify the Office of Human Resources at Family Health Centers, Inc.