Today' s Date: _____

Camarillo HEALTH CARE DISTRICT

APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER

Name: _____

Street Address: _____

City: State: Zip Code:

Home Telephone: Cell Telephone: Email:

GENERAL INFORMATION

Position Applied For: _____ Salary Desired _____

Date Available to Start Work: _____ Full Time ☐ Part Time ☐ Temporary ☐

If applying for temporary work, during what period of time will you be available?

From: _____ To: _____

If you are under age 18, can you provide a work permit if offered a job? Yes ☐ No ☐

Can you, after employment, submit verification of your legal right to work in the U.S.? Yes ☐ No ☐

Have you ever applied for a position or worked for the Camarillo Health Care District before? Yes ☐ No ☐

If yes, specify dates: From: _____ To: _____

To assist us in checking records and verifying prior employment and education, please indicate whether you were ever employed or enrolled under a name other than that used on this application: Yes ☐ No ☐

If yes, please specify the name under which you were employed or enrolled: _____

If you are employed now, may we contact your current employer? Yes ☐ No ☐

Are you able to perform the essential duties of the position for which you are applying, either with or without reasonable accommodations? Yes ☐ No ☐

If necessary, please indicate what type(s) of reasonable accommodations are needed: _____

(Please note that the District complies with the ADA and considers reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential job functions. Hire may be subject to passing a medical examination and to skill and agility tests.)

GENERAL INFORMATION (Cont'd.)

Please list any job-related professional, trade, business or civic activities, organizations and associations to which you belong. (You may omit those which indicate race, color, religion, national origin, ancestry, sex, age, or the existence of a disability.):

_____

_____

_____

Some of our clients do not speak English. Do you speak, write, or understand any foreign languages?

Yes ☐ No ☐ If yes, which language(s)? _____

Do you have any friends or relatives working for the Camarillo Health Care District? Yes ☐ No ☐

If yes, state name(s) and relationship(s) _____

_____

What prompted you to apply for employment with the Camarillo Health Care District:

Referral _____ By whom?_____

Do we have your permission to distribute your application to other agencies? Yes ☐ No ☐

Please answer the following questions if you are applying for a professional position:

Are you licensed/certified for the job applied for? Yes ☐ No ☐

Type of license/certification _____

Issuing state/Agency _____

License/certification number _____

Has your license/certification ever been revoked or suspended? Yes ☐ No ☐

If yes, state reason(s), date of revocation or suspension and date of reinstatement: _____

_____

EDUCATION

	NAME AND ADDRESS OF SCHOOL	DEGREE/MAJOR	NO. OF YEARS COMPLETED	DID YOU GRADUATE?
HIGH SCHOOL				
COLLEGE/ UNIVERSITY				

ADDITIONAL SKILLS

Do you have any other experience, training, qualifications or skills which you feel make you especially suited for work at the Camarillo Health Care District? If so, please explain:_____

Please list your computer hardware/software skills:_____

EMPLOYMENT HISTORY

Please list your present and past work experience for the last 10 years, beginning with your current job. You may include volunteer activities. If you need additional space, please continue on a separate page. You must complete this section even if attaching a resume.

Name of Employer:	From Month Year	To Month Year
Address:	Telephone:	
Position:	Supervisor:	
Description of Duties:		
Reason for Leaving:		

Name of Employer:	From Month Year	To Month Year
Address:	Telephone:	
Position:	Supervisor:	
Description of Duties:		
Reason for Leaving:		

EMPLOYMENT HISTORY (cont'd.)

Name of Employer:	From Month Year	To Month Year
Address:	Telephone:	
Position:	Supervisor:	
Description of Duties:		
Reason for Leaving:		

Name of Employer	From Month Year	To Month Year
Address:	Telephone:	
Position:	Supervisor:	
Description of Duties:		
Reason for Leaving:		

MILITARY SERVICE

Are you a veteran of the United States Military Service? Yes ☐ No ☐

If yes, please state branch of service: _____

Have you obtained any special skills or abilities as the result of service in the military? Yes ☐ No ☐

If so, please describe: _____

_____

Camarillo HEALTH CARE DISTRICT

PROFESSIONAL REFERENCES

List three persons who have knowledge of your work performance. Please do not include relatives.

Name_____ No. of Years Acquainted_____

Address_____ Telephone No. __( )_____

Position/Capacity in Which Known_____

Name_____ No. of Years Acquainted_____

Address_____ Telephone No. __( )_____

Position/Capacity in Which Known_____

Name_____ No. of Years Acquainted_____

Address_____ Telephone No. __( )_____

Position/Capacity in Which Known_____

I hereby certify that the information contained in this application is true and correct to the best of my knowledge. I agree to have any of the statements checked by the Camarillo Health Care District (hereinafter referred to as the CHCD) unless I have indicated to the contrary. I authorize the references listed above, as well as all other individuals whom the CHCD contacts, to provide the CHCD any and all information concerning my previous employment and any other pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to the CHCD as well as from the use or disclosure of such information by the CHCD or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or, if I am hired, my dismissal from employment.

In consideration of my employment, I agree to conform to the rules and standards of the CHCD. I further agree that my employment and compensation can be terminated at-will, with or without cause, and with or without notice, at any time, either at my option or the option of the CHCD. I understand that no employee or representative of the CHCD, other than the Chief Executive Officer (CEO), has the authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing. Further, the CEO may not alter the at-will nature of the employment relationship unless the CEO and I both sign a written agreement that clearly and expressly specifies the intent to do so. I agree that this constitutes an integrated agreement with respect to the at-will nature of my employment relationship, that it is final and fully binding, and that there are no oral or collateral agreements regarding this issue.

I also understand that all offers of employment are conditioned on the provision of satisfactory proof of an applicant's identity and legal authority to work in the United States.

_____ _____

Signature of Applicant Date