

## 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 <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
Can you, after employment, submit verification of your legal right to work in the U.S.?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever applied for a position or worked for the Camarillo Health Care District before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
Are you able to perform the essential duties of the position for which you are applying, either with or without reasonable accommodations?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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.):

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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: \_\_\_\_\_

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### 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 <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please state branch of service: _____		
Have you obtained any special skills or abilities as the result of service in the military?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If so, please describe: _____		
_____		

## 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