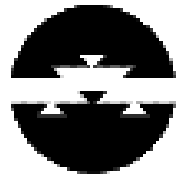


K'ima:w Medical Center
 An entity of the Hoopa Valley Tribal Council
EMPLOYMENT & VOLUNTEER APPLICATION
 P. O. Box 1288 · Hoopa, CA 95546 · (530)625-4261



POSITION APPLIED FOR:		Date:	
Name:		Social Security Number:	
Mailing Address:		City	State
Telephone: Home () -		Cell () -	Work () -
Zip			

Can you, after employment, submit verification of your legal right to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	Salary requirement: _____ Have you ever worked for K'ima:w Medical Center <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" when? _____ What position: _____
--	---

Is Indian Preference Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No Tribe: _____ Roll Number: _____ Attach Verification	Veterans Preference <input type="checkbox"/> Yes <input type="checkbox"/> No Attach Verification
---	--

Check time willing to work <input type="checkbox"/> Full time <input type="checkbox"/> Part-time Hours per week: _____ <input type="checkbox"/> Days <input type="checkbox"/> Evenings No. of days per week: _____ <input type="checkbox"/> Overtime occasionally if necessary	If offered employment, when can you start? _____ What is your anticipated length of employment? _____ Have you given notice to your present employer?
---	--

EDUCATION

Diploma <input type="checkbox"/> Yes <input type="checkbox"/> No GED <input type="checkbox"/> Yes <input type="checkbox"/> No	Last High School Attended: Address:
--	--

College (attach transcripts), Trade School or Special Training (attach certificates):

Name of School	Address	Dates Attended	Degree/Trade/Training

CERTIFICATES OR LICENSES (ATTACH COPY)

License Type: X-ray R.N. L.V.N Lab Tech. EMT Paramedic Other # _____

Give Expire Date: _____ Date Earned: _____ State Issued: _____

Are all certificates current? Yes No

Positions requiring Driving License: License #: _____ Expiration Date: _____

CPR Certified: Yes No

PAST EMPLOYMENT HISTORY: Please list your employers, starting with your most recent position.
 May we contact your previous employer? Yes No

From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:
From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:
From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:
From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:
From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:
From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:
From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:
From:	Name of Company
	Telephone of Company
	Immediate Supervisor
To:	Position & Duties:
	Reason for leaving:

Job related training, honors/awards, accomplishments (Title/Year) or other information, skills, that would specifically prepare you to work with K'ima:w Medical Center?

EXPERIENCE & SKILLS

Have you had experience in the following:

Word Perfect	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Computer Problem Solving/Programming	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
MS Excel	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Insurance Processing	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Other computer programs	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Professional Medical Applicants Only	
Word Processing	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Set-up and assist with minor surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Typing (WPM____)	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Do EKG's	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Filing	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Do venipunctures	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Heavy phones	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Do throat cultures	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Scheduling appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Urinalysis by dipstick	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Know medical terminology	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Microscopic Urinalysis	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Transcription from tape	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Give Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Computer Billing	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	Supply & instrument inventory/ordering	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____
Data entry (speed____)	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____	List any other procedures with which you have assisted:	
Account Collections	<input type="checkbox"/> Yes <input type="checkbox"/> No Years: _____		

PERSONAL REFERENCES:

Name:	Address:	Phone:	Years Known:
Name:	Address:	Phone:	Years Known:
Name:	Address:	Phone:	Years Known:

EMPLOYMENT APPLICATION DISCLAIMERS

<i>Initial</i>	<i>The K'ima:w Medical Center is an equal opportunity employer. Your application will be given every consideration, but our receipt of it does not guarantee that you will be employed. Employee selection is consistent with the Hoopa Tribal TERO Ordinance. Applicants selected will be subject to alcohol and drug testing pursuant to the Hoopa Tribes Alcohol Policy.</i>
<i>Initial</i>	<i>All applicants to positions located at an K'ima:w Medical Center facility shall provide documentations of immunity of Measles and Rubella, and annual PPD prior to or at the time of their entrance on duty. Employees or volunteers subject to this policy who are not immune to Rubella and Measles and refuse the recommended vaccine(s) are subject to be reassigned or removed from their position. I understand that at any time during my employment, I may be required to take a physical examination which may include an alcohol and drug test if management reasonably suspects a condition exists that will prevent me from performing my job in a manner that does not endanger my own health or the safety and health of others. I authorize all providers of health care who examine me to disclose to the medical center or its agents, All medical information revealed during such examinations. I further authorize the medical center to disclose such information to any other persons, if at any time my medical condition is put at issue in any proceedings by myself or others. In the event that I have a disability which will affect my ability to take the test, I will so inform the medical center so that a reasonable accommodation can be made. The medical center reserves the right to require medical documentation concerning the need for accommodation.</i>

<i>Initial</i>	<i>I understand that all offers of employment are conditioned upon my providing satisfactory documentary proof of my identity and legal right to live and work in the US.</i>
<i>Initial</i>	<i>I declare under penalty of perjury that the facts contained in the application (or resume or other documents submitted) are true and complete to the best of my knowledge. I certify that I, the undersigned applicant, have personally completed this application. I understand that any misrepresentation or omissions will disqualify me from further considerations for employment, and will be justification for my dismissal from employment or volunteering, if discovered at a later date.</i>
<i>Initial</i>	<i>I authorize any persons, school, current employer (except as expressly noted), past employer(s), and organizations named in this application from (and accompanying resume or other documentation, if any) to provide the medical center with relevant information and opinions, personal or otherwise, that may be useful in making a hiring decision. I release all parties from all liability for any damage that may result from furnishing information and opinion to you.</i>
<i>The period during which this application will be considered active is limited TO THE OPENING APPLIED TO and individuals must re-apply (COMPLETE A NEW APPLICATION) for any other open position.</i>	

Applicants Signature _____

Date: _____



DISCLOSURE AND AUTHORIZATION FOR CONSUMER REPORTS

In connection with my application for employment (including contract or volunteer services), I understand consumer reports will be requested by K'ima:w Medical Center ("Company"). These reports may include, as allowed by law, the following types of information, as applicable: names and dates of previous employers, reason for termination of employment, work experience, education, accidents, licensure, credit, etc. I further understand that such reports may contain public record information such as, but not limited to: my driving record, workers' compensation claims, judgments, bankruptcy proceedings, criminal records, etc., from federal, state, and other agencies that maintain such records.

In addition, investigative consumer reports (gathered from personal interviews, as applicable, with former employers, past or current associates of mine, etc.) to gather information regarding my work performance, character, general reputation and personal characteristics, and mode of living (lifestyle) may be obtained.

If I am hired, I understand that my employer can use this disclosure and authorization to continue to obtain such consumer reports throughout my employment, contract period or volunteer service.

Authorization

I hereby authorize procurement of consumer report(s) and investigative consumer report(s) by Company. If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for Company to procure such reports at any time during my employment, contract, or volunteer period. I authorize without reservation, any person, business or agency contacted by the consumer reporting agency to furnish the above-mentioned information.

This authorization is conditioned upon the following representations of my rights:

I understand that I have the right to make a request to the consumer reporting agency: Background Profiles, Inc. ("Agency"), 3478 Buskirk Avenue #102, Pleasant Hill, CA 94523, telephone number (925) 974-1820, upon proper identification, to obtain copies of any reports furnished to Company by the Agency and to request the nature and substance of **all information** in its files on me at the time of my request, including the sources of information, and the Agency, on Company's behalf, will provide a complete and accurate disclosure of the nature and scope of the investigation covered by any investigative consumer report(s). The Agency will also disclose the recipients of any such reports on me which the Agency has previously furnished within the two year period for employment requests, and one year for other purposes preceding my request (California three years). I hereby consent to Company obtaining the above information from the Agency. I understand that I can dispute, at any time, any information that is inaccurate in any type of report with the Agency. I may view the Agency's privacy policy at their website: www.backgroundprofiles.com.

I understand that if the Company is located in California, Minnesota or Oklahoma, that I have the right to request a copy of any report Company receives on me at the time the report is provided to Company. By checking the following box, I request a copy of all such reports be sent to me. Check here:

As a California applicant, I understand that I have the right under Section 1786.22 of the California Civil Code to contact the Agency during reasonable hours (9:00 a.m. to 5:00 p.m. (PTZ) Monday through Friday) to obtain all information in Agency's file for my review. I may obtain such information as follows: 1) In person at the Agency's offices, which address is listed above. I can have someone accompany me to the Agency's offices. Agency may require this third party to present reasonable identification. I may be required at the time of such visit to sign an authorization for the Agency to disclose to or discuss Agency's information with this third party; 2) By certified mail, if I have previously provided identification in a written request that my file be sent to me or to a third party identified by me; 3) By telephone, if I have previously provided proper identification in writing to Agency; and 4) Agency has trained personnel to explain any information in my file to me and if the file contains any information that is coded, such will be explained to me.

I understand that if I am applying for employment in New York, that I have the right to receive a copy of Article 23-A of the New York Correction Law _____(initial if this applies).

I understand that if the report is provided to an employer in the State of Washington, that I can contact the following office for more information regarding my rights under Washington state law in regard to these reports: State of Washington Attorney General, Consumer Protection Division, 800 5th Ave, Ste. 2000, Seattle, Washington 98104-3188, (206) 464-7744.

In connection with my application for employment, I direct the following regarding my current employer: (please check one). Yes, my current employer may be contacted _____ / No, my current employer cannot be contacted _____

I understand that I have rights under the Fair Credit Reporting Act, and I acknowledge receipt of the Summary of Rights _____ (initials).

Printed Name: _____

Signature: _____

Date: _____

For identification purposes:

Social Security No.: _____; Date of Birth: _____.

Drivers License No.: _____; State of Issue: _____.