First Choice Health Centers
For All Your Health Care Needs

EQUAL OPPORTUNITY EMPLOYER

94 CONNECTICUT BOULEVARD
EAST HARTFORD, CT 06108

APPLICATION FOR EMPLOYMENT

PLEASE REVIEW ENTIRE APPLICATION FIRST THEN ANSWER ALL QUESTIONS

LAST FIRST MIDDLE INITIAL

NAME: _____

LIST ALL PREVIOUS NAMES/ALIASES: _____

POSITION APPLIED FOR: _____ SALARY DESIRED _____

ARE YOU OVER 18? YES ☐ NO ☐ ; RELATIVES EMPLOYED AT FCHC? YES ☐ NO ☐ IF YES, PROVIDE NAME(S): _____

CURRENT ADDRESS: _____

CITY/TOWN _____ STATE _____ ZIP CODE _____

AVAILABILITY

DATE AVAILABLE FOR WORK: _____ HOURS DESIRED: _____

APPLYING FOR FULL-TIME ☐ OR PART-TIME ☐

E-MAIL ADDRESS: _____ CELL PHONE: _____

HOME PHONE: _____

ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? YES_____ NO _____

EDUCATION

LIST ALL COLLEGES, BUSINESS SCHOOLS OR TECHNICAL SCHOOLS YOU ATTENDED, IN CHRONOLOGICAL ORDER WITH MOST RECENT FIRST:

NAME OF SCHOOL	ADDRESS	COURSE OR MAJOR	DEGREE RECEIVED

OTHER TRAINING OR PROFESSIONAL LICENSES, SPECIAL COURSES, WORK TRAINING PROGRAMS, ARMED FORCES TRAINING. GIVE NAME AND LOCATION WHERE TRAINING WAS GIVEN, CERTIFICATE (IF ANY), DATES ATTENDED, SUBJECT OF TRAINING, NUMBER OF HOURS PER WEEK, AND OTHER DETAILS RELATED TO THE JOB FOR WHICH YOU ARE APPLYING.

_____

_____

_____

HAVE YOU EVER BEEN DISCHARGED FROM A PLACE OF EMPLOYMENT FOR CAUSE? YES ☐ NO ☐

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LIST BELOW, CHRONOLOGICALLY (MOST RECENT DATES FIRST) YOUR CURRENT EMPLOYER AND EVERY PREVIOUS EMPLOYER. INCLUDE ANY PART-TIME EMPLOYMENT. GIVE CORRECT, FULL ADDRESSES. GIVE DATES OF UNEMPLOYMENT IN PROPER SEQUENCE. ATTACH ADDITIONAL SHEETS AS NEEDED.

NAME OF EMPLOYER:

EMPLOYER'S ADDRESS: TELEPHONE NO.

TITLE OF POSITION NAME AND TITLE OF SUPERVISOR

EMPLOYMENT DATES
FROM: TO: REASON FOR LEAVING:

DESCRIPTION OF DUTIES, RESPONSIBILITIES AND SIGNIFICANT ACCOMPLISHMENTS

NAME OF EMPLOYER:

EMPLOYER'S ADDRESS: TELEPHONE NO.

TITLE OF POSITION NAME AND TITLE OF SUPERVISOR

EMPLOYMENT DATES
FROM: TO: REASON FOR LEAVING:

DESCRIPTION OF DUTIES, RESPONSIBILITIES AND SIGNIFICANT ACCOMPLISHMENTS

NOTICE: A PROSPECTIVE EMPLOYEE WILL BE REQUIRED TO SUBMIT TO A URINALYSIS DRUG TEST. ANY OFFER OF EMPLOYMENT WILL BE CONDITIONED UPON THE SUCCESSFUL RESULT OF THIS TEST.

I HEREBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN BY ME ON THIS APPLICATION ARE TRUE AND COMPLETE. I AGREE THAT ANY FALSE STATEMENT, OMISSION OR MISREPRESENTATION WOULD ALLOW FOR MY BEING DISCONTINUED FROM THE SELECTION PROCESS AND/OR DISMISSAL FROM EMPLOYMENT OBTAINED THROUGH THIS APPLICATION WHENEVER SUCH FALSIFICATION IS DISCOVERED.

NAME DATE

SIGNATURE

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REFERENCE FORM

I, _____, AUTHORIZE FIRST CHOICE HEALTH CENTERS, INC. TO CONTACT ANY ORGANIZATION OR INDIVIDUAL THAT I HAVE LISTED ON MY EMPLOYMENT APPLICATION OR RESUME OR MENTIONED IN JOB INTERVIEWS AND OBTAIN FROM THEM ANY RELEVANT INFORMATION ABOUT MY JOB QUALIFICATIONS, INCLUDING MY EXPERIENCE, SKILLS, AND ABILITIES. I UNDERSTAND THAT I AM CONSENTING TO THE RELEASE OF ANY REFERENCE-RELATED INFORMATION ABOUT ME HELD OR KNOWN BY MY FORMER EMPLOYERS, SUPERVISORS, AND CO-WORKERS. IN ADDITION, I CONSENT TO THE RELEASE OF ANY INFORMATION ABOUT MY EDUCATION, EXPERIENCE, ABILITIES, OR WORK-RELATED CHARACTERISTICS OR TRAITS HELD OR KNOWN BY OTHER ORGANIZATIONS OR INDIVIDUALS, INCLUDING SCHOOLS AND EDUCATIONAL INSTITUTIONS, PROFESSIONAL OR BUSINESS ASSOCIATES, AND FRIENDS AND ACQUAINTANCES THAT THE COMPANY MIGHT CONTACT IN THE COURSE OF CONDUCTING A REFERENCE CHECK OR BACKGROUND INVESTIGATION OF MY SUITABILITY FOR EMPLOYMENT.

I UNDERSTAND AND ACKNOWLEDGE THAT THIS AUTHORIZATION OF INFORMATION CAN INVOLVE MY QUALIFICATIONS, PERFORMANCE, CREDENTIALS, OR OTHER CHARACTERISTICS OR FACTORS AFFECTING MY SUITABILITY FOR EMPLOYMENT WITH THE COMPANY. SPECIFICALLY, I AM AUTHORIZING INFORMATION ABOUT MY PERFORMANCE, EXPERIENCE, CAPABILITY, ATTITUDE, OR OTHER WORK-RELATED CHARACTERISTICS THAT CURRENTLY ARE IN THE POSSESSION OF THE FOLLOWING ORGANIZATIONS OR THEIR MANAGERS OR REPRESENTATIVES:

1. _____ _____ _____
   COMPANY NAME REFERENCE NAME REFERENCE EMAIL OR FAX
2. _____ _____ _____
   COMPANY NAME REFERENCE NAME REFERENCE EMAIL OR FAX
3. _____ _____ _____
   COMPANY NAME REFERENCE NAME REFERENCE EMAIL OR FAX

IN EXCHANGE FOR THE COMPANY'S CONSIDERATION OF MY EMPLOYMENT APPLICATION, I AGREE NOT TO FILE OR PURSUE ANY COMPLAINTS, CLAIMS, OR LEGAL ACTIONS OF ANY KIND AGAINST ANY ORGANIZATION OR INDIVIDUAL THAT PROVIDES WORK-RELATED INFORMATION ABOUT ME TO THE COMPANY OR ITS AGENTS IN ACCORDANCE WITH THE TERMS AND INTENT OF THIS RELEASE. I ALSO AGREE NOT TO FILE OR PURSUE ANY COMPLAINTS, CLAIMS, OR LEGAL ACTIONS AGAINST THE COMPANY OR ANY OF ITS EMPLOYEES, REPRESENTATIVES, OR AGENTS ARISING OUT OF THEIR EFFORTS TO OBTAIN WORK-RELATED INFORMATION ABOUT ME.

ACKNOWLEDGMENT:

SIGNATURE OF APPLICANT:_____ DATE:_____

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VOLUNTARY SELF-IDENTIFICATION OF DISABILITY

WHY ARE YOU BEING ASKED TO COMPLETE THIS FORM?

BECAUSE WE DO BUSINESS WITH THE GOVERNMENT, WE MUST REACH OUT TO, HIRE, AND PROVIDE EQUAL OPPORTUNITY TO QUALIFIED PEOPLE WITH DISABILITIES. TO HELP US MEASURE HOW WELL WE ARE DOING, WE ARE ASKING YOU TO TELL US IF YOU HAVE A DISABILITY OR IF YOU EVER HAD A DISABILITY. COMPLETING THIS FORM IS VOLUNTARY, BUT WE HOPE THAT YOU WILL CHOOSE TO FILL IT OUT. IF YOU ARE APPLYING FOR A JOB, ANY ANSWER YOU GIVE WILL BE KEPT PRIVATE AND WILL NOT BE USED AGAINST YOU IN ANY WAY.

IF YOU ALREADY WORK FOR US, YOUR ANSWER WILL NOT BE USED AGAINST YOU IN ANY WAY. BECAUSE A PERSON MAY BECOME DISABLED AT ANY TIME, WE ARE REQUIRED TO ASK ALL OF OUR EMPLOYEES TO UPDATE THEIR INFORMATION EVERY FIVE YEARS. YOU MAY VOLUNTARILY SELF-IDENTIFY AS HAVING A DISABILITY ON THIS FORM WITHOUT FEAR OF ANY PUNISHMENT BECAUSE YOU DID NOT IDENTIFY AS HAVING A DISABILITY EARLIER.

YOU ARE CONSIDERED TO HAVE A DISABILITY IF YOU HAVE A PHYSICAL OR MENTAL IMPAIRMENT OR MEDICAL CONDITION THAT SUBSTANTIALLY LIMITS A MAJOR LIFE ACTIVITY, OR IF YOU HAVE A HISTORY OR RECORD OF SUCH AN IMPAIRMENT OR MEDICAL CONDITION.

DISABILITIES INCLUDE, BUT ARE NOT LIMITED TO:

- BLINDNESS
- AUTISM
- BIPOLAR DISORDER
- POST-TRAUMATIC STRESS DISORDER (PTSD)
- DEAFNESS
- CEREBRAL PALSY
- MAJOR DEPRESSION
- OBSESSIVE COMPULSIVE DISORDER
- CANCER
- HIV/AIDS
- MULTIPLE SCLEROSIS (MS)
- IMPAIRMENTS REQUIRING THE USE OF A WHEELCHAIR
- DIABETES
- EPILEPSY
- SCHIZOPHRENIA
- MUSCULAR DYSTROPHY
- MISSING LIMBS OR PARTIALLY MISSING LIMBS
- INTELLECTUAL DISABILITY (PREVIOUSLY CALLED MENTAL RETARDATION)

PLEASE CHECK ONE OF THE BOXES BELOW:

____ YES, I HAVE A DISABILITY (OR PREVIOUSLY HAD A DISABILITY)

____ NO, I DON'T HAVE A DISABILITY

____ I DON'T WISH TO ANSWER

_____ _____

YOUR NAME TODAY'S DATE

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EEO-1 Voluntary Self Identification Form:

The Equal Employment Opportunity Commission (EEOC) requires organizations with 100 or more employees to complete an EEO-1 report each year. Completion of this data is completely voluntary and will not affect your opportunity for employment or terms or conditions of employment. This form will be used for EEO-1 reporting purposes only and will be kept separate from all other personnel records only accessed by Human Resources Department. Please return completed forms to the Human Resources Department.

NAME: _____

JOB TITLE: _____

DATE: _____

Referral Source:

__ EMPLOYEE REFERRAL __ OTHER

__ INDEED

__ LINKEDIN

__ RECRUITER

Self-Identification (PLEASE CHECK ALL THAT APPLY):

Gender:

_____Male

_____Female

Race/Ethnicity:

____Hispanic or Latino

____White (Not Hispanic or Latino)

____Black or African American

____Native Hawaiian or Other Pacific Islander

____Asian

____American Indian or Alaska Native

____Two or More Races

Veteran Status:

___ I am a protected veteran

___ I am not a protected veteran

___ I chose not to disclose