CENTRAL CARE
INTEGRATED HEALTH SERVICES
8610 Martin Luther King Jr. Blvd.
Houston, TX 77033
(713) 734-4580 FAX (713) 734-1564

# APPLICATION FOR EMPLOYMENT

*"CCIHS IS AN EQUAL OPPORTUNITY EMPLOYER"*

**PLEASE TYPE/PRINT ALL INFORMATION** Date: _____

Applicant's Name: _____
Last Name First M.I.

Address: _____ City _____ State _____ Zip Code _____

Telephone: Home _____ Work _____ Other _____

Date of Birth: _____ Driver's License No.: _____

Email Address: _____

Position Desired: _____ Salary Desired: _____

If hired, can you furnish proof of citizenship or legal entry into the U.S.? ____Yes ____No

Do you give consent to perform a criminal background check? ____Yes _____No

Have you ever been convicted of a crime? ____Yes ____ No. If "YES" please explain **(Conviction of a crime is not an automatic bar to employment. The Clinic will consider the nature of the offense, the date, and the relationship between the offense and the position applied for.)**

_____

_____

Are you an active service member? ☐ Yes ☐ No

Have you ever served in the U.S. Armed Forces? ☐ Yes ☐ No

If "Yes", Branch of Service: _____

List in Training received while in service: _____

_____

_____

Do you have any physical conditions or a handicap, which may limit your ability to perform the job applied for? If yes, what can be done to accommodate your limitation? _____

_____

_____

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Would you be willing to take a Physical Examination and Drug Test at the Clinic's expense if offered the job? _____Yes _____No

Do you have any friends or relatives currently working for us or serving on our Board of Directors or Task Force? ____Yes _____No

If "Yes", please list their name:_____

_____

Are you currently employed? _____Yes _____No

## EDUCATION

| **Name of Institution** | | | **Graduate** ***Y/N*** |
|---|---|---|---|
| High School | City | State | |
| Vocational Tech | City | State | |
| College/University | City | State | |
| Other (Specify) | City | State | |

Do you have job related licenses or certifications? ____Yes _____No

If "Yes", please specify: _____
Title Number

List any experiences; skills, training, or qualifications, which you feel, would be especially helpful in the job you are applying for:_____

_____

_____

List Clerical Skills, if any: _____

_____

_____

Specialized Programs (Accounting, Database, File Management): _____

_____

_____

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## EMPLOYMENT HISTORY

(List chronologically, starting with the most recent employer)

1. Name of Employer: _____

Address: _____

Telephone No.: _____ Dates of Employment: _____ TO _____

Supervisor's Name/Title: _____ Starting Salary: _____ Ending: _____

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a Month

Reason for Leaving:

_____

_____

Position held/Description of your duties:

_____

_____

_____

2. Name of Employer: _____

Address: _____

Telephone No.: _____ Dates of Employment: _____ TO _____

Supervisor's Name/Title: _____ Starting Salary: _____ Ending: _____

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a Month

Reason for Leaving:

_____

_____

Position held/Description of your duties:

_____

_____

_____

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3. Name of Employer: _____

Address: _____

Telephone No.: _____ Dates of Employment: _____ TO _____

Supervisor's Name/Title: _____ Starting Salary: _____ Ending: _____

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a Month

Reason for Leaving:

_____

_____

Position held/Description of your duties:

_____

_____

_____

4. Name of Employer: _____

Address: _____

Telephone No.: _____ Dates of Employment: _____ TO _____

Supervisor's Name/Title: _____ Starting Salary: _____ Ending: _____

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a Month

Reason for Leaving:

_____

_____

Position held/Description of your duties:

_____

_____

_____

May we contact your previous employers? _____ Yes _____ No. If "NO", please explain and indicate which employer. _____

_____

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References: Excluding Relatives

| Name and Occupation | Address | Telephone Number |
|---|---|---|
| | | |
| | | |
| | | |

Applicant's Authorization and Certification:

Please Read CAREFULLY before signing: I certify that all the information provided by me in connection with my application, whether on this document or not, is true and complete, and I understand that any misstatement, falsification, or omission of information shall be grounds for refusal to hire, or, if hired, termination. I authorize any of the persons, organizations, and educational institutions referenced in this application to give officials of Central Care Integrated Health Services any and all information concerning my previous employment, education, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application, and I release all such parties from all liabilities from any damages which may result from furnishing such information to Central Care Integrated Health Services.

I UNDERSTAND THAT ALL PERSONS OFFERED EMPLOYMENT BY THE CENTRAL CARE INTEGRATED HEALTH SERVICES MUST SUCCESSFULLY PASS A DRUG TEST AS A CONDITION OF EMPLOYMENT.

I UNDERSTAND THAT NOTHING IN THIS APPLICATION SHALL BE CONSTRUED AS A CONTRACT OR AN OFFER OF EMPLOYMENT. IF HIRED, I UNDERSTAND THAT I WILL BE EMPLOYED AT-WILL, AND CENTRAL CARE INTEGRATED HEALTH SERVICES HAS THE RIGHT TO TERMINATE MY EMPLOYMENT AT ANY TIME AND I MAY TERMINATE MY EMPLOYMET AS WELL.

_____
Print

_____
Signature

_____
Date

# DRUG TESTING CONSENT FORM

I hereby agree, upon a request made under the drug/alcohol testing policy of Central Care Integrated Health Services, to submit to a pre-employment or random drug test and to furnish a sample of my urine, and/or blood for analysis. I further authorize and give full permission to have Central Care Integrated Health Services send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to Central Care Integrated Health Services and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize Central Care Integrated Health Services Company to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly-authorized Central Care Integrated Health Services officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

I will hold harmless Central Care Integrated Health Services, its company physician, and any testing laboratory Central Care Integrated Health Services might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing.

This drug testing policy and authorization has been explained to me in a language I understand, and I have been informed that if I have any questions about the test or the policy, they will be answered.

_____ _____

Signature Date

_____ _____

CCIHS Representative Date

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# Background Check Authorization Form

I, _____ the undersigned applicant, hereby authorize Central Care Integrated Health Services to obtain and verify verbally, in writing, or electronically such information about my background and qualifications for employment as Central Care Integrated Health Services, in its sole discretion, deems relevant to its decision whether to hire me for the position I am applying for, including without limitation professional and personal references, employment verifications, educational verifications, license and credentials, criminal records, motor vehicle records, credit reports, and Social Security number verifications.

In consideration of Central Care Integrated Health Services considering my application for employment, I hereby release Central Care Integrated Health Services and its officers, directors, agents, and employees from any and all claims I may have arising out of the obtaining and verification of such information.

I hereby authorize any and all persons to disclose information to the company about my previous employment or suitability for future employment. In consideration of any person agreeing to provide information to Central Care Integrated Health Services as authorized by this form, I hereby release any such person and any affiliated offices, directors, agents, and employees from any and all claims I may have arising out of the disclosure of such information.

Date: _____

Printed Name: _____

Applicant's Signature: _____

**For Identification Purposes Only:**

Date of Birth: _____

Social Security Number: _____

Driver's License Number: _____

Current Street Address: _____

City, State, Zip Code: _____

Telephone No.: _____

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# Confidentiality Statement

I, _____, understand that I am prohibited from releasing or disclosing any information concerning the identity of patients or services provided to patients of Central Care Integrated Health Services. Medical records and patient information may only be released upon authorization by the CEO/COO, Medical Director, Physicians and Medical Records Supervisor of Central Care Integrated Health Services.

I understand that any proceedings or information generated on behalf of or at the request of the of Central Care Integrated Health Services Compliance/Performance Improvement Program are confidential medical peer review documents, are not subject to subpoena or discovery, and can only be released as authorized by the CEO/COO upon consent of the client or as required by law.

I understand that only the Governing Board or Administration is authorized to release written or verbal business information to any agency or person requesting it, except when disclosure or reporting is required.

I understand that inappropriate disclosure of confidential information is cause for termination and may result in liability.

_____
Employee/Employee Volunteer Signature

_____
Title