



## EMPLOYMENT APPLICATION

387 Quarry Street Suite 100  
Fall River, MA 02723  
Phone: 508-627-1283  
Fax: 508-679-8116

**HEALTHFIRST FAMILY CARE CENTER, INC. is an Equal Opportunity Employer (EOE) - Race, color, sex, creed, national origin, religion, physical or mental disability, age, military reserve membership, sexual orientation, marital status or other characteristics protected by federal, state, or local laws are not factors in hiring, promotion, compensation, termination or any other aspect of employment. HEALTHFIRST FAMILY CARE CENTER, INC. strives for a workplace free of unlawful discrimination and harassment.**

**Application Instructions: If you need help filling out this application form or for any phase of the employment process, please notify the person that gave you this form and every effort will be made to accommodate your needs in a reasonable amount of time. Please read the Employment Application carefully, note "Not Applicable" if not answering a question(s) and print clearly because incomplete or illegible applications will not be processed. Please attach a resume to the Employment Application and ONLY complete Education and Training, Special Skills, and Employment History information that is NOT on your resume and indicate "Refer to Resume".**

**Note: This application form is intended for use in evaluating your qualifications for employment. This is not an employment contract.**

*\*Do not fill out any part of this employment application that you believe is non-job related.*

Please Print

Date: \_\_\_\_\_

### Applicant Information

Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone/Cell: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Prior Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Are you authorized to work in the United States ?  Yes  No

Have you ever been employed by HEALTHFIRST FAMILY CARE CENTER, INC.?  Yes  No

Do you have any friends or relatives working for HEALTHFIRST FAMILY CARE CENTER, INC.?  
 Yes  No

If yes, state name and relationship: \_\_\_\_\_

How did you hear about us/this opening?  
\_\_\_\_\_

State briefly why you would like to work for HEALTHFIRST FAMILY CARE CENTER, INC.:  
\_\_\_\_\_  
\_\_\_\_\_

### General Information About Employment Desired

Position you are applying for? \_\_\_\_\_ If hired, date you can start? \_\_\_\_\_

Category you prefer?  Full-time  Part-time  Temporary

Schedule your available?  Weekdays  Weekends  Evening  Other \_\_\_\_\_

Hourly rate of pay or monthly salary desired: \_\_\_\_\_

If the job requires, do you have a valid driver's license and use of a personal vehicle?  Yes  No

### Education and Training

	<u>School/Location</u>	<u>Course of Study/Degree Type</u>	<u>Graduated</u>
High School			<input type="checkbox"/> Yes <input type="checkbox"/> No
Trade School			<input type="checkbox"/> Yes <input type="checkbox"/> No
College(s)/University(s)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Certificates/Other			

### Special Skills

Do you have any other experience, training, qualifications or skills which you feel make you especially suited for work at HEALTHFIRST FAMILY CARE CENTER, INC.?  Yes  No If so, explain in detail below:  
\_\_\_\_\_

Professional Society Memberships: \_\_\_\_\_

Are you licensed, registered or certified in your profession?  Yes  No

Licenses (list states): \_\_\_\_\_

Use the space below to summarize other relevant experience, skills and background:  
\_\_\_\_\_  
\_\_\_\_\_

## Employment History

*\*List all previous employers starting with your present or most recent position.*

**Most Recent Employer: Are you currently working for this employer?**  Yes  No

**If yes, may we contact?**  Yes  No

Name of company: \_\_\_\_\_  
Name of supervisor: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Telephone Number: ( ) \_\_\_\_\_  
Positions and Duties: \_\_\_\_\_  
Dates of Employment: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

### Second Most Recent Employer

Name of company: \_\_\_\_\_  
Name of supervisor: \_\_\_\_\_ May we contact  Yes  No  
Address: \_\_\_\_\_  
Street City State Zip Code  
Telephone Number: ( ) \_\_\_\_\_  
Position and Duties: \_\_\_\_\_  
Dates of Employment: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

### Third Most Recent Employer

Name of company: \_\_\_\_\_  
Name of supervisor: \_\_\_\_\_ May we contact  Yes  No  
Address: \_\_\_\_\_  
Street City State Zip Code  
Telephone Number: ( ) \_\_\_\_\_  
Position and Duties: \_\_\_\_\_  
Dates of Employment: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

## Professional References

*\*Include only individuals familiar with your work ability. Do not include relatives.*

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Years Known</u>

## Applicant's Certification and Agreement

I certify that the facts set forth in this Application for Employment are true and complete to the best of my knowledge. I understand that if I am employed, false statements, omissions or misrepresentations may result in my dismissal. I authorize the Company to make an investigation of any of the facts set forth in this application. I also understand that my employment is dependent upon satisfactory completion of a background investigation. I hereby authorize my past employers and other firms, persons, corporations, and Government agencies to furnish HEALTHFIRST FAMILY CARE CENTER, INC. my records of employment, including job performance information unless otherwise stated. I understand that employment at the Company is "at will," which means either I or the Company can terminate the employment relationship at any time, with or without prior notice, and for any reason not prohibited by the statute. All employment is continued on that basis. My signature below certifies that I have read and understand this complete page, and agree to the terms and conditions outlined in this document.

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**Applicant's Signature**

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**Date**