APPLICATION FOR EMPLOYMENT

Sacred Circle Healthcare
660 S 200 E Suite 250
Phone:801-359-2256
Fax: 801-364-4392

Position applied for:______________________________________ Agency (if applicable):__________________________

Social Security No:_________________________________ *(Note: Your social security no. is optional. It may be required on other forms prior to employment but will not prohibit an employment consideration.)*

Name:____ Home Phone: (____)______________
Last First Middle

Address:____ Business Phone: (_____)____________

____ E-mail:__________________________
City State Zip

Are you legally eligible for employment in the United States? ☐ Yes ☐ No
(Under the Immigration Reform and Control Act of 1986, you will be required to provide documentation to certify your eligibility and identity, should you be employed.)

Employment Preference: ☐ Full-time ☐ Part-time ☐ Temporary ☐ Other Date Available:____________________

Days Available: ☐Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐Fri. ☐ Sat. ☐ Sun. Salary Desired:____________________

Hours Available: ☐Day ☐ Evening ☐ Night ☐ Rotating ☐ Weekends Specify Shift Hours:_______________

Do you have any relatives employed at our office? ☐Yes ☐No If yes, who?_______________________________

Have you ever filed an application with us before? ☐Yes ☐No If yes, when?______________________________

May we contact your current employer? ☐ Yes ☐ No May we contact your previous employer? ☐ Yes ☐No

RECORD OF EMPOYMENT (beginning with your most recent employer)

1. Name of Employer				Address	Telephone #	Your Position
Dates Employed		Rate of Pay		Reason for Leaving:	Supervisor's Name & Title	
From:	To:	Starting:	Ending:			
MM/YY	MM/YY					
Your Duties:						

2. Name of Employer	Address	Telephone #	Your Position

Dates Employed		Rate of Pay		Reason for Leaving:	Supervisor's Name & Title
From:	To:	Starting:	Ending:		
MM/YY	MM/YY				
Your Duties:					

3. Name of Employer	Address	Telephone #	Your Position

Dates Employed		Rate of Pay		Reason for Leaving:	Supervisor's Name & Title
From:	To:	Starting:	Ending:		
MM/YY	MM/YY				
Your Duties:					

EDUCATION

Type	Name	Major	Last Year Completed	Did you Graduate?	Degree
High School			☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ Yes ☐ No	
College			☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ Yes ☐ No	
Graduate Studies			☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ Yes ☐ No	
Other (specify)			☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ Yes ☐ No	

TECHNICAL SKILLS

☐ Word Processor ☐ WPM ☐ Adding Machine ☐ Data Entry ☐ Personal Computer

☐ Software Skills:

Special Credentialing, Certifications, or Professional Licensing:

Additional Skills and Qualifications:

WORK REFERENCES

Name:	Name:
Company:	Company:
Address:	Address:
Phone:	Phone:

PERSONAL REFERENCES

Name:	Name:
Address:	Address:
Phone:	Phone:

Have you been convicted of a felony or misdemeanor, or presently have charges pending against you for a felony or misdemeanor?
☐ Yes ☐ No If yes, please explain:

Have you ever been convicted of any type of billing fraud including Medicare, or Medicaid? ☐ Yes ☐ No

Have you ever been included on the Office of Inspector General's database of suspended persons? ☐ Yes ☐ No

Have you read and understand the duties and responsibilities for this position? ☐ Yes ☐ No

Is there any reason why you could not perform all the described duties associated with this position? ☐ Yes ☐ No
If yes, please explain:____

Are you an enrolled member of a federally recognized Tribe (CTGR or Other)? ☐ Yes ☐ No
If yes, please list your Tribal ID or C.I.B. No.:____

Sacred Circle Health Care/Confederated Tribes of the Goshute Reservation gives preference to qualified American Indian/Alaskan Native Applicants.

I hereby certify that the information provided in this application along with its attachments are true and complete. I also agree and understand that any falsification of information herein, regardless of time of discovery may forfeit my employment with this practice. I understand that all information on this application is subject to verification and I consent to any criminal history background checks. I also authorize this practice to contact my references, educational institutions, or any other person or organization that may have information relevant to my employment. I further authorize the practice to rely upon and use, as it sees fit, any information received from such contacts. Information contained on this application may be disseminated to other agencies, non-governmental organizations or systems on a need-to-know basis for good cause shown as determined by the agency head or designee.

Applicant Signature:____Date: ______________