# Preventative Care Health Services, Inc.

**1605 N. Ft. Davis Hwy. Ste. B Alpine, TX 79830**
**Ph. 432-837-4812**
Fax: 432-837-4823

**General Staff Application**

**Date:** _____

**Position applying for:** _____

**APPLICANT NAME:** _____
[Last] [First] [Middle] [Maiden]

P.O. Box : _____
[City] [State] [Zip]

Telephone No.: _____ Cell Phone: _____

RESIDENCE ADDRESS: _____
[Street] [City] [State] [Zip]

SOCIAL SECURITY NUMBER: _____/_____/_____ DOB: _____
*(To be used for identification purposes only)*

**Please provide a Photo ID with the application**

**EDUCATION**

UNDERGRADUATE /TECHNICAL EDUCATION

_____
School/College or University Address

_____
[City] [State] [Zip]

Dates of Enrollment: ___/___/___ to ___/___/___ Degree: _____

Date of Graduation: ____/____/____

## GRADUATE EDUCATION

_____

[Graduate School]

_____

[Address] [City] [State] [Zip]

Dates of Enrollment: _____

Degree: _____ Date of Graduation: _____

## PROFESSIONAL EDUCATION

_____

[Name of Institution]

_____

[Address] [City] [State] [Zip]

Dates of Enrollment: _____

Degree: _____ Date of graduation: _____

## LICENSURE

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | ____/___/_____ |
| [State] | [Date Issued] | [Number] | [Expiration Date] |
| _____ | _____ | _____ | ____/___/_____ |
| [State] | [Date Issued] | [Number] | [Expiration Date] |
| _____ | _____ | _____ | ____/___/_____ |
| [State] | [Date Issued] | [Number] | [Expiration Date] |
| _____ | _____ | _____ | ____/___/_____ |
| [State] | [Date Issued] | [Number] | [Expiration Date] |

**PROFESSIONAL SPECIALIZATION CERTIFICATION**

Are you certified by a Professional Board or Association? ☐ Yes ☐ No

If yes, please answer the following (**PLEASE ATTACH A COPY TO APPLICATION**):

Name of Board(s) or Association(s): _____

_____

Type of Certification: _____

Issued: _____/_____/_____ Expiration Date: _____/_____/_____

**MILITARY SERVICE**

Have you served in the Military? ☐ Yes ☐ No
If yes, please answer the following:

_____
[Branch] [Rank]

_____ _____
[Dates] [Type of Discharge]

**CONTINUING EDUCATION**

Please attach a list of the continuing education programs that you have attended or presented for the period since last license renewal.

☐ CPR
☐ Basic Life Support for Healthcare Providers
☐ Advanced Life Support
☐ Instructor

**OTHER CERTIFICATION:**

_____
Type of Certifications [Date of Certification]

_____
Type of Certifications [Date of Certification]

_____
Type of Certifications [Date of Certification}

## Employment/Privileges History

Please list (most recent first) all companies/organizations where you have practiced, had staff privileges or been employed. Also, please explain any periods of time not accounted for since graduation from professional educational program. Use additional page(s) if necessary. *All time periods must be accounted for, including periods of unemployment and vacations between employments.*

1. Company Name: _____
Contact: _____ Telephone #: (___) _____
_____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: _____Dates: ___/___/___ to __/___/___
Reason for Leaving:_____

2. Company Name: _____
Contact: _____ Telephone #: (___) _____
_____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: _____Dates: ___/___/___ to __/___/___
Reason for Leaving:_____

3. Company Name: _____
Contact: _____ Telephone #: (___) _____
_____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: _____Dates: ___/___/___ to __/___/___
Reason for Leaving:_____

4. Company Name: _____
Contact: _____ Telephone #: (___) _____
_____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: _____Dates: ___/___/___ to __/___/___
Reason for Leaving:_____

**Professional References**

Please list the names, full mailing addresses, and telephone numbers of three professional references.

***Professional References*** (persons not related to you and with first-hand knowledge of your professional work).

1. Name: _____ Title: _____
Employer: _____
_____
[Address] [City] [State] [Zip]

Telephone #: (_____) _____

2. Name: _____ Title: _____
Employer: _____
_____
[Address] [City] [State] [Zip]

Telephone #: (_____) _____

3. Name: _____ Title: _____
Employer: _____
_____
[Address] [City] [State] [Zip]

Telephone #: (_____) _____

**I have reviewed and hereby submit my application. With my signature, I attest that with this information my application is complete and correct to the best of my knowledge and belief.**

By: _____
[Applicant's Signature] [Date]

Category: Human Resources
Subject: Background Check Policy

Effective date: 10-2010

## APPLICANT/EMPLOYEE AUTHORIZATION

Print Name: _____
First Middle Last

Maiden Name: _____ Other last names used: _____

Signature: _____ Date: _____

**List all cities and states where you have lived for the past 7 years – Attach additional sheet if necessary**

Street City County State ZIP How Long?

Current: _____

2. _____

3. _____

4. _____

Present Phone Number: ____/_____ Social Security Number: _____ - _____ - _____

Date of Birth* (for identification purpose only): _____

Sex*: Male _____ Female _____ Driver's License Number: _____

State: _____

*This information will be used for background screening purposes only and will not be used as hiring criteria.