



Denver Harbor Clinic
Houston Community Health Centers, Inc.

General Staff Application

Position applying for _____ Date _____

Referred by _____

APPLICANT NAME: _____

Last
First
Middle
Maiden

RESIDENCE ADDRESS: _____ Telephone _____

Street
City
State
Zip

Email Address _____

Social Security Number _____ **DOB** _____
(For Identification Purposes Only)

Are you related to any employees, contractors, consultants, or board members at HCHC, Inc? Yes No

Name and Relationship _____

EDUCATION

UNDERGRADUATE /Technical EDUCATION

School/College or University
Address
City/
State/Zip
Phone Number

 Dates of Enrollment ___/___/___ to ___/___/___ Degree _____ Date of Graduation ___/___/___

GRADUATE EDUCATION

Graduate School
Address
City
State/Zip
Phone Number

 Dates of Enrollment _____ Degree _____ Date of Graduation _____

PROFESSIONAL EDUCATION

Institution
Address
City
State/Zip
Phone Number

 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



PROFESSIONAL SPECIALIZATION CERTIFICATION

Are you certified by a professional board or association? Yes No If yes, please answer the following:

Name of Board or Association _____

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 Advanced Life Support Instructor

OTHER CERTIFICATION _____
Type of certification _____ Date of Certification _____

Questions #1-3 for providers and support professionals ONLY

1. Are you currently taking controlled substances by prescription or otherwise? Yes No
"Currently" means recently enough so that the use of the substance may have an ongoing impact on one's functioning, or within the past two years.
"Controlled Substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the licensed transcriber's direction, as well as those used illegally.
"Ability to provide health care services" is to be construed to include the following:

- a. The cognitive capacity to make appropriate assessments and judgments and learn and keep abreast of health care services developments; and
- b. The ability to communicate those judgments and health care information to patients and other health care providers with or without the use of aides or devices, such as voice amplifiers; and
- c. The physical capability to perform health care services tasks such as checking vital signs and assigned portions of the physical examination procedures and tasks that may fall within your scope of practice, with or without the use of aides or devices, such as corrective lenses or hearing aids.

If you answered, "yes" to question 1, please answer a and b below.

- a. Does your use of controlled substances in any way impair or limit your ability to provide health care services with reasonable skill and safety? Yes No
- b. Are you currently participating in a professionally supervised program that monitors you in order to assure that you are not illegally utilizing the controlled substances? Yes No

2. Do you have a medical condition that would require special accommodations for you to provide health care services with reasonable skill and safety? Yes No

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV/AIDS, tuberculosis, drug addiction and alcoholism.

If you answered "yes" to question 2, please answer a & b below.

- a. Are any limitations that may be related to your medical condition ameliorated by current ongoing treatment or participation in a monitoring program? Yes No
- b. Are any limitations that may be related to your medical condition overcome by the manner in which you have chosen to provide health care services? Yes No

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? Yes No

If you answered "Yes" to any of the above, please attach explanation and related documents.



Have you ever been convicted of a crime (not including traffic violations)? Yes No

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed.

Employment/Privileges History

Please list (most recent first) all places 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 _____

Contact _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

Starting Pay Rate \$ _____ Ending Pay Rate \$ _____

Reason for Leaving:

2. Company _____

Contact _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

Starting Pay Rate \$ _____ Ending Pay Rate \$ _____

Reason for Leaving:

3. Company _____

Contact _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

Starting Pay Rate \$ _____ Ending Pay Rate \$ _____

Reason for Leaving:



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4. **Company** _____
Contact _____ Phone Number _____

Address _____ *City* _____ *State* _____ *Zip* _____
Position/Title/Status _____ Dates: ____/____/____ to ____/____/____
Starting Pay Rate \$ _____ Ending Pay Rate \$ _____
Reason for Leaving: _____

Professional References

Please list the names, full mailing addresses, and phone 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* _____
Phone Number _____

2. Name _____ Title _____
Employer _____

Address _____ *City* _____ *State* _____ *Zip* _____
Phone Number _____

3. Name _____ Title _____
Employer _____

Address _____ *City* _____ *State* _____ *Zip* _____
Phone Number _____

I do hereby agree that everything on this application is true, to the best of my knowledge. I give Houston Community Health Centers permission to check with past employers, educational institutions, and references that are mentioned on this application.

Applicant Signature

Date