Please return to: Benton-Franklin Health District
attn: Human Resources Director
7102 West Okanogan Place
Kennewick, WA 99336

EMPLOYMENT APPLICATION

The Benton-Franklin Health District is an Equal Opportunity Employer.

Instructions: Type or legibly print this application. Sign and date the application. An incomplete application may remove you from consideration. A copy of an application will be accepted only with an **original** signature.

GENERAL INFORMATION

Position For Which Applying:			
Last Name	First Name		Middle Initial
Street Address	City	State	Zip Code
Home Phone ( ) / Work Phone ( )	Message Phone ( )	Social Security Number (Optional)	

EDUCATION

Did you graduate from high school or receive a GED certificate? Yes ☐ No ☐

Name of college, university, vocational school	Major	Dates Attended From	Dates Attended To	Degrees Conferred Title	Degrees Conferred Date

Indicate any experience gained through hobbies, volunteer work, etc., which you believe is relevant to this position.

Indicate any other trades, skills or licenses you possess related to the position. Include licensing state and expiration date.

Veterans' Preference: If you have served in the Armed Forces of the United States you may be eligible for Veterans' Preference.
Do you claim veterans' preference? Yes ☐ No ☐ (Proof of veteran status [form DD214] may be required if hired.)

Valid Washington State Driver's License? Yes ☐ No ☐

Criminal Conviction. (Conviction does not automatically bar you from employment. Each case is considered on job duties performed.) Have you been convicted of a misdemeanor or felony within the last seven (7) years? Yes ☐ No ☐

EMPLOYMENT HISTORY

Beginning with the most recent, list your work experience including self employment, military service, volunteer work and periods of unemployment. You must include a complete employment history to ensure correct placement in salary ranges if you are hired. Attach additional sheets if necessary.

Employer	Total Time Employed
Address	_____years _____months
Position No. of employees supervised	From _____/_____ month /year
Supervisor Phone	To _____/_____ month /year
Specific Duties:	Hours Worked Each Week
	Starting Salary
Reason for leaving or considering change:	Final Salary

Employer	Total Time Employed
Address	_____years _____months
Position No. of employees supervised	From _____/_____ month /year
Supervisor Phone	To _____/_____ month /year
Specific Duties:	Hours Worked Each Week
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CERTIFICATION AND SIGNATURE

I hereby certify, under the penalty of perjury in the State of Washington, that this application contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge and belief. I am aware that should investigation at any time disclose any such misrepresentation or falsification, my application may be rejected, my name may be removed from consideration or I may be discharged from employment, if hired.

Signature of Applicant Date

(If submitting electronically, signature will be requested if interviewed.)

AFFIRMATIVE ACTION

The Benton-Franklin Health District is an Equal Opportunity Employer. To help us comply with government recordkeeping, reporting and other legal requirements, please complete the affirmative action data below. **Providing this information is voluntary. The data are kept for statistical purposes only and are separated from the employment application prior to receipt by the hiring authority.**

Name: _____ **Application Date:** _____

GENDER: **Female** ☐ **Male** ☐ **BIRTH YEAR:** _____

ETHNIC GROUP/RACE:

If you identify with more than one "ethnic origin" below, we respect your desire to mark multiple boxes. For statistical purposes, however, it would be helpful if you mark the one "ethnic origin" with which you most identify.

☐ **African American/Black:** Persons having origins in any of the Black racial groups of Africa.

☐ **American Indian/Alaska Native:** Persons having origins in the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition.

☐ **Asian/Pacific Islander:** Persons having origins in the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. These areas include China, Japan, Korea, the Philippine Islands, and Samoa.

☐ **Hispanic/Latino:** Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin unique to the Americas, regardless of race.

☐ **White/Caucasian:** Persons having origins in any of the original peoples of Europe, North Africa, the Middle East or Southwest Asia.

DISABILITY: **Yes** ☐ **No** ☐

A disability is a permanent physical, mental or sensory condition that substantially limits one or more major life activities. The disability must be substantial rather than slight, and permanent in that it is seldom fully corrected by medical replacement, therapy or surgical means. Substantial means you are either unable to perform or are significantly restricted in performing a major life activity, such as caring for yourself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working.

THIS CONFIDENTIAL INFORMATION IS MAINTAINED FOR AFFIRMATIVE ACTION PURPOSES ONLY. IT WILL NOT BECONSIDERED AS A REQUES T FOR ACCOMMODATION. If you require accomodation completing the application, please call (509) 460-4200.

VETERAN STATUS

Dates served: _____ **to** _____

Vietnam-era Veteran **YES** ☐ **NO** ☐ Percent of disability: _____

"A person who served on active duty for a period of more than 180 days, and was discharged or released therefrom with other than dishonorable discharge, if any part of such active duty occurred: (1) In Vietnam between 2-28-61 and 5-7-75; or between 8-5-64 and 5-7-75, in all other cases; or (2) was discharged or released from active duty for a service-connected disability if any part of such active duty was performed;(3) in Vietnam between 2-28-61and 5-7-75; or between 8-5-64 and 5-7-75, in all other cases."

Special Disabled Veteran YES ☐ **NO** ☐ Percent of disability: _____

"A veteran who is entitled to compensation or who but for the receipt of military retired pay would be entitled to compensation, under laws administered by the U.S. Department of Veterans Affairs for disability: (1) Rated at 30 percent or more; or Rated 10 or 20 percent in the case of a veteran who has been determined under 38 U.S.C. 3106 to have a serious employment handicap; or (2) A person who was discharged or released from active duty for a service connected disability."

Thank you for your interest in the Benton-Franklin Health District

EMPLOYMENT HISTORY (continued)

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Position / No. of employees supervised	From _____/_____ month /year
Supervisor / Phone	To _____/_____ month /year
Specific Duties:	Hours Worked Each Week
	Starting Salary
Reason for leaving or considering change:	Final Salary

Employer	Total Time Employed
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Specific Duties:	Hours Worked Each Week
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Specific Duties:	Hours Worked Each Week
	Starting Salary
Reason for leaving or considering change:	Final Salary

Benton Franklin Health District

My initials and signature in the statements below indicate that I have read and understand the statements:

I understand that my employment with Benton-Franklin Health District (BFHD) will be contingent upon proof of identity, and verification of eligibility in the United states in accordance with the Immigration Reform and Control Act of 1986. Initials _____

I understand that my employment is contingent upon checking of references. I authorize BFHD to contact my current and previous employes regarding my work performance as well as any personal references furnished by me. I release all parties and persons connected with the request form any liability in sharing factual and pertinent information that maybe be of assistance in determining my job suitability in the position(s) available with BFHD. Further, I understand that as part of the application/ employment process, my background may be checked by an employment screening agency, as well as the Washington State Patrol and/or FBI for any criminal history information. Initials _____

I understand that upon hire, my first six months of employment will be considered a period of initial evaluation, during which time my job performance and job suitability will be evaluated. Initials _____

I certify by my signature that the information provided by me in this application for employment is true and complete to the best of my knowledge. I understand that any falsified and misleading statements on this application may be cause for rejection of my application, removal of my name from a register, or dismissal, if employed. Initials _____

Applicant Signature: _____ Date: _____