TOIYABE INDIAN HEALTH PROJECT, INC.

250 See Vee Lane, Bishop, CA 93514
Phone (760) 873-8464 Facsimile (760) 873-3935

EMPLOYMENT APPLICATION

We consider applicants for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, the present of a non-job-related medical condition or handicap, or any other legally protected status. Toiyabe Indian Health Project, Inc. is an equal opportunity employer within the confines of the American Indian Preference act (Title 25, U.S. Code, Section 472 & 473)

PLEASE PRINT OR TYPE

Position(s) Applied for____________________________________ Date of Application_______________

How did you hear about the job? Advertisement ___ Relative___ Friend___ Walk-in___ Other________________________

Personal Data

Full Name ____
Last **First** **MI**

Have you used other Names: Yes___ No___ If yes, please list____________________________________

Home Address ____
City State Zip Code

Phone Number (_____) ______-_________ Email ____

Driver's License Number _____________________ State _____ SS# ____________________________

Tribal Affiliation ____
(Documentation must be attached for Indian Preference Eligibility)

Have you been employed with us before? Yes___ No___ If yes, give date _________________________

Do you have any relatives currently employed by Toiyabe? No___ Yes___ If yes give name and relationship

____

Are you currently employed? Yes___ No ___ May we contact your present employer? Yes ___ No___

When are you available to work? _________________________________

Are you able to work: Full Time______ Part Time______ Temporary ______

Have you ever been convicted of a crime against another person or of any criminal violation of law; Are you now under pending investigation or charge of violation of criminal law? Yes___ No___ If yes, please explain *(attach sheet if necessary)* ____

____

____

TOIYABE INDIAN HEALTH PROJECT, INC.

250 See Vee Lane, Bishop, CA 93514
Phone (760) 873-8464 Facsimile (760) 873-3935

EMPLOYMENT APPLICATION

REFERENCES

Give Name, Address and telephone number of three persons who are NOT related to you and are NOT previous employers

1.____

2. ____

3. ____

Have you ever had any job-related training in the United States Military? Yes No

If Yes, please describe:____

____

Are you physically or otherwise unable to perform the duties of the job for which you are applying? Yes No

EDUCATION

	High School	Undergraduate/University	Graduate
School Name and Location			
Years Completed			
Diploma/ Degree Major/ Concentration			
Course of Study			

Describe any specialized training, apprenticeship, skills and extra-curricular activities:________________________

____

Describe any honors you have received: ________________________________

____

State any additional information helpful for considering your application: ________________________

____

TOIYABE INDIAN HEALTH PROJECT, INC.

250 See Vee Lane, Bishop, CA 93514
Phone (760) 873-8464 Facsimile (760) 873-3935

EMPLOYMENT APPLICATION

EMPLOYMENT EXPERIENCE (Start with present or last job, include the past seven years. Include any job-related military service assignments and volunteer experiences)

Employer		Dates employed From:	
Address		To:	
Telephone Number		Hourly Rate:	
Job Title		Supervisor Name & Phone #	
Reason for leaving:			

Employer		Dates employed From:	
Address		To:	
Telephone Number		Hourly Rate:	
Job Title		Supervisor Name & Phone #	
Reason for leaving:			

Employer		Dates employed From:	
Address		To:	
Telephone Number		Hourly Rate:	
Job Title		Supervisor Name & Phone #	
Reason for leaving:			

Employer		Dates employed From:	
Address		To:	
Telephone Number		Hourly Rate:	
Job Title		Supervisor Name & Phone #	
Reason for leaving:			

TOIYABE INDIAN HEALTH PROJECT, INC.

250 See Vee Lane, Bishop, CA 93514
Phone (760) 873-8464 Facsimile (760) 873-3935

EMPLOYMENT APPLICATION

SPECIAL SKILLS & QUALIFICATIONS

Summarize special job-related skills and qualifications acquired from employment or other experiences (or attach resume)

APPLICANTS STATEMENT

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application as may be necessary in arriving at an employment decision.

I certify that I will comply with Toiyabe Indian Health Project's infectious disease policy and will agree to comply with any required vaccinations and testing, including a flu vaccine, COVID-19 testing and any other vaccines or tests as required during my employment at Toiyabe.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I also understand that I am required to abide by all rules, policies and regulations of the employer.

____ ____
Applicants Signature Date

PLEASE NOTE: Toiyabe Indian Health Project, Inc. is committed to complying with all federal and state regulations. AS an initial step in ensuring program compliance, Toiyabe Indian Health Project, Inc. will check with appropriate Federal and State agencies at the time of application and no less than annually to ensure that all the employees, medical staff, independent contractors, and entities have NOT been excluded from participation in federally funded programs.

____ ____
Applicants Signature Date

TOIYABE INDIAN HEALTH PROJECT, INC.

Reference Check

Company: ______________________________

____

Address: ______________________________

____

Applicant:

has given you permission to furnish reference information to us.

Please complete this form within ten working days and mail or fax to:

Toiyabe Indian Health Project, Inc.
52 Tu Su Lane
Bishop, CA 93514
ATTN: Personnel

(760) 873-8464 ext. 224
(760) 873-3935 Fax

Please call Personnel prior to faxing

Thank you,

Personnel Officer **Date**

-TO BE COMPLETED BY APPLICANT-

Supervisor	
Name while employed	Social Security Number
Title or Occupation	Dates of Employment to
Reason for leaving	

I hereby authorize you to release information you may have regarding my services and character, and do hereby unconditionally release your company from all liability from any damage whatsoever which might result from furnishing same.

Applicant's signature Date

-TO BE COMPLETED BY FORMER EMPLOYER-

Occupation Employed From To

	Poor	Fair	Average	Very Good	Excellent
Quality of Work					
Quantity of Work					
Iniatiave					
Cooperation					
Attendance					
Dependability					
Personal Appearance					

Would you recommend applicant for employment? Yes No

Previous level of

Do you have knowledge of applicant ever having been convicted of a crime?

Why did applicant leave your company?

Would you re-hire? If no, why?

Remarks

Title Phone

Signature Date

TOIYABE INDIAN HEALTH PROJECT, INC.

Reference Check

Company: ______________________________

____

Address: ______________________________

____

Applicant:

has given you permission to furnish reference information to us.

Please complete this form within ten working days and mail or fax to:

Toiyabe Indian Health Project, Inc.
52 Tu Su Lane
Bishop, CA 93514
ATTN: Personnel

(760) 873-8464 ext. 224
(760) 873-3935 Fax

Please call Personnel prior to faxing

Thank you,

Personnel Officer **Date**

-TO BE COMPLETED BY APPLICANT-

Supervisor	
Name while employed	Social Security Number
Title or Occupation	Dates of Employment to
Reason for leaving	

I hereby authorize you to release information you may have regarding my services and character, and do hereby unconditionally release your company from all liability from any damage whatsoever which might result from furnishing same.

Applicant's signature Date

-TO BE COMPLETED BY FORMER EMPLOYER-

Occupation Employed From To

	Poor	Fair	Average	Very Good	Excellent
Quality of Work					
Quantity of Work					
Iniatiave					
Cooperation					
Attendance					
Dependability					
Personal Appearance					

Would you recommend applicant for employment? Yes No	Previous level of
Do you have knowledge of applicant ever having been convicted of a crime?	
Why did applicant leave your company?	
Would you re-hire?	If no, why?
Remarks	
Title	Phone
Signature	Date

TOIYABE INDIAN HEALTH PROJECT, INC.
PAIUTE PROFESSIONAL BUILDING

AUTHORIZATION TO OBTAIN MOTOR VEHICLE REPORT (MVR)

I am aware that consumer and motor vehicle reports may be obtained as part of Toiyabe Health Project evaluation of my job application and / or employment. The reports may be procured by Toiyabe Indian Health Project, or its insurance company representative(s), and may include personal information obtained from state motor vehicle departments, my driving record, an assessment of my insurability for the insurance program, or other consumer reports.

By signing this letter, I hereby provide my authorization for Toiyabe Indian Health Project or their insurance company representative(s) to procure such information and reports, as well as additional reports about me from time to time as deemed appropriate, to evaluate my insurability or for other permissible purposes.

Sincerely,

____
Signature of Applicant / Employee

____
Printed Name as it appears on Drivers License

____
Drivers License Number State of Issuance

____
Date of Birth

The following is for Identification purposes only to perform the background check and will not be used for any other purposes.

Applicant's Name	***First***	***Middle***	***Last***

Other Name(s) Used	***First***	***Middle***	***Last***	***Dates You Stopped Using Other Name(s)***

Current Address	***City***	***State***	***Zip Code***

Previous Address	***City***	***State***	***Zip Code***

Previous Address	***City***	***State***	***Zip Code***

Social Security Number	***Date of Birth***	***Driver's License Number***	***State Issued***

Signature	***Today's Date***