



105 Park Street  
 Hyannis, MA 02601  
 (508) 771-9599  
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 www.duffyhealthcenter.org

*Partners on the road to health, hope and home.*

**APPLICATION FOR EMPLOYMENT**

**ALL POTENTIAL EMPLOYEES ARE EVALUATED WITHOUT REGARD TO RACE, COLOR, RELIGION, AND GENDER, NATIONAL ORIGIN, AGE, SEXUAL ORIENTATION, MARITAL OR VETERAN STATUS, THE PRESENCE OF A NON-JOB RELATED HANDICAP OR ANY OTHER LEGALLY PROTECTED STATUS.**

Position Sought: \_\_\_\_\_

How did you learn about the position? \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Email Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

On what date would you be available for work? \_\_\_\_\_ Desired Wage/Salary \$ \_\_\_\_\_

Are you a U.S. citizen, or are you otherwise authorized to work in the U.S. without any restriction? [  ] Yes  
 [  ] No

Have you ever been convicted of a felony? [  ] Yes [  ] No If yes, please describe circumstances: \_\_\_\_\_

Have you ever been involuntarily terminated or asked to resign from any position of employment? [  ] Yes  
 [  ] No

If yes, please describe circumstances:  
 \_\_\_\_\_

If selected for employment, are you willing to submit to a pre-employment drug screening test? [  ] Yes  
 [  ] No

Are you or have you ever been a patient at Duffy? [  ] Yes [  ] No If yes, when? \_\_\_\_\_

Do you have a friend, relative or household member who works at Duffy? [  ] Yes [  ] No

If yes, who? \_\_\_\_\_

**Print Last Name** \_\_\_\_\_

*Print Last Name* \_\_\_\_\_

<i>School Name and Location</i>	<i>Years Attended</i>	<i>Degree Received</i>	<i>Major</i>

*Other training, certifications, or licenses held, and state, if applicable:*

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*Computer skills:*  Yes  No      *Type WPM* \_\_\_\_\_

*Check familiar programs:*  Word     Excel     Outlook     PowerPoint     Internet  
*Other* \_\_\_\_\_

*List other information pertinent to the employment you are seeking:*

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*Are you a veteran?*  Yes  No      *If yes, type of discharge:* \_\_\_\_\_

*Print Last Name* \_\_\_\_\_

**EMPLOYMENT**

*(Most Recent First).*

1. *Employer* \_\_\_\_\_ *Job Title* \_\_\_\_\_

*Dates Employed* \_\_\_\_\_ *Prior Position Held within Company (if any):*  
\_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Phone* \_\_\_\_\_ *Job Title* \_\_\_\_\_ *Supervisor* \_\_\_\_\_

*Starting Salary* \_\_\_\_\_ *Ending Salary* \_\_\_\_\_

*Duties Performed* \_\_\_\_\_

*Reason for Leaving* \_\_\_\_\_

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2. *Employer* \_\_\_\_\_ *Job Title* \_\_\_\_\_

*Dates Employed* \_\_\_\_\_ *Prior Position Held within Company (if any):*  
\_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Phone* \_\_\_\_\_ *Job Title* \_\_\_\_\_ *Supervisor* \_\_\_\_\_

*Starting Salary* \_\_\_\_\_ *Ending Salary* \_\_\_\_\_

*Duties Performed* \_\_\_\_\_

*Reason for Leaving* \_\_\_\_\_

**Print Last Name** \_\_\_\_\_

3. *Employer* \_\_\_\_\_ *Job Title* \_\_\_\_\_

*Dates Employed* \_\_\_\_\_ *Prior Position Held within Company (if any):*  
\_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Phone* \_\_\_\_\_ *Job Title* \_\_\_\_\_ *Supervisor* \_\_\_\_\_

*Starting Salary* \_\_\_\_\_ *Ending Salary* \_\_\_\_\_

*Duties Performed* \_\_\_\_\_

*Reason for Leaving* \_\_\_\_\_

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4. *Employer* \_\_\_\_\_ *Job Title* \_\_\_\_\_

*Dates Employed* \_\_\_\_\_ *Prior Position Held within Company (if any):*  
\_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Phone* \_\_\_\_\_ *Job Title* \_\_\_\_\_ *Supervisor* \_\_\_\_\_

*Starting Salary* \_\_\_\_\_ *Ending Salary* \_\_\_\_\_

*Duties Performed* \_\_\_\_\_

*Reason for Leaving* \_\_\_\_\_

**May we contact your prior employers for references?**     **Yes**    **No**

Print Last Name \_\_\_\_\_

*Please write a paragraph about your professional goals, why you think you are the right candidate for this position, why you are interested in working at Duffy Health Center and why you would hire yourself.*

***Thank you for your interest in Duffy Health Center. Your application will receive individual evaluation and you will be notified as to the next step in the process.***

Last Name \_\_\_\_\_

**ACKNOWLEDGMENT AND AUTHORIZATION**

*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 for employment as may be necessary in arriving at an employment decision.*

*This application for employment shall be considered active for a period of time not to exceed 60 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.*

*I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an “at will” nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this “at will” employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.*

*I also acknowledge that any offer of employment is contingent on appropriate licensing required to perform the duties of the position, the return of a CORI report which is acceptable for employment at Duffy Health Center, and the receipt of all necessary references.*

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

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*