HealthPoint
Your Community Health Center

Dear Applicant,

Thank you for your interest in HealthPoint. We value compassion, quality and innovation. Our HealthPoint Mission is to strengthen communities and improve people's health by delivering quality health care services, breaking down barriers and providing access to all.

Enclosed you will find our Application, Background Check Information Form and Background Check Authorization. Please review, complete, sign and return them along with a resume.

Should you have any questions or concerns please feel free to contact me.

Best regards,

Christy Painter
Medical Staff Coordinator
cpainter@healthpointchc.org
#425-277-1311 x 1152

HealthPoint

# Non-Employee Application

**Please attach a CV or resume with your application. A letter of reference is REQUIRED with your application if you are applying for a Volunteer position. Please mail to Christy Painter 955 Powell Ave. SW, Renton, WA 98057, e-mail to cpainter@healthpointchc.org or fax to Attn: Christy Painter (use full name) at 425-277-1566.**

**Please Check the Position you are applying for below:**

**Volunteer** _____ **Observer**_____ **Student Rotation**_____ **Other**_____

Name (First, MI, Last): _____ Birth Date: _____ Gender: _____

Address: _____ City: _____ Zip: _____

Phone No: _____ Cell Phone/Pager: _____ E-Mail: _____

Emergency Contact: _____ Phone: _____ ☐ Home ☐ Work

Relationship: _____ Alternate Phone: _____ ☐ Work ☐ Cell

Address: _____ City: _____ Zip: _____

In addition to English, what languages do you speak? _____

Do you have any special medical needs or requirements that you would like on record or medications you wish to be given in an emergency situation?

☐ Yes ☐ No

If you answered yes, please explain:_____

_____

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, please describe the nature of the offense_____

_____

**Education/Work Experience**

Present Occupation: Student ____ Unemployed____ Retired____ Employed____

**If you are a student**

In what field are you studying? _____ What school are you attending? _____

Address of School_____ How long is your program? _____

**If you are employed**

What is your job title_____ Where do you work?_____

Phone number:_____ Address_____

**Please indicate the hours you are available to be in clinic below.**

Hours: Mondays 8-12p___ 1-5p___ Tuesdays 8-12p___ 1-5p___ Wednesdays 8-12p___ 1-5p___ Thursdays 8-12p___ 1-5p___

Fridays 8-12p___ 1-5p___

Available start date:_____ End date:_____

**Which HealthPoint Clinics are you interested in?**

All Clinics ☐Yes ☐No Auburn ☐Yes ☐No Bothell ☐Yes ☐No Federal Way ☐Yes ☐No

Kent ☐Yes ☐No Renton ☐Yes ☐No Redmond ☐Yes ☐No SeaTac ☐Yes ☐No

Tyee ☐Yes ☐No Administration ☐Yes ☐No

Are you currently a patient at HealthPoint? ☐Yes ☐No

If you answered yes, which clinic?_____Who was your provider?_____

Have you ever been a patient at HealthPoint? ☐Yes ☐No

If you answered yes, which clinic?_____Who was your provider?_____

How did you hear about HealthPoint?

_____

Why are you interested in HealthPoint?

_____

_____

What goals would you like to accomplish during your experience with us?

_____

_____

What prior experiences have you had that you think may be relevant?

_____

_____

What skills do you have that you think may be useful during your experience?

_____

_____

**Volunteer Interest**

**I will commit to a minimum of:**

4 hours per week for 2 months ☐

Special program/event ☐

Please list your top three Volunteer Position Choices:

1st Choice_____

2nd Choice_____

3rd Choice_____

**Student Rotation Requests**

Please indicate the type of rotation you are requesting _____

Please attach program information and requirements from your school.

_____ _____

Signature of Applicant Date

*******If under 18 years of age, parent or legal guardian must sign this form.**

**I understand that any offer of volunteer placement is contingent from satisfactory results of a criminal background check. I authorize the investigation of all statements obtained in this application for volunteer placement. I understand that misrepresentation or omission of facts called for hereon will be sufficient cause for cancellation of consideration for volunteer placement or dismissal from the agency's service if I have been placed.**

**I agree that HealthPoint shall not be held liable in any respect if any volunteer placement offer is not tendered, is withdrawn, or is terminated due to falsity of the statements and answers in this application form.**

**I am advised that in compliance with the Fair Credit Reporting Act, a routine investigation may be made concerning my character, general reputation, personal characteristics and mode of living. I have the right to make a written request, within a reasonable period of time, for a summary disclosure of the nature and scope of the investigation.**

**I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND IT.**

**Signature**: ☞ _____ Date: _____

*******If under 18 years of age, parent or legal guardian must sign this form.**

## AGREEMENT, AUTHORIZATION, AND CONSENT FOR RELEASE OF BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I, _____
LAST NAME FIRST NAME MIDDLE NAME (PLEASE INCLUDE Jr., Sr., II, III Etc.)

understand that in conjunction with my application for employment, work to be performed under contract, promotion, volunteer position, reassignment, and/or retention ("Engagement"), **HealthPoint** will use the services of an outside agency to research and verify the information I have provided on my application for Engagement including my personal background, character, professional standing, work history and qualifications. This agency will provide a written report of its findings to **HealthPoint**. **HealthPoint** uses **Abso**, a consumer-reporting agency, as an agent to perform its Employment related background investigations.

**Abso** will utilize various sources of information it deems appropriate including but not limited to: criminal records, current and former employers, department of motor vehicle records, military records, credit reporting agencies, education records, licensing authorities, state and federal sanctioning authorities, professional and personal references and workers compensation records including any and all injuries in compliance with the Americans with Disabilities Act. I agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to **HealthPoint**, and **Abso**.

I agree, authorize and consent to the procurement of a Consumer Report and/or an Investigative Consumer Report and understand that it may contain information about my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. This authorization in original or copy form shall be valid for my term of Engagement from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by **HealthPoint** if Engagement is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to **HealthPoint**. I further understand that I may request a copy of the report, and that when doing so, proper identification will be required and I should direct my request to: **Abso**, 101 Creekside Ridge Ct., 2nd Floor, Roseville, CA 95678. I understand that residents of all states will automatically receive a copy of the report if an adverse action is taken regarding the employment application, or upon request as outlined herein.

☐ CHECK THIS BOX IF you are applying for work with a California, Minnesota or Oklahoma based employer and you would like a copy of your Consumer Report if one is prepared in the investigation of your background. CA Codes 1785.20.5 & 1786.16(a)(5)(b)(1), MN Code 13C Subdivision 2, OK Code 24 O.S. §148

**LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES FOR POSITIVE IDENTIFICATION PURPOSES REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. PLEASE PRINT CLEARLY.**

_____ _____
**Signed** **Today's Date**

_____ _____
**Name as it appears on your driver's license** **Position Applied For**

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

**Other names you have used, or are also known as, including maiden name, name changes and any aliases:**

_____

**PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST 7 YEARS**

**Mo./Yr. / Mo./Yr**

**Current Address**: _____ /_____
**Street** **Apt.#** **City** **State** **Zip Code** **From / To?**

**Former Address**: _____ /_____
**Street** **Apt.#** **City** **State** **Zip Code** **From / To?**

**Former Address**: _____ /_____
**Street** **Apt.#** **City** **State** **Zip Code** **From / To?**

**Former Address**: _____ /_____
**Street** **Apt.#** **City** **State** **Zip Code** **From / To?**

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# Background Check Authorization

By signing this release below, I hereby authorize *HealthPoint* to run a Background Check. This is in accordance to chapter 486, Laws of Washington, 1987 that stipulates that healthcare agencies must request information regarding whether applicants have been convicted of any crimes against persons, or found to have sexually assaulted, abused or exploited any minor.

All applicants who accept employment with *HealthPoint* must make a written disclosure of such convictions. Background inquires regarding prior convictions will be made with the Washington State Patrol, other law enforcement agencies and the services of an outside agency to research and verify the information provided on my application. Failure to disclose prior convictions or falsification of the disclosure clause on the employment application form may be considered misconduct and grounds for termination.

Applicants and employees who are discovered to have had conviction for a crime against another person may be discharged.

I release from all liability all persons, companies, schools supplying such information. I indemnify *HealthPoint* against any liability, which may result from making such requests. This authorization in original or copy form shall be valid for my term of Engagement from the date indicated next to my signature. I understand I have a right to request additional disclosures regarding the nature and scope of the investigation. I also understand that I will be given a copy of the consumer report and a written description of my rights under the Fair Credit Reporting Act.

The information I have provided is accurate, true and correct and that I fully understand the terms of this release.

Name:_____ Date:_____

☞ Signature:_____