

## ARNP Resident Employment Application

P.O. Box 3007 | Seattle, WA 98114-3007  
 Administrative Office [206] 788-3650 | Fax [206] 490-4011  
 Email: arnpresidency@ichs.com

Last Name		First Name		Middle Initial	
Street Address		Apt #	City		State Zip Code
Home Phone #		Cellular Phone #		Email Address	

Do you have immediate family members or any relatives currently working for ICCHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name(s) of family member /relative	
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1. Can you provide documentation which authorizes you to work in the Unites States?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
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2. Have you been on the Office of Inspector (OIG) list of excluded individuals?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
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If you answered "yes" to #2, please explain:  
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How did you learn of this position? Please specify below.

Online/Job Posting \_\_\_\_\_  Newspaper \_\_\_\_\_  ICCHS website  Walk-in  
 Other (Name/Source) \_\_\_\_\_  ICCHS Employee Name \_\_\_\_\_

**EDUCATION** Your name used while attending school if different from above.

Last Name		First Name		Middle Initial	
Name of High School Attended		City & State	Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, year?		G.E.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Colleges/Universities Attended:		Major	Dates Attended: (Mo/Yr) From: To:		Degrees Conferred <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Colleges/Universities Attended:		Major	Dates Attended: (Mo/Yr) From: To:		Degrees Conferred <input type="checkbox"/> Yes <input type="checkbox"/> No
Technical Institute/Business Attended:				Dates Attended: (Mo/Yr) From: To: Degrees Conferred <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SKILLS** List any vocational or on-the-job training you have completed; any special training you have completed; and any special license(s) or certification(s) which are necessary or useful.

\_\_\_\_\_

License, Certificate, or Registration		State Issued	Number	Expiration Date
License, Certificate, or Registration		State Issued	Number	Expiration Date

**LANGUAGE FLUENCY** Are you proficient in any languages other than English?  Yes  No (If Yes, list them below.)

Language	Years of Experience		
	Read	Write	Speak
1)	# of Years	# of Years	# of Years
2)	# of Years	# of Years	# of Years

**EXPERIENCE** List all work experience, including relevant volunteer experience.

\_\_\_\_\_



Employed by:	Job Title:
Address:	Your Duties:
City & State:	
Employed (Mo/Yr) From: / To: /	
Supervisor:	
Phone: May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Average Hours/Week: End Salary: \$	
Reason for leaving:	

Employed by:	Job Title:
Address:	Your Duties:
City & State:	
Employed (Mo/Yr) From: / To: /	
Supervisor:	
Phone: May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Average Hours/Week: End Salary: \$	
Reason for leaving:	

Employed by:	Job Title:
Address:	Your Duties:
City & State:	
Employed (Mo/Yr) From: / To: /	
Supervisor:	
Phone: May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Average Hours/Week: End Salary: \$	
Reason for leaving:	

**JOB REQUIREMENTS**

Do you believe you are capable of performing the essential functions of the job, with or without reasonable accommodation for which you are applying for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you require any accommodation during the application, testing, or interview process, you may note them here if you wish:	

**AUTHORIZATION AND CERTIFICATION**

I certify that to the best of my knowledge and belief, the answers given by me to the questions and the statements made in my application materials are true, complete and written solely by me. Should I be accepted for employment, I understand that any false or inaccurate information contained in my application materials may result in immediate discipline, up to and including termination of employment.

I authorize International Community Health Services (ICHS) and/or its agents to conduct background investigations of my personal history, including current and past employment. This research may include, but is not limited to information obtained from employers, persons named as references, licensing departments, school officials, etc. Should ICHS first offer me employment that is conditioned upon the results of a "criminal background check," as that term is defined in Seattle Ordinance No. 124201 (the "Ordinance"), I hereby authorize ICHS to perform such a criminal background check on me and I also agree to provide ICHS with "criminal history record information," as defined in the Ordinance, if so asked by ICHS. I release all parties providing such information from any liability for any loss or damage whatsoever resulting from providing such information. A photocopy, fax, or other kind of electronically transmitted copy of this certificate will be considered equally valid as the signed original.

I understand that if I have ever worked for ICHS through a temporary placement services agency, I will be fully responsible for paying any and all agency fees that may apply for the position I accept with ICHS.

I understand that if I am hired, I will be required to provide proof of identity, legal work authorization, and a copy of my degree and/or certification. I understand that employment at ICHS is "at will," which means that either I or ICHS can terminate employment for any reason not prohibited by law. I understand that no supervisor, manager, director or other representative of ICHS has any authority to alter the foregoing, except the Chief Executive Officer, who may do so in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Affirmative Action Information Request**

**APPLICATION INFORMATION**

International Community Health Services is a federal contractor, and as such is mandated by Presidential Executive Order 11246, amended by Executive Order 11375, to request the following information from applicants. This information is kept confidential, and is used to fulfill reporting requirements. Completion of this form is voluntary: a decision not to provide this information will not result in adverse treatment of your employment application. You may provide the information now, or at any time after employment.

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>
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**US Veteran Status**

- 1) Have you ever served in the United States Armed Forces?  Yes  No If yes, which, if any, apply?  
 Vietnam Era veteran  Special disabled veteran  Recently separated veteran  Other protected veteran

**Ethnic Origin**

- African American/Black – Persons of Black African descent (not Hispanic/Latino)  
 Asian – Persons of Far Eastern or Indian subcontinent descent (not Hispanic/Latino)  
 Caucasian/White – Persons of European, Middle Eastern, or North African descent (not Hispanic/Latino)  
 Hispanic/Latino – Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.  
 Native American/Indian – Persons from the original peoples of the Americas, and who maintain tribal affiliation of community attachment.  
 Native Hawaiian/ or Pacific Islander descent (not Hispanic/Latino)  
 2 or more races (not Hispanic/Latino) \_\_\_\_\_

**Other Information**

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female

**EEO STATEMENT**

International Community Health Services reaffirms its policy of equal opportunity regardless of race, color, creed, religion, national origin, sex, gender identity, political ideology, sexual orientation, age, marital status, disability, use of a service animal, or status as a disabled veteran or Vietnam era veteran. This policy applies to all programs and facilities including, but not limited to, employment, and patient services. Any discrimination action can be a cause for disciplinary action. Discrimination is prohibited by Presidential Executive Order 11246 as amended, Washington State Gubernatorial Executive Orders 89-01 and 93-07, Titles VI and VII of the Civil Rights Act of 1964, Section 503 and 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990 and Americans with Disabilities Act Amendment Act of 2009, Age Discrimination in Employment Act of 1967 as amended, Age Discrimination Act of 1975, Vietnam Era Veteran’s Readjustment Assistance Act of 1972 as amended, other federal and state statutes, regulations, and ICHS policy.

Coordination of the compliance efforts of International Community Health Services with respect to all these laws and regulations is under the direction of Human Resources at PO Box 3007, Seattle, WA 98114-3007.

If you wish to request a disability accommodation during the application process, please contact Human Resources at 206-788-3658.

<b>Signature</b>	<b>Date</b>
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**The completed form should be treated as confidential and should not be seen by anyone other than the employee to whom it refers to; no copies should be made of completed forms.**



## SUPPLEMENT TO THE ARNP RESIDENT EMPLOYMENT APPLICATION

Applicants must submit the following in addition to the ARNP Resident Employment Application:

1. Personal Statement addressing in 1,000 words (2 pages) or less
  - a. Why did you choose to do a residency at International Community Health Services?
  - b. What are your experiences working with under-served and vulnerable populations? And
  - c. What are your career goals?
2. A copy of your Curriculum Vitae (CV)
3. Three (3) sealed letters of recommendation:
  - a. One professional
  - b. One academic; and
  - c. One of your choice
4. ARNP transcript – official and sealed
5. ARNP Diploma and certifications, if applicable.

**The application deadline is March 16th, 2020.**

Please send all application material in one packet to:

DoQuyen Huynh  
ARNP Residency Program Director  
International Community Health Services  
PO Box 3007 | Seattle, WA 98114-3007

Should you have any questions, please contact:

Phone: (206) 788-3569  
FAX: (206) 490-4011 (Attn: DoQuyen Huynh)  
EMAIL: [arnpresidency@ichs.com](mailto:arnpresidency@ichs.com)