



Native Village of Eyak's Ilanka Community Health Center

EMPLOYMENT APPLICATION FORM

_____ Title of Position Applied For

1. Name: _____
2. Contact Phone: _____ Email Address: _____
If a confidential message cannot be left at this number or address, how should we contact you? _____
3. Mailing Address: _____
4. Are you known by any other name? Yes No Other Name(s): _____
5. Are you Alaska Native? Yes No. If yes, name your ANCSA Village Corporation _____
 & Regional Corporation: _____
6. Are you an enrolled member of a federally-recognized tribe? If yes, identify the tribe and its location: _____
7. U.S. Citizen? Yes No. How did you hear about us? _____
8. Are you a veteran? Yes No. Type of Discharge: _____ Branch of Service: _____

9. EDUCATION

Circle years completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Elementary High School College Post-Graduate

High School Name/Address: _____

Did you graduate? Yes No. Year diploma received: _____

High School Equivalency Certificate (GED) State: _____ Date: _____ #: _____

Name & Address	From	To	Degree	Major	Date of Degree
College					
Graduate School					
Other					

ADDITIONAL & SPECIAL QUALIFICATIONS

10. Membership in Professional Association, Unions: _____
11. Registration, Certification and/or Licenses: _____
12. Language spoken other than English: _____
13. Clerical and Office Skills: Typing __wpm Shorthand ____wpm WORD: _____
14. Office machines experienced in: _____
15. Software: _____

16. Mechanical equipment, electronic equipment or machinery you are qualified to operate and/or repair:

17. Will you accept a position requiring travel? Continuous Frequent Occasional
 Remote Areas No Travel

18. Are you available for the following types of positions: Full-Time Part-Time
 Seasonal Temporary

19. PREVIOUS/CURRENT EXPERIENCE

Employer:	Employment Dates	Job Title:
	From _____ To _____	
		Work Performed:
Address:	Hourly Rate/Salary	
	Starting _____ Final _____	
Supervisor & Phone No.:		
Reason for Leaving:		
Employer:	Employment Dates	Job Title:
	From _____ To _____	
		Work Performed:
Address:	Hourly Rate/Salary	
	Starting _____ Final _____	
Supervisor & Phone No.:		
Reason for Leaving:		
Employer:	Employment Dates	Job Title:
	From _____ To _____	
		Work Performed:
Address:	Hourly Rate/Salary	
	Starting _____ Final _____	
Supervisor & Phone No.:		
Reason for Leaving:		

Use additional pages or attach resume to describe last 7 years of employment and any other relevant experience.

20. CHARACTER REFERENCES

List at least three references (not related to you) who have knowledge of your character, experience and ability:

Name and Relationship	Address	Phone

Please feel free to attach relevant letters of reference.

21. PROFESSIONAL REFERENCES

List at least three professional references (not related to you) who have knowledge of your professional qualifications, ethics, competence, experience and ability. If you have previously identified individuals qualified to provide a professional reference, please indicate.

Name and Relationship	Address	Phone

Please feel free to attach relevant letters of reference.

22. When are you available to start work? _____

CRIMINAL HISTORY

23. Have you ever been convicted of a felony? Yes No

If yes, identify the date of conviction, where the charges were determined, the nature of the charge, and case number. _____

24. Have you ever been convicted of a misdemeanor involving violence, minors under the age of 18, or weapons? Yes No

If yes, identify the date of conviction, where the charges were determined, the nature of the charge, and case number. _____

25. Answer the following question if the position applied for is a child contact position subject to the Indian Child Protection and Family Violence Protection Act:

Have you ever been arrested or charged in connection with sexual abuse or sexual assault of a minor or adult? Yes No

If yes, identify the date of conviction, the result of the charge or arrest, the nature of the charge, location of proceedings, and case number. _____

26. CERTIFICATION AND AUTHORIZATION

I certify the information provided on this application to be correct and accurate. In order to be considered for employment, I authorize the Native Village of Eyak to investigate the information provided and my background, including criminal and credit records.

Date: _____ Applicant Signature: _____

Pages 4 - 7 **only** to be completed by applicants who are licensed medical providers.

LICENSURE INFORMATION

27. List all states, territories, and foreign countries in which you hold or have held medical licenses, including Alaska.

STATE OR COUNTRY WHERE LICENSED	LICENSE NUMBER	CURRENT STATUS	DATE ISSUED
a.			
b.			
c.			
d.			
e.			

28. Identify any certificates of professional training or credentials (e.g., practical nurse, specialties, Emergency Medical Technician) that you have at any time, date obtained, date last current.

CERTIFICATE	DESCRIPTION	DATE ISSUED	CURRENT STATUS
a.			
b.			
c.			
d.			
e.			

29. Have you ever had hospital or clinic privileges in any hospital? Yes No

If so, give name and address of facility and period of service. _____

DISCIPLINARY HISTORY

30. Have you ever been denied a certificate by, or the privilege of taking an examination before, any state medical board?

Yes No

31. Have you ever been the subject of an inquiry or under investigation by any state board or other licensing agency concerning a violation or alleged violation or any state regulation, statute, or law, for any violation or alleged violation of the medical practice act, or unprofessional or unethical conduct, or for sexual misconduct? Yes

No

32. Have you ever had a license to practice medicine disciplined, restricted, limited, suspended, revoked, or otherwise disciplined by any licensing agency, credentialing authority, medical board, or military authority? Yes No
33. Have you ever voluntarily agreed to limitations or restrictions being placed on your license or voluntarily surrendered your license to practice medicine in any licensing jurisdiction? Yes No
34. Have you ever been charged or convicted of a violation of a law, statute, or regulation of the United States, Canada, or Mexico, excluding minor traffic violations? Yes No
35. Have you ever been charged with or convicted of a violation of any United States, Canadian, or Mexican narcotics or controlled substances laws? Yes No
36. During your medical school education, were you ever placed on probation, suspended, restricted, or otherwise disciplined for any reason? Yes No
37. Have you ever been under investigation or disciplined by military authorities or any hospital, medical school, or internship or residency program relating to the practice of medicine (including been placed on probation, received a letter of reprimand, censured, etc.)
Yes No
38. Have you ever had privileges revoked, conditioned, restricted, or had any disciplinary action regarding your privileges? (Temporary suspensions due to failure to meet administrative requirements are included) Yes No
39. Have you ever applied for and been denied a DEA Registration Number? Yes No
40. Have you ever surrendered your DEA Registration Number? Yes No
41. Have you ever been convicted of a violation of any federal or state narcotic laws? Yes No
42. Have you ever had any malpractice settlements or judgments paid on your benefit?
Yes No

Explain any **yes** answers on separate sheet(s). Refer specifically to the corresponding question numbers.

43. MEDICAL WORK HISTORY

Provide any additional medical work history not identified in your previous responses. Include volunteer work history of any significant length.

Dates	Name and Address	Position/Privileges/Scope of Practice

43. CERTIFICATION

I HEREBY CERTIFY that the information contained in this application is true and correct to the best of my knowledge. I further certify that all credentials supplied by me are true and correct. I understand that any false information or falsification of credentials may result in dismissal, rejection of my application, ineligibility for future consideration, and referral/reporting to appropriate agencies, including law enforcement agencies.

Date: _____ Applicant Signature: _____

Complete the next page, containing the *Provider Applicant's Statement of Understanding, Authorization, and Liability Release* as a condition of initiating Ilanka Clinic's credentialing process.

**THE NATIVE VILLAGE OF EYAK
ILANKA CLINIC**

**Provider Applicant's Statement of Understanding, Authorization, and Liability
Release**

In connection with applying for employment, and/or clinic privileges with Ilanka Clinic, I hereby authorize the Ilanka Clinic, and its medical staff, representatives, employees and agents, to consult the following entities and individuals:

- Current and former representatives and employees of health care organizations, providers or entities with which I have been associated on a professional basis, including supervisors or collaborative physicians and;
- Individuals or organizations, including past and present malpractice carriers, employers, and state regulatory authorities, who may have information bearing on my professional competence, character, and ethical qualifications.

I authorize the above entities and individuals to disclose fully any and all information or records about me that may be relevant to the research, references, and information requests of Ilanka Clinic. I release any and all individuals and entities who provide information to Ilanka Clinic in response to this authorization, or who otherwise provide information concerning my professional competence, ethics, character or other qualifications, from any and all claims, causes of action, or liability whatsoever.

I also authorize Ilanka Clinic to inspect or copy all records and documents, including medical records at other hospitals or healthcare organizations, that may be material to its evaluation of my professional qualifications and competence to carry out the clinical privileges requested, and my moral and ethical qualifications for staff membership.

I hereby consent to the release of any information by Ilanka Clinic that may be relevant to or that may be disclosed in connection with seeking information and references concerning my licensure, competence, ethics, character and other qualifications.

I fully release Ilanka Clinic, its medical staff, representatives, employees and agents from all claims or liability for acts and omissions, including communications, that occur in connection with evaluating my application, credentials, qualifications, character and suitability.

I understand and assume the duty and responsibility of informing Ilanka Clinic, in a timely manner, of subsequent changes in any information provided on or relative to this application.

Print Name

Signature

Date