Native Village of Eyak
110 Nicholoff Way
P.O. Box 1388
Cordova, Alaska 99574-1388
P (907) 424-7738 * F (907) 424-7739
www.eyak-nsn.gov

10,000 years in our Traditional Homeland, Prince William Sound, the Copper River Delta, and the Gulf of Alaska

EMPLOYMENT APPLICATION
Ilanka Community Health Center

_____
Position Applying For

PERSONAL INFORMATION

Name: _____ _____ _____
Last First MI
Telephone: _____ Email: _____
Mailing address: _____
Are you known by any other name? Yes ☐ No ☐ Other name(s): _____
Are you Alaska Native? Yes ☐ No ☐ Do you have a C.I.B? Yes ☐ No ☐
If yes, list your tribe of origin: _____
Are you legally eligible for employment in the United States? Yes ☐ No ☐
Are you a veteran? Yes ☐ No ☐ Branch of Service_____
Type of Discharge: _____
Will you accept a position requiring travel? Yes ☐ No ☐
Type of travel available for: Continuous ☐ Frequent ☐ Occasional ☐ Remote Areas ☐
Will you accept a position requiring weekend work? Yes ☐ No ☐
Type of position seeking: Full Time ☐ Part Time ☐ Seasonal ☐ Temporary ☐ As Needed ☐
Date you are available to begin work: _____

EDUCATION

High school name: _____
Number of years completed: _____ Diploma: Yes ☐ No ☐ GED: Yes ☐ No ☐
City: _____ State: _____

College and/or vocational school name: _____
Number of years completed: _____ Major: _____
Degrees earned: _____ City: _____ State: _____

Graduate/Professional school name: ____
Number of years completed: ________ Major: ______________________________________
Degrees earned: ____________________ City: ________________ State: ____________

Other training/degrees/certificates: ____
Course: __________________________ City: ________________ State: ____________
Degree or certificate earned: _______________________________

EMPLOYMENT HISTORY

Employer:	Employment Dates		Work Performed:
Address:	From:	To:	
	Hourly Rate/Salary		
Telephone:	Starting:	Final:	
Job Title:			
Supervisor:	Supervisor Telephone:		
Reason for leaving:			

Employer:	Employment Dates		Work Performed:
Address:	From:	To:	
	Hourly Rate/Salary		
Telephone:	Starting:	Final:	
Job Title:			
Supervisor:	Supervisor Telephone:		
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Employer:	Employment Dates		Work Performed:
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Telephone:	Starting:	Final:	
Job Title:			
Supervisor:	Supervisor Telephone:		
Reason for leaving:			

Use additional pages or attach resume to describe the last 10 years of employment and other relevant experience.

PROFESSIONAL LICENSE or MEMBERSHIP

Membership in professional association: _____
Type of license held: _____ State: _____
Expiration date: _____ License number: _____

SKILLS AND QUALIFICATIONS

Office machines experienced in: _____
_____
Software: _____
_____
Mechanical equipment or machinery you are qualified to operate and/or repair: _____
_____
Other qualifications such as special skills, other languages or other information relevant to the position: _____

REFERENCES

List one character reference and three professional references who are not related to you that have knowledge of your professional qualifications, ethics, competence, experience and ability.

Name	Professional/ Character	Address	Telephone	Occupation	Years Known

Please feel free to attach relevant letters of reference.

CRIMINAL HISTORY

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: _____

_____

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: _____

_____

Answer the following 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, where the charges were determined, the nature of the charge and case number: _____

_____

MEDICAL LICENSURE

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

License Type: _____ License Number: _____
Location of License (State/Country): _____
Date Issued: _____ Current Status: _____
Expiration Date: _____

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Location of License (State/Country): _____
Date Issued: _____ Current Status: _____
Expiration Date: _____

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Location of License (State/Country): _____
Date Issued: _____ Current Status: _____
Expiration Date: _____

License Type: _____ License Number: _____
Location of License (State/Country): _____
Date Issued: _____ Current Status: _____
Expiration Date: _____
Please attach information for any additional licenses, current or expired.

MEDICAL CERTIFICATES

Identify any certificates of professional training or credentials (e.g. LPN specialty, E.M.T.) that you have held.

Certificate: _____
Description: _____
Date Issued: _____ Current Status: _____
Expiration Date: _____

Certificate: _____
Description: _____
Date Issued: _____ Current Status: _____
Expiration Date: _____

Certificate: _____
Description: _____
Date Issued: _____ Current Status: _____
Expiration Date: _____

Certificate: _____
Description: _____
Date Issued: _____ Current Status: _____
Expiration Date: _____
Please attach information for any additional certificates, current or expired.

HOSPITAL PRIVILEGES

Have you ever been privileged to work at a hospital or a clinic? Yes ☐ No ☐
If *yes,* please provide the following information for each privileged location:

Facility Name: _____
Facility Address: _____
Period of Service: _____

Facility Name: _____
Facility Address: _____
Period of Service: _____

Facility Name: _____
Facility Address: _____
Period of Service: _____

Facility Name: _____
Facility Address: _____
Period of Service: _____
Please attach information for any additional privileges you may have held.

MEDICAL DISCIPLINARY HISTORY

Have you ever been denied a certificate or the ability to take an examination by a state medical board? Yes ☐ No ☐

Have you ever been the subject of an inquiry or been under investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute or law of the malpractice act, for unprofessional or unethical conduct, or for sexual misconduct? Yes ☐ No ☐

Have you ever had a license to practice medicine that was disciplined, restricted, limited, suspended, revoked or have you ever had other adverse action taken by any licensing agency, credentialing authority, medical board or military authority? Yes ☐ No ☐

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 ☐

Have you ever been charged with or convicted of a violation of a law, statute or regulations of the United States, Canada or Mexico (excluding minor traffic violations)? Yes ☐ No ☐

Have you ever been charged or convicted of a violation of any law regarding controlled substances in the United States, Canada or Mexico? Yes ☐ No ☐

During your medical schooling, were you ever placed on probation, suspended or otherwise disciplined for any reason? Yes ☐ No ☐

Have you ever been under investigation or disciplined by any hospital, medical school, military authority, internship or resident program relating to the practice of medicine? Yes ☐ No ☐

Have you ever had privileges revoked, conditioned, restricted or disciplined (including temporary suspensions from failure to meet administrative requirements)? Yes ☐ No ☐

Have you ever applied for and been denied a DEA Registration Number? Yes ☐ No ☐

Have you ever surrendered your DEA Registration Number? Yes ☐ No ☐

Have you ever been convicted of a violation of any federal or state narcotic laws? Yes ☐ No ☐

Have you ever had any malpractice settlements or judgements paid on your behalf?
Yes ☐ No ☐
Please attach additional information for any questions answered with a yes.

CERTIFICATION AND AUTHORIZATION

I _____certify the information provided on this application is correct and accurate. I further certify that all credentials listed are true and correct. I understand that 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. 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 checks.

_____ _____

Applicant Signature Date

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

The Native Village of Eyak
Ilanka Community Health Center
Provider Applicant's Statement of Understanding, Authorization, and Liability Release

In connection with applying for employment, and/or clinic privileges with the Ilanka Community Health Center, I hereby authorize the Ilanka Clinic, it's 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 the Ilanka Community Health Center. I release any and all individuals and entities who provide information to the Ilanka Community Health Center 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 the Ilanka Community Health Center 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 the Ilanka Community Health Center that may be relevant to or that may be disclosed regarding seeking information and references concerning my licensure, competence, ethics, character, or other qualifications.

I fully release the Ilanka Community Health Center, its medical staff, representatives, employees and agents from all claims or liability for acts and omissions, including communications, that occur regarding evaluating my application, credentials, qualifications, character, and suitability.

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

_____

Applicant Printed Name

_____ _____

Applicant Signature Date

Submit