

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: |        |                 |
| Reason for leaving: |                       |        |                 |

|                     |                       |        |                 |
|---------------------|-----------------------|--------|-----------------|
| Employer:           | Employment Dates      |        | Work Performed: |
| Address:            | From:                 | To:    |                 |
|                     | Hourly Rate/Salary    |        |                 |
| 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/<br>Character | Address | Telephone | Occupation | Years<br>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: \_\_\_\_\_

License Type: \_\_\_\_\_ License Number: \_\_\_\_\_

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: \_\_\_\_\_



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, 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 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.

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Applicant Printed Name

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Applicant Signature

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Date