MCHD
mobile county health department
A legacy of excellence since 1816

EMPLOYMENT APPLICATION

MCHD provides equal employment opportunity to all qualified applicants without regard to race, color, religion, sex (including pregnancy, childbirth and related medical conditions), national origin, age (40 or over), citizenship, status of a disabled veteran or veteran of the Vietnam Era. MCHD provides equal employment opportunities for qualified disabled individuals. This Application must be completed in full, signed and dated. Applications not meeting these requirements will not be considered.

FULL NAME (PRINT)		SOCIAL SECURITY NUMBER	DATE
ADDRESS		HOME PHONE	CELL PHONE
CITY	STATE	EMAIL ADDRESS	
ZIP CODE	DRIVERS LICENSE	STATE DRIVERS LICENSE ISSUED	EXPIRATION DATE OF DRIVERS LICENSE

EMPLOYMENT DESIRED		
1	2	3
HAVE YOU PREVIOUSLY WORKED AT MCHD? ☐NO ☐YES DATE(S):	HAVE YOU PREVIOUSLY SUBMITTED AN APPLICATION? ☐NO ☐YES DATE(S):	WHAT PROMPTED YOU TO APPLY?
YOUR NAME AT THE TIME WAS		

EDUCATION				
SCHOOL	NAME/ADDRESS	COURSE OF STUDY	YEARS COMPLETED	DIPLOMA/DEGREE/GED/GRADUATION DATES
HIGH SCHOOL				
UNDERGRADUATE COLLEGE				
GRADUATE COLLEGE				
OTHER (SPECIFY)				

PROFESSIONAL LICENSURE AND CERTIFICATION	
TYPE OF LICENSURE AND/OR CERTIFICATION	
LICENSE #	EXPIRATION DATE OF LICENSE AND/OR CERTIFICATION
NAME ON LICENSURE AND/OR CERTIFICATION	

GENERAL INFORMATION	
ARE YOU FLUENT IN OTHER LANGUAGES? ☐NO ☐YES LANGUAGES SPOKEN:	
ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES UNDER U.S. IMMIGRATION LAWS? ☐NO ☐YES (If you are offered employment, you will be required to produce valid documents approved by the Immigration & Naturalization Service to prove your identity and your eligibility to work in the United States)	
HAVE YOU HAD A HISTORY OF (1) ANY ARREST(S) AND/OR CONVICTION(S) INVOLVING DRIVING WHILE INTOXICATED BY, WHILE IMPAIRED BY, OR WHILE UNDER THE INFLUENCE OF ALCOHOL OR A DRUG; OR (2) HISTORY OF ANY ARREST(S) AND/OR CONVICTION(S), AND/OR ADMINISTRATIVE ACTION(S) INVOLVING AN OFFENSE(S) WHICH RESULTED IN THE DENIAL, SUSPENSION, CANCELLATION, OR REVOCATION OF DRIVING PRIVILEGES OR WHICH RESULTED IN ATTENDANCE AT AN EDUCATIONAL OR REHABILITATION PROGRAM. (3) HISTORY OF NON-TRAFFIC CONVICTION(S) (MISDEMEANORS, FELONIES, ARREST); (4) HISTORY OF ANY ADVERSE ACTIONS WITH LAW ENFORCEMENT? ☐NO ☐YES. EXPLAIN:	
DO YOU HAVE A RELATIVE(S) OR FRIEND(S) EMPLOYED AT MCHD? ☐NO	☐YES. NAME AND TITLE: RELATIONSHIP:

Hiring and initial placement decisions of MCHD are based primarily on information supplied by applicants concerning education, technical training and prior employment. It is necessary that you supply detailed information about your previous experience and training including company names, dates and duties that will enable MCHD to verify this information. (Use additional paper if needed). Begin with your present or last employer and work back, listing all previous employment.

EMPLOYMENT HISTORY - PRESENT EMPLOYER			
EMPLOYER (PRINT)		DATE STARTED	DATE ENDED
STREET ADDRESS		BEGINNING PAY	ENDING PAY
CITY	STATE	JOB TITLE	
ZIP CODE	SUPERVISOR'S NAME		PHONE
REASON FOR LEAVING		LIST JOB DUTIES	

PREVIOUS EMPLOYER TWO			
EMPLOYER (PRINT)		DATE STARTED	DATE ENDED
STREET ADDRESS		BEGINNING PAY	ENDING PAY
CITY	STATE	JOB TITLE	
ZIP CODE	SUPERVISOR'S NAME		PHONE
REASON FOR LEAVING		LIST JOB DUTIES	

PREVIOUS EMPLOYER THREE			
EMPLOYER (PRINT)		DATE STARTED	DATE ENDED
STREET ADDRESS		BEGINNING PAY	ENDING PAY
CITY	STATE	JOB TITLE	
ZIP CODE	SUPERVISOR'S NAME		PHONE
REASON FOR LEAVING		LIST JOB DUTIES	

PREVIOUS EMPLOYER FOUR			
EMPLOYER (PRINT)		DATE STARTED	DATE ENDED
STREET ADDRESS		BEGINNING PAY	ENDING PAY
CITY	STATE	JOB TITLE	
ZIP CODE	SUPERVISOR'S NAME		PHONE
REASON FOR LEAVING		LIST JOB DUTIES	

REFERENCES - LIST TWO CHARACTER REFERENCES OTHER THAN RELATIVES			
NAME	ADDRESS	OCCUPATION	TELEPHONE OR CELL NUMBER

RELEASE AND AUTHORIZATION OF EMPLOYMENT/MEDICAL INFORMATION

I certify that the information I gave in this Employment Application is true and complete. I understand that MCHD may refuse to hire me or, if I am hired by MCHD, may discharge me if I give false, misleading or incomplete information in this Employment Application. I understand that I will be required to undergo a medical examination and a drug screen before beginning work for MCHD, and that any offer of employment is conditioned upon satisfactory completion of the medical examination and drug screen. Upon request, I will sign a medical records release authorization to enable MCHD to obtain any medical information necessary to facilitate my medical examination. I understand that all medical information obtained by MCHD will be maintained in confidence to the extent required by applicable laws, and will not be included in my personnel file. I authorize each person, school and former employer identified in this employment application to provide MCHD with any information that MCHD may request, and I authorize MCHD to obtain complete information concerning any conviction, guilty plea or plea of nolo contendere for any crime. I consent to the release of all such information to MCHD, and I release each such person, school or employer from any liability or damage related in any way to the furnishing of such information.

SIGNATURE	DATE

MOBILE COUNTY HEALTH DEPARTMENT
NOTIFICATION AND RELEASE OF INFORMATION CONSENT

The purpose of this form is to notify you that a Consumer Report and/or an Investigative Consumer Report, defined as ANY report used to determine an individual's eligibility, as outlined in the Fair Credit Reporting Act (FCRA), which includes employment (pre-employment, promotion, reassignment, periodic background checks), used in connection with a financial transaction/extension of credit or the underwriting of insurance, will be conducted on you in the course of determining your eligibility as a prospective employee.

In consideration of Mobile County Health Department review of my application for employment, I _____hereby authorize First Advantage or its authorized agents bearing this release or copy thereof, to obtain a consumer report for employment. To the extent permitted by the applicable Federal, State and Local Law, I hereby authorize and permit First Advantage to obtain, and any person, firm or entity to release to First Advantage or its authorized representatives, the following: 1) my employment record; 2) records concerning any criminal history that I may have; 3) records concerning my driving history; 4) records concerning my credit history; 5) records concerning my worker's compensation history; 6) verification of my academic and or professional credentials. I agree that a copy of this authorization has the same effect as an original. I hereby release and hold harmless any person, firm, or entity that discloses matters in accordance with this authorization and the Mobile County Health Department and its authorized representatives from liability that might otherwise result from the request for, use of and/or disclosure of all the foregoing information. This release shall remain in effect for the length of my employment relationship. I understand I have the right to obtain a copy of this consumer report if; (1) Any adverse action/decision is made based on the information in the consumer report, & (2) If the request is made in writing within sixty (60) days of the adverse action. I believe to the best of my knowledge that all information I have provided is accurate, true and correct and that I fully understand the terms of this release.

Please print clearly in black or blue ink only.

LAST NAME	FIRST NAME	MIDDLE NAME
DATE OF BIRTH	I AUTHORIZE CONTACT OF MY CURRENT EMPLOYER ☐YES ☐NO	LIST ANY NAMES THAT YOU HAVE WORKED OR ATTENDED SCHOOL UNDER, INCLUDING MAIDEN NAMES
SOCIAL SECURITY NUMBER	DRIVERS LICENSE NUMBER	STATE DRIVERS LICENSE ISSUED
CURRENT ADDRESS	CITY STATE ZIP	LENGTH OF RESIDENCE

Please complete previous address section if you have lived at your current address for less than seven years.

PREVIOUS ADDRESS 1	CITY STATE ZIP	LENGTH OF RESIDENCE

PREVIOUS ADDRESS 2	CITY STATE ZIP	LENGTH OF RESIDENCE

PREVIOUS ADDRESS 3	CITY STATE ZIP	LENGTH OF RESIDENCE

Signature _____ Date _____

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MOBILE COUNTY HEALTH DEPARTMENT
SELF IDENTIFICATION VOLUNTARY DISCLOSURE

To enable the Agency to compile data necessary to file annual statistical reports required by the U. S. Government, and to facilitate the preparation and implementation of an Affirmative Action Plan, we invite you to provide the following information. Submission of this information by you is voluntary. You will not be subjected to any adverse treatment if you do not provide the requested information. If you provide the information, it will be maintained in confidence and will be used only in accordance with applicable U. S. Government regulations.

Please print clearly in black or blue ink only.

LAST NAME	FIRST NAME	MIDDLE NAME
JOB TITLE	SEX ☐MALE ☐FEMALE	EEO CLASSIFICATION ☐WHITE (NOT OF HISPANIC ORIGIN) ☐BLACK OR AFRICAN AMERICAN ☐HISPANIC OR LATINO ☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐AMERICAN INDIAN OR ALASKA NATIVE ☐TWO OR MORE RACES

ARE YOU A DISABLED INDIVIDUAL? ☐NO ☐YES.

IF YES, WHAT IS THE NATURE OF YOUR DISABILITY?

ARE YOU A DISABLED VETERAN? ☐NO ☐YES.

IF YES, ARE YOU ENTITLED TO DISABILITY COMPENSATION UNDER LAWS ADMINISTERED BY THE VETERANS ADMINISTRATION FOR A DISABILITY RATED AT 30% OR MORE?

WERE YOU DISCHARGED OR RELEASED FROM ACTIVE DUTY FOR A DISABILITY INCURRED OR AGGRIVATED IN THE LINE OF DUTY? ☐NO ☐YES

ARE YOU A VIETNAM ERA VETERAN? ☐NO ☐YES. IF YES, DURING WHAT TIME PERIOD WERE YOU ON ACTIVE DUTY? FROM TO .

WERE YOU DISCHARGED OR RELEASED FROM ACTIVE DUTY FOR A SERVICE-CONNECTED DISABILITY? ☐NO ☐YES

WHEN WERE YOU DISCHARGED OR RELEASED FROM THE ARMED SERVICES?

ARE YOU A NEWLY SEPARATED VETERAN? ☐NO ☐YES

ANY VETERAN WHO SERVED ON ACTIVE DUTY IN THE U.S. MILITARY, GROUND, NAVAL OR AIR SERVICE DURING THE ONE-YEAR PERIOD BEGINNING ON THE DATE OF SUCH VETERAN'S DISCHARGE OR RELEASE FROM ACTIVE DUTY.

ARE YOU AN OTHER PROTECTED VETERAN? ☐NO ☐YES

SEE ATTACHED PAGE AND CIRCLE APPLICABLE DATA.

IF YOU IDENTIFIED YOURSELF AS A DISABLED INDIVIDUAL AND/OR A DISABLED VETERAN ABOVE, PLEASE ADVISE US OF ANY INFORMATION YOU HAVE WHICH MIGHT AID IN PROPER PLACEMENT OR APPROPRIATE ACCOMMODATION TO YOUR DISABILITY.

Signature _____ Date _____

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MOBILE COUNTY HEALTH DEPARTMENT
VOLUNTARY SELF-IDENTIFICATION OF DISABILITY

WHY ARE YOU BEING ASKED TO COMPLETE THIS FORM?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[1] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

HOW DO I KNOW IF I HAVE A DISABILITY?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

Blindness	Cerebral palsy	Multiple sclerosis (MS)
Deafness	HIV/AIDS	Missing limbs or partially missing limbs
Cancer	Schizophrenia	Post-traumatic stress disorder (PTSD)
Diabetes	Muscular dystrophy	Obsessive compulsive disorder
Epilepsy	Bipolar disorder	Impairments requiring the use of a wheelchair
Autism	Major depression	Intellectual disability (previously called mental retardation)

Please check one of the boxes below

☐YES, I HAVE A DISABILITY (or previously had a disability)
☐NO, I DO NOT HAVE A DISABILITY
☐I DO NOT WISH TO ANSWER

Signature _____ Date _____

Print name _____

REASONABLE ACCOMMODATION NOTICE

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

_____

_____

[1] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

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MOBILE COUNTY HEALTH DEPARTMENT
NEWS MEDIA AND PHOTO/VIDEO CONSENT

I, the undersigned subject or on behalf of the subject, hereby grant to the Mobile County Health Department ("MCHD"), permission to be interviewed and/or to capture and reproduce my physical image and/or voice or that of my minor child, by photographic, digital, magnetic or other electronic means. This may be by traditional, digital or other electronic means for still photography, videography, motion picture film, or sound recording.

I understand that the interviews and images or voice tracks so recorded may be publicly displayed and used by the MCHD for public, non-commercial purposes including but not limited to their use in print media, billboards, television, satellite or internet broadcasts (live or recorded), CD, DVD, videotape or other magnetic or digital form.

I understand and agree that I will not be paid or otherwise receive any compensation for the use of my interviews, images or voice tracks.

I understand that this release is continuing and does not have an ending date.

I hereby release, hold harmless and discharge the MCHD, its officers, employees and agents from any and all liability arising out of or in connection with the making, producing, reproducing, processing, exhibiting, distributing, publishing, transmitting by any means or otherwise using the above-mentioned interviews, images or voice tracks.

I understand that all rights to the interviews, images or voice tracks including the right to claim the protection of a copyright under the laws of the United States are the sole property of the MCHD and I hereby relinquish any claim I might have to such rights.

I agree that I have read and understand the above and forgoing and give this release of my own free will without any threat, coercion or promise of benefit.

If subject is under 18 years of age, I am the parent/legal guardian of _____ and agree to this Consent Form.

Name: _____

Signature: _____

Date: _____

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MOBILE COUNTY HEALTH DEPARTMENT
SERVICE FOR EXCELLENCE
SERVICE STANDARDS FOR INTERNAL AND EXTERNAL CUSTOMERS

PROFESSIONALISM
- Act and look professional. Maintain a neat and well-groomed appearance, appropriate for the workplace.
- Remain calm when a customer is upset. Don't take their anger personally.
- Always treat others with dignity, compassion, respect and sensitivity.
- Perform work ethically and honestly with enthusiasm, commitment and pride.
- Seek common ground with other staff members, setting aside differences.
- Be a lifelong learner. Take a personal initiative to expand your skills whenever possible.

POSITIVE ATTITUDE
- Be welcoming and go the extra mile for everyone you meet.
- Use a positive tone of voice. Speak professionally about all staff and services.
- Be willing to listen objectively to the concerns of others.
- Express empathy with a client's situation.
- Don't judge others for their differences.
- Offer co-workers and clients other options instead of saying "No."
- Accept assignments, such as working other shifts, conscientiously and with a positive demeanor.

COMMUNICATION
- Offer a warm greeting and a friendly smile.
- Be approachable. Use eye contact to make others feel welcome.
- Identify yourself when greeting or speaking in person or by phone.
- Update patients/family members during visits. Thank clients for waiting. Apologize for delays.
- Use kind words and be compassionate. You never know what someone is going through.
- Encourage and positively support co-workers.
- If you don't know the answer to a question, cheerfully seek out someone who does.

TEAMWORK
- Welcome new employees and offer assistance.
- Anticipate the needs of others.
- Ask for help when needed.
- Be informed about the agency's services, sites and business operations.
- Recognize, acknowledge and praise the good work of others.
- Find positive solutions to challenges and discuss problems privately.

EMPLOYEE BEST PRACTICES
- Cheerfully follow all MCHD and Family Health policies and procedures.
- Arrive on time, ready to work your scheduled hours.
- Confidentially report breaches, irregularities, felonious activity and questionable practices or violations.
- Promptly report changes in personal status such as address and marital status.
- Avoid any interest or activity which may be perceived as being in conflict with your official duties.
- Always wear your ID badge.
- Protect confidential information at all times. Disclose only to those who need to know.

ELECTRONIC USE BEST PRACTICES
- Proactively plan and organize your work, avoiding the need for urgent email requests.
- Respond to email requests in a timely manner. Offer a time frame for assistance if a request can't be met within 24 hours.
- Avoid sending any unnecessary emails, or copying emails to those who don't have an immediate need to see or respond to the message.
- When sending an email, be as concise as possible. Use bullets when applicable.
- Always use a clear subject line, a polite greeting and closing.
- Use the intranet and internet and other communication devices as required for your position and according to agency policies.
- Limit all personal communication to break times.
- Avoid using personal cell phones for calls, texts or emails in public work areas.

I commit to upholding the above standards. Signature _____ Date _____

Print name _____

The Mission of the Mobile County Health Department is to promote, improve and protect the health of Mobile County, as such all locations are drug-free, smoke-free environments.