

APPLICATION FOR EMPLOYMENT

Women's Resource Medical Centers of Southern Nevada
2915 W Charleston Blvd Suite 1
Las Vegas, Nevada 89102



Position(s) applied for _____ Date of application ____ / ____ / ____

How were you referred to WRMCSN? _____

Name _____
LAST FIRST MIDDLE

Address _____ Social Security # _____
STREET CITY STATE ZIP

Telephone (____) _____ E-mail address _____

If necessary, the best time to call you at home is ____ : ____ a.m. p.m.

May we contact you at work? Yes No

If yes, work number (____) _____ Best time to call ____ : ____ a.m. p.m.

Have you ever been employed here before? Yes No

If yes, please give date(s) _____

Are you legally eligible for employment in this country? Yes No

Date available for work ____ / ____ / ____ Desired salary range \$ _____

Type of employment desired Full-time Part-time Temporary

Are you able to meet the attendance requirements of the position? Yes No

Will you work overtime if required? Yes No

If no, please explain _____

Have you ever been bonded? Yes No

Have you ever pled "guilty" or "no contest" to, or been convicted of a crime other than minor traffic violation? Yes No

If yes, please give date(s) and details _____

Briefly state what makes you interested in working with the WRMCSN

Have you ever attended a WRMCSN volunteer training seminar? Yes No

If no, would you be willing to attend such a seminar? Yes No

Describe **current and past** positions held or services performed for other non-profit organizations or ministries.

EDUCATION

High School or last grade completed

Name of school _____

Address of school _____
STREET CITY STATE ZIP

Course of study _____ Number of years completed _____

Degree/Diploma _____ Graduation date ____ / ____ / ____

College or Technical School

Name of school _____

Address of school _____
STREET CITY STATE ZIP

Course of study _____ Number of years completed _____

Degree/Diploma _____ Graduation date ____ / ____ / ____

Other Schooling or Training

Name of school _____

Address of school _____
STREET CITY STATE ZIP

Course of study _____ Number of years completed _____

Degree/Diploma _____ Graduation date ____ / ____ / ____

Other Schooling or Training

Name of school _____

Address of school _____
STREET CITY STATE ZIP

Course of study _____ Number of years completed _____

Degree/Diploma _____ Graduation date ____ / ____ / ____

MILITARY EXPERIENCE

Branch of service _____ Dates of service ____ / ____ / ____ to ____ / ____ / ____

Rank/Type of service _____

Job-related training/experience _____

EMPLOYMENT HISTORY

Provide the following information of your past and current employers, assignments or volunteer activities, beginning with the most recent. Explain any gaps in employment in the comments section below.

Employer _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

Position title _____ Supervisor _____

Dates of employment ____ / ____ / ____ to ____ / ____ / ____ Beginning salary \$ _____ Ending salary \$ _____

Duties _____

Reason for leaving _____

May we contact for a reference? Yes No

Employer _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

Position title _____ Supervisor _____

Dates of employment ____ / ____ / ____ to ____ / ____ / ____ Beginning salary \$ _____ Ending salary \$ _____

Duties _____

Reason for leaving _____

May we contact for a reference? Yes No

Employer _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

Position title _____ Supervisor _____

Dates of employment ____ / ____ / ____ to ____ / ____ / ____ Beginning salary \$ _____ Ending salary \$ _____

Duties _____

Reason for leaving _____

May we contact for a reference? Yes No

Comments (including explanation of any gaps in employment) _____

SKILLS AND QUALIFICATIONS

Summarize any special training, skills, gifts, experience, licenses/certificates.

GENERAL INFORMATION

In this section, please make a general evaluation of your knowledge in the following areas:

Knowledge of how abortions are performed/methods used to perform abortion.

- Excellent Good Fair Poor

Knowledge of existing laws regulating abortion.

- Excellent Good Fair Poor

Knowledge of what the Bible teaches concerning the sanctity of human life.

- Excellent Good Fair Poor

Under what circumstances, if any, is abortion justifiable, in your opinion? Please explain.

What questions would you like to have someone address concerning abortion and/or the sanctity of human life?

When do you feel sexual intercourse is morally permissible? Please explain.

Are you uncomfortable with any aspect of the WRMCSN Statement of Faith or Statement of Principle?

Do you consider yourself a Christian? Yes No

What is a Christian? _____

How long have you been a Christian? _____

Please describe how you came to know Christ as your personal Savior and Lord. _____

How has your life changed since your personal relationship with Jesus Christ began? _____

Please provide information about your local church:

Church Name _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

Senior Pastor's Name _____

Denominational ties, if any _____

How long have you been involved in your church? _____

Are you currently in a Bible study? Yes No If yes, how long? _____

REFERENCES

Work-related References

Please list the names and addresses of two work-related references.

Name _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

Name _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

Character References

Please list the names and addresses of two character references.

Name _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

Name _____ Telephone (____) _____

Address _____
STREET CITY STATE ZIP

STATEMENT

Please read this statement carefully before signing this application:

I understand that employment with Women’s Resource Medical Centers of Southern Nevada (the Organization) is at-will, meaning that I or the Organization may terminate my employment at any time, or for any reason consistent with applicable state or federal law.

I authorize the Organization to conduct a thorough background investigation of my work and personal history, and verify all data given on this application and during interviews. I hereby release the Organization, and its representatives or agents, from any liability that might result from such an investigation. I authorize all individuals, schools, and firms named to provide any requested information and release them from all liability for providing the requested information.

I understand this application will be active for a period of six months. After that time, if I wish to be considered for employment, I must submit a new application. I certify that all the statements in this completed application are true and understand that any falsification or willful omission shall be sufficient cause for dismissal or refusal to hire.

Signature of applicant _____ Date signed ____/____/____
FOR ELECTRONIC SUBMISSION, PLEASE TYPE YOUR NAME ABOVE IN LIEU OF SIGNATURE