If you have the latest version of Adobe Reader, please complete the following THP job application on your computer screen. Click or tab through the areas that you need to enter information. When you are finished, you have the option to:

MAIL the job application to:

The Health Plan
ATTN: Carla Bell, PHR, SHRM-CP
Senior Vice President of Human Resources
1110 Main Street
Wheeling, WV 26003-2704

FAX the job application to:

740.699.6256
The Health Plan ATTN: Carla Bell, PHR, SHRM-CP
Senior Vice President of Human Resources

OR **EMAIL** the job application to:

hr@healthplan.org
Carla Bell, Senior Vice President of Human Resources
In the subject line of the email, please type: **APPLICATION**

(To email the job application, you will need to go to 'File,' 'Save As,' and select PDF. Save the file on your computer in an area where you will remember where it is located. Open your email program, compose your email and attach the PDF document you just saved. Hit 'Send'.)

Date: _____

THE HEALTH PLAN EMPLOYMENT APPLICATION

Please type or print.

POSITION APPLYING FOR:

Applications are active for six months.

The Health Plan is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

PERSONAL

Name: _____ Social Security # (voluntary) _____

LAST FIRST MI

Present Address _____ Home Phone _____

Cell Phone _____

_____ Work Phone _____

CITY STATE ZIP Email Address _____

Best time to contact you at home: _____ ☐am ☐pm

Are you at least 18 years of age? ☐ Yes ☐ No

Immigration Status: Are you eligible to work in the U.S.? ☐ Yes ☐ No

Proof of citizenship or immigration status will be required upon employment.

Under what other name(s) can background information be obtained? _____

Have you ever been *convicted* of a felony? ☐ Yes ☐ No If yes, please explain where, when, and disposition of case below:

NOTE: A conviction will not necessarily be a bar to employment. Factors such as date, nature and number of offenses, age at the time of offense, and rehabilitation will be considered.

Have you ever filed an application with us before? ☐ Yes ☐ No If yes, give date: _____

Have you ever been employed with us before? ☐ Yes ☐ No If yes, give date: _____

Are you related to anyone currently working at this facility? ☐ Yes ☐ No

If yes, please give his/her name: _____

Relationship to you: _____

Are you currently employed? ☐ Yes ☐ No

May we contact your present employer? ☐ Yes ☐ No

Are you currently on "lay-off" status and subject to recall? ☐ Yes ☐ No

How did you hear about this position? ☐ Advertisement ☐ Employment Agency ☐ Friend ☐ Internet

☐ HP Website ☐ Inquiry ☐ Relative ☐ Other: _____

Can you travel if this job requires it? ☐ Yes ☐ No

THE HEALTH PLAN IS AN EO EMPLOYER - VETERANS/DISABLED AND OTHER PROTECTED CATEGORIES

THE HEALTH PLAN PARTICIPATES IN E-VERIFY

POSITION

Position(s) Desired: _____

Clinical Specialty Preference(s): _____

Date available to work: _____ What is your desired salary range? _____

Are you available to work: *(check all that apply)* ☐ Full Time ☐ Part Time

If Part Time, indicate hours per week you are able to work: _____

Are you able to work weekends and holidays? ☐ Yes ☐ No

SKILLS

Word Processing	☐ Yes	☐ No	Medical Terminology	☐ Yes ☐ No
Spreadsheets	☐ Yes	☐ No	CPT Coding	☐ Yes ☐ No
Database	☐ Yes	☐ No	ICD-10	☐ Yes ☐ No
Foreign Language	☐ Yes	☐ No		

Please list foreign language(s): _____ ☐ Read ☐ Speak ☐ Write

_____ ☐ Read ☐ Speak ☐ Write

_____ ☐ Read ☐ Speak ☐ Write

Please list other office machines you can operate skillfully:

Please state any additional specialized information you may feel helpful in considering you for this position:

List professional, trade, business, or civic activities and offices held.
You may exclude membership which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status.

DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS FOR THIS POSITION!

Can you perform the essential functions of the job, for which you are applying, either with or without a reasonable accommodation? ☐ Yes ☐ No

LICENSE

PROFESSIONAL LICENSE, REGISTRATION, CERTIFICATION

Do you have a professional license? ☐ Yes ☐ No ☐ Nursing ☐ Marketing ☐ Other, list: _____

State information: ☐ Ohio Ohio License/Registration # _____ Expiration date _____

☐ West Virginia WV License/Registration # _____ Expiration date _____

☐ Other, list state and # _____ Expiration date _____

If license is not in Ohio, have you applied? ☐ Yes ☐ No Date Applied:

If license is not in WV and is required, have you applied? ☐ Yes ☐ No Date Applied:

REFERENCES

PERSONAL / PROFESSIONAL REFERENCES *(Do not include family members)*

	COMPANY / OCCUPATION	NAME	PHONE NUMBER	BEST TIME TO CALL	Supervisor?
1.	Company Occupation			☐ am ☐ pm	☐ Current ☐ Former
2.	Company Occupation			☐ am ☐ pm	☐ Current ☐ Former
3.	Company Occupation			☐ am ☐ pm	☐ Current ☐ Former

EDUCATION

HIGH SCHOOL	Name / Address	Course of Study	Years Completed	Diploma / Degree
Name Street City St. Zip				

COLLEGE, etc.	Name / Address	Course of Study	Years Completed	Diploma / Degree
Name Street City St. Zip				
GRADUATE SCHOOL	**Name / Address**	**Course of Study**	**Years Completed**	**Diploma / Degree**
Name Street City St. Zip				

	CONTINUING EDUCATION COURSES COMPLETED WITHIN THE LAST TWO YEARS				
1		Date Completed:		Units Earned:	
2		Date Completed:		Units Earned:	
3		Date Completed:		Units Earned:	

EMPLOYMENT HISTORY

List employment beginning with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, gender; national origin, disabilities or other protected status.

			From Date	To Date	Job Title and Responsibilities
1	Employer				
	Address				Title
		Street ST ZIP			Responsibilities
	Supervisor				
	Phone				
	Reason for Leaving				
					May we contact? ☐ Yes ☐ No

			From Date	To Date	Job Title and Responsibilities
2	Employer				
	Address				Title
		Street ST ZIP			Responsibilities
	Supervisor				
	Phone				
	Reason for Leaving				
					May we contact? ☐ Yes ☐ No

EMPLOYMENT HISTORY CONTINUED

3	Employer		From Date	To Date	Job Title and Responsibilities
	Address				Title
		Street ST ZIP			Responsibilities
	Supervisor				
	Phone				
	Reason for Leaving				
					May we contact? ☐ Yes ☐ No

4	Employer		From Date	To Date	Job Title and Responsibilities
	Address				Title
		Street ST ZIP			Responsibilities
	Supervisor				
	Phone				
	Reason for Leaving				
					May we contact? ☐ Yes ☐ No

COMMENTS: Include explanation of any gaps in employment.

AUTHORIZATION (Please read carefully before signing.)

I authorize The Health Plan of West Virginia, Inc., (The Health Plan), to verify any information I have provided and I further authorize any of the named schools, companies or persons listed to provide any information about me contained in their records. I understand and agree that any misrepresentation, falsification or omissions by me in this application may be sufficient cause for disqualification of the application and/or separation from The Health Plan if I have since been employed. My signature below hereby authorizes disclosure of information and releases The Health Plan, its officers, agents and employees from liability for such disclosure.

I understand that if employed by The Health Plan, my first 90 calendar days will be on an introductory basis. As an employee, I agree to abide by all rules and regulations of The Health Plan.

I recognize The Health Plan's right to require a drug test. I further understand that submitting to various tests is a condition of my employment, and I agree to cooperate in their administration. I understand that my employment may be contingent upon verification by any state or federal government agency for Medicare or Medicaid false claims, fraud or abuse. In the event any such investigation is initiated, I will immediately notify The Health Plan.

I further understand that The Health Plan is a "tobacco/smoke free campus" and no use of tobacco products is permitted within the facilities or on the campus of The Health Plan, including parking lots and vehicles on company property.

I understand that should I be hired for the position for which I am applying, or any subsequent position, either The Health Plan or I may terminate the working relationship at any time and for any reason. I understand that no contract may be made orally, regardless of the reliance of the employee on such statements made by any manager at The Health Plan. I further understand that if employed, my wages and position may change, but my status as an employee-at-will will never change during my employment. Completion and/or submission of this application does not constitute an offer of employment.

DATE: _____ Signature: _____

☐ By checking this box I agree that the typed name I have entered above will be the electronic representation of my signature.

EQUAL EMPLOYMENT OPPORTUNITY (EEO)
SELF-IDENTIFICATION FORM

It is the policy of The Health Plan to provide equal employment opportunity to all qualified applicants for employment without regard to race, color, religion, national origin, gender, age, veteran status or disability. This company is subject to certain nondiscrimination and affirmative action record-keeping and reporting requirements which require us to invite job applicants and current employees to voluntarily complete this self-identification form. All information collected will be kept strictly confidential and may only be used in accordance with the provisions of applicable federal laws and regulations, including those which require the information to be summarized and reported to the federal government for civil rights enforcement purposes. Completion of this form is voluntary and will not affect the decision regarding your application for employment. This form will be maintained separate from your application.

NAME:_____ DATE:_____

POSITION: _____

GENDER (check one): ☐ Male ☐ Female

RACE (check one):

☐ White ☐ Black or African American ☐ Hispanic or Latino
☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaskan Native
☐ Two or More Races

Are you a veteran? ☐ Yes ☐ No

If you are a veteran, please check the appropriate box(es):

☐ Disabled Veteran – Veteran of the US military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation). A person who was discharged or released from active duty because of a service-connected disability.

☐ Other Protected Veteran – A veteran of the US military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized.

☐ Armed Forces Service Medal Veterans – A veteran who, while serving on active duty in the US military, ground, naval or air service, participated in a US military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

☐ Recently Separated Veteran - A veteran during the three-year period beginning on date of such veteran's discharge or release from active duty in the US military, ground, naval or air service.

Do you have a disability that requires accommodation to perform this position? ☐ Yes ☐ No

If yes, please explain what accommodations would allow you to handle this job successfully:

_____

Company: _____ Date: _____

Contact Person: _____

Authorization: I hereby authorize you to supply The Health Plan with the requested information.

Thank You. _____ Date: _____

Applicant's Signature

_____ , Applicant, has applied to us for employment as a(n) _____ . The applicant indicates dates of employment with you from _____ to _____ as a(n) _____ . This information will be held in the strictest confidence. Thank you for your cooperation.

Human Resource Manager

Reference Information

Period of employment: _____ to _____

Reason for leaving: _____

Eligible for Rehire? ☐ Yes ☐ No

If No, why not? _____

Please rate each item below:

Item	Excellent	Good	Fair	Poor
Careful, conscientious worker	☐	☐	☐	☐
Volume of work	☐	☐	☐	☐
Initiative	☐	☐	☐	☐
Good attitude toward work and company	☐	☐	☐	☐
Attendance / Promptness	☐	☐	☐	☐

Additional Comments:

_____

Signature: _____ Date: _____

Position: _____