NET HEALTH
NORTHEAST TEXAS PUBLIC HEALTH DISTRICT

P.O. BOX 2039 • TYLER, TX 75710

APPLICATION FOR EMPLOYMENT

WE ARE AN EQUAL OPPORTUNITY EMPLOYER DEDICATED TO A POLICY OF NONDISCRIMINATION IN EMPLOYMENT ON ANY BASIS INCLUDING RACE, COLOR, AGE, SEX, RELIGION, DISABILITY OR NATIONAL ORIGIN.

EMPLOYMENT DESIRED:

POSITION:_____ DATE YOU CAN START:_____ SALARY DESIRED: _____

TYPE OF EMPLOYMENT: FULL-TIME ☐ PART-TIME ☐ SUMMER ☐ TEMPORARY ☐

ARE YOU EMPLOYED NOW? YES ☐ NO ☐ IF SO, CAN WE CONTACT YOUR PRESENT EMPLOYER? YES ☐ NO ☐

HAVE YOU EVER APPLIED TO THE NORTHEAST TEXAS PUBLIC HEALTH DISTRICT BEFORE? YES ☐ NO ☐

WHERE:_____ WHEN: _____

PERSONAL INFORMATION:

LAST NAME:_____ FIRST:_____ MIDDLE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

TELEPHONE:_____ REFERRED BY: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES ☐ NO ☐

EDUCATION:

HIGH SCHOOL ATTENDED AND LOCATION: _____

No. of Years Completed:_____ Did you Graduate? YES ☐ NO ☐

COLLEGE ATTENDED AND LOCATION: _____

No. of Years Completed:_____ Did you Graduate? YES ☐ NO ☐ Degree:_____

TRADE, BUSINESS, OR CORRESPONDENCE SCHOOL ATTENDED: _____

No. of Years Completed:_____ Did you Graduate? YES ☐ NO ☐

GENERAL:

SPECIAL COURSES OR TRAINING: _____

EXPERIENCE/SKILLS RELATED TO THE POSITION FOR WHICH YOU ARE APPLYING: _____

OFFICE/SECRETARIAL APPLICATIONS:

TYPING: YES ☐ NO ☐ YEARS OF EXPERIENCE:_____ WORDS PER MINUTE: _____

SHORTHAND: YES ☐ NO ☐ WORD YEARS OF EXPERIENCE:_____ WORDS PER MINUTE: _____

PROCESSING: YES ☐ NO ☐ YEARS OF EXPERIENCE:_____ WORDS PER MINUTE: _____

SOFTWARE: _____

LIST SECRETARIAL TRAINING COURSES OR ANY OTHER INFORMATION WHICH MAY BE HELPFUL IN CONSIDERING YOUR APPLICATION:

EMPLOYMENT HISTORY (LIST PRESENT OR MOST RECENT POSITION FIRST):

NAME OF EMPLOYER:____TELEPHONE:_______________________

ADDRESS:____

TYPE OF BUSINESS:______________________DEPARTMENT:_____________________YOUR POSITION: ______________________

DUTIES:____

NAME AND POSITION OF IMMEDIATE SUPERVISOR: ____

DATE HIRED:_____________DATE LEFT:______________STARTING SALARY:______________FINAL SALARY: _____________

REASON FOR LEAVING: ____

NAME OF EMPLOYER:____TELEPHONE:_______________________

ADDRESS:____

TYPE OF BUSINESS:______________________DEPARTMENT:_____________________YOUR POSITION: ______________________

DUTIES:____

NAME AND POSITION OF IMMEDIATE SUPERVISOR: ____

DATE HIRED:_____________DATE LEFT:______________STARTING SALARY:______________FINAL SALARY: _____________

REASON FOR LEAVING: ____

NAME OF EMPLOYER:____TELEPHONE:_______________________

ADDRESS:____

TYPE OF BUSINESS:______________________DEPARTMENT:_____________________YOUR POSITION: ______________________

DUTIES:____

NAME AND POSITION OF IMMEDIATE SUPERVISOR: ____

DATE HIRED:_____________DATE LEFT:______________STARTING SALARY:______________FINAL SALARY: _____________

REASON FOR LEAVING: ____

NAME OF EMPLOYER:____TELEPHONE:_______________________

ADDRESS:____

TYPE OF BUSINESS:______________________DEPARTMENT:_____________________YOUR POSITION: ______________________

DUTIES:____

NAME AND POSITION OF IMMEDIATE SUPERVISOR: ____

DATE HIRED:_____________DATE LEFT:______________STARTING SALARY:______________FINAL SALARY: _____________

REASON FOR LEAVING: ____

APPLICANT: PLEASE READ CAREFULLY AND SIGN

I affirm that the information provided is true and complete and that I have not withheld any fact(s). Any misrepresentation, falsification, omission or derogatory information that is discovered may prevent my being hired, of if hired, may subject me to disciplinary action, up to and including immediate employment dismissal.

I understand that the company to which I am applying for employment will seek to keep all such information confidential except where such information is required to be released by law.

I understand that this is an application for employment and that no employment contract is being offered. I also understand that, if offered employment, I will be an at-will employee which means that employment can be terminated at any time for any reason, with or without notice, at the option of either the company or myself, and that no representative of the company has any authority to make any representation to the contrary.

I have read, understand and agree to the above.

SIGNATURE:____ **DATE:** ____________________

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

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