Capital Health PLAN℠
An Independent Licensee of the Blue Cross and Blue Shield Association
2140 Centerville Place • Tallahassee, Florida 32308
P.O. Box 15349 • Tallahassee, Florida 32317-5349
Phone (850) 383-3300 • www.capitalhealth.com

For your information. Capital Health Plan is a smoke-free company. Employees are not allowed to smoke on company property.

As part of Capital Health Plan's employment procedures, an applicant is required to undergo preemployment drug and alcohol screening as a condition of employment

POSITION APPLIED FOR: _____

EMPLOYMENT APPLICATION
AN EQUAL OPPORTUNITY EMPLOYER
(Type or Print in ink)

PERSONAL DATA

NAME _____
Last First Middle

ADDRESS _____
Number, Apartment, Street or R.F.D. City County State Zip Code

SOCIAL SECURITY NO. _____ TELEPHONE (RES.) ____ / _____

(BUS.) ____ / _____

U.S. CITIZEN? YES _____ NO _____

State the minimum salary which you are willing to accept: _____

When could you begin work? _____

Check type of employment you will accept: PART TIME _____ FULL TIME _____ TEMPORARY _____

Would you accept a position requiring travel? NONE _____ LIMITED _____ EXTENSIVE _____

Are you available to work WEEKENDS _____ EVENINGS _____ HOLIDAYS _____

MILITARY

Have you ever served in the military service of the U.S.? _____

Date of Induction: _____ Branch of Service: _____

Date of Discharge: _____ Last Rank: _____

Military Occupation: _____ Member of Reserve Organization? _____

Current Draft Classification: _____

_____

Have you ever been convicted of any violation of law other than minor traffic violations? YES _____ NO _____
If yes, explain details below:

WHERE ARRESTED_____ DATE _____ NATURE OF CHARGE _____

DISPOSITION_____

_____

_____

_____

Are you related in any way to anyone currently employed by Capital Health Plan?

YES _____ NO _____ HOW?_____

EDUCATION

Circle Highest Grade Completed:

GRADE SCHOOL 1 2 3 4 5 6 7 8 HIGH SCHOOL 1 2 3 4

COLLEGE 1 2 3 4 GRADUATE SCHOOL 1 2 3 4

Schools	Name &Address of Schools Attended	Dates Attended	Did you Graduate?	S/Q Hours	Major/Minor Coursework	Degree
High School						
College or University						
Vocational Business						
Other Schools or Studies						

EMPLOYMENT

Have you any objections to Capital Health Plan making inquiry of your PRESENT employer regarding your character, qualifications, etc.? YES _____ NO _____

Have you ever been discharged, or forced to resign, for misconduct or unsatisfactory service from any job?
YES _____ NO _____ If yes, explain details on page 4 Remarks Section.

Instructions: Begin with your present or last job and describe in detail all periods of employment, including self-employment. Include military service and part-time employment. Account for your time during intervals of unemployment other than those when you were attending school.
Use additional sheet, if necessary.

1. Name of Employer _____ From _____ To _____

_____ Full Time _____ Part Time _____

Address _____ Salary _____

_____ Supervisor's Name & Title

Your Job Title _____ _____

Specific Duties _____ Reason for Leaving _____

_____ _____

2. Name of Employer _____ From _____ To _____

_____ Full Time _____ Part Time _____

Address _____ Salary _____

_____ Supervisor's Name & Title

Your Job Title _____ _____

Specific Duties _____ Reason for Leaving _____

_____ _____

3. Name of Employer _____ From _____ To _____

_____ Full Time _____ Part Time _____

Address _____ Salary _____

_____ Supervisor's Name & Title

Your Job Title _____ _____

Specific Duties _____ Reason for Leaving _____

_____ _____

EMPLOYMENT

4. Name of Employer _____ From _____ To _____

_____ Full Time _____ Part Time _____

Address _____ Salary _____

_____ Supervisor's Name & Title

Your Job Title _____ _____

Specific Duties _____ Reason for Leaving _____

_____ _____

5. Name of Employer _____ From _____ To _____

_____ Full Time _____ Part Time _____

Address _____ Salary _____

_____ Supervisor's Name & Title

Your Job Title _____ _____

Specific Duties _____ Reason for Leaving _____

_____ _____

A Resume of your employement record will NOT be accepted in lieu of the above information.

REMARKS

Use this space for additional comments as necessary.

_____

_____

_____

PERSONAL REFERENCES

Give name of at least three persons to whom you are not related and by which you have not been employed.

Name & Address	Occupation	Years Known

CERTIFICATE OF APPLICANT (Read carefully before signing)

I hereby certify that all statements made in this application are true, and I agree and understand that any misstatements of material facts herein will cause forfeiture of my employment, if hired. The agency is authorized to request a transcript where necessary to verify my educational record. I further agree to a physical examination if I am offered employment.

SIGNATURE_____ DATE_____

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PERSONAL DATA SHEET FOR EXTERNAL APPLICANTS

Application Date: _____

Social Security No. _____

_____
FIRST NAME LAST NAME

_____
MAILING ADDRESS NUMBER AND STREET APT. NO.

_____
CITY STATE ZIP

_____
HOME TELEPHONE NUMBER

Job Applied For _____

For record keeping only, please complete the following information. This form will be regarded as confidential and will not be used in the departmental interview process nor will it be made a part of your personnel folder if hired. It is intended only to provide information necessary to comply with federal government regulations. Failure to complete this form will in no way prejudice the consideration of your application.

SEX _____
M=Male
F=Female

RACE _____
C=Caucasian
B=Black
O=Asian/Oriental
S=Hispanic
I=American Indian or Alaskan Native

VETERAN STATUS _____
DV=Disabled Veteran
VE=Vietnam Era/8-64 - 5/75
VO=Veteran-Other

Date of Birth: _____

Date of Discharge _____

_____
Signature of Applicant

_____
Date

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_____
NAME (PLEASE PRINT)

EMPLOYMENT VERIFICATION

Permission is hereby granted to Capital Health Plan to verify all information on my application, and to request my former employees, schools, and organizations to furnish their records of my service. I hereby release said former employers, schools, and organizations from all liability for any damage for issuing this information.

_____
Signature

_____
Date

_____
Social Security Number

The above named applicant has applied for employment with our agency as an _____ _____ and has given us the above written authorization to inquire into his/her employment background. You may be assured that information furnished by you will be kept in confidence. A business reply envelope is enclosed for your convenience.

Sincerely,

PRE-EMPLOYMENT DRUG TESTING
CONSENT AND RELEASE FORM

Job applicants at Capital Health Plan prior to employment will undergo screening for the presence of illegal drugs or alcohol as a condition of employment.

Applicants will be required to submit to a test at a qualified laboratory chosen by Capital Health Plan by signing a consent agreement which will release Capital Health Plan from liability.

Any applicant who refuses to take the test or whose test results are positive will be denied employment at that time, but may initiate another inquiry with Capital Health Plan after one (1) year.

Capital Health Plan will not discriminate against applicants for employment because of past abuse of drugs or alcohol. It is the current abuse of drugs or alcohol which prevents employees from properly performing their jobs that Capital Health Plan will not tolerate.

I hereby consent to submit to a urinalysis and/or other tests as shall be determined by Capital Health Plan in the selection process of applicants for employment for the purpose of determining the drug content thereof.

I agree that Laboratory Corporation of America (LabCorp) may collect these specimens for tests and may test them or forward them to a testing laboratory designated by Capital Health Plan for analysis.

I further agree to and hereby authorize the release of the results of said tests to Capital Health Plan.

I further agree to hold harmless Capital Health Plan and its agents from any liability arising in whole or in part, out of the collection of specimens, testing and use of the information from said testings in connection with Capital Health Plan's consideration of my application for employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant:
Print Name:_____ SS #_____

Applicant:
Signature:_____ Date:_____