



**EMPLOYEE APPLICATION FORM**

Date this application was filled out

First Name Middle Initial Last Name

Address

City State Zip Social Security No.

Home Phone Cell Phone

E-mail Address

Birth Date Age Place of Birth

Marital Status  Single  Married  Widowed Spouse's Name

Emergency Contact Name Phone

Do you have an immediate family member that is a current client or was a client within the last 12 months?  Yes  No If yes, what is the client's name?

Because The Hope Clinic is an interdenominational Christian organization, would you be willing to work and cooperate with other Christians whose doctrines may differ from your own?

Yes  No

Do you consider yourself a Christian?  Yes  No If yes, how many years?

In your own words, give your definition of a Christian.

Please provide the following information about your church.

Church Name Address

City State Zip<sup>SS</sup> Denomination

Years Attended Pastor's Name Phone

What made you interested in working with The Hope Clinic or Margie's Place?

If female, have you ever counseled a woman with a crisis pregnancy? Yes No  
How do you feel about abortion?

If female, have you had an abortion?    Yes      No

\*Please note: Answers to this question are kept in the strictest of confidence. Our only objective in asking is to encourage potential staff to find hope and healing through our *Tender Mercies* post-abortion recovery program.

**Christian Testimony**

*Please tell us about your faith in and relationship with Jesus Christ, and your participation in a local church community.*

What are your strengths—how have you been gifted?

Discuss your personal strengths and weaknesses

Please provide 2 references who are not family members or pastor/priest

Name	Address		
City	State	Zip	Phone
Name	Address		
City	State	Zip	Phone

Have you been convicted of any criminal offense in the last seven years?    Yes    No

(Conviction will not necessarily disqualify you from employment.)

If yes, indicate the nature of the offense, date, court and disposition:

I, the undersigned, understand that the information I have provided may be verified, if necessary, by contacting persons named on this form. I agree to release from liability any person or organizations that provide such information. I also understand and agree that The Hope Clinic may do further background checks on my personal driving record and criminal history (if any). I release The Hope Clinic from any responsibility of doing such a check. I understand that this information may be used to determine my eligibility for an employment position. I also understand that as long as I remain an employee at The Hope Clinic, the Clinic may repeat these background checks at any time. By signing this form, I affirm that the information I have provided is true and correct.

Signature (Typed)

Date