



HOUSING AUTHORITY OF JACKSON COUNTY

2251 TABLE ROCK ROAD MEDFORD OR 97501

PH/TDD (541) 779-5785

FAX (541) 857-1118

IMPORTANT DIRECTIONS: Print or type. The information you provide will be used to determine if you meet minimum qualifications for the position. Resumes will not be considered as a substitute for completed applications. We will not contact you for clarification on portions of the application which are incomplete or illegible. Sign the application. Failure to observe these directions will result in your application not being considered for employment.

<p>Name and Address</p> <hr/> <p>Last First Middle Initial</p> <hr/> <p style="text-align: center;">Mailing Address</p> <hr/> <p>City State Zip Code</p> <hr/> <p>Phone Number(s)</p>	<p>POSITION APPLIED FOR:</p> <hr/> <p>Use one application for each position for which you are applying.</p>
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Are you legally able to work in the United States? Yes No (Proof will be required upon hire)

On what date would you be available for work? _____

Are you available for work Full time Part time Shift work Temporary

Are you on layoff and subject to recall? Yes No

Can you travel if a job requires it? Yes No

Do you have a valid Driver's License? Yes No State of Issue _____ Number _____

Have you ever worked for the Housing Authority of Jackson County? Yes No If yes, when? _____

Have you ever participated in the Oregon Public Retirement System? Yes No

Are you willing to accept the starting salary stated in the job announcement? Yes No (If no, please specify amount) _____

How did you hear of this employment opportunity?

Friend Relative Walk-in Oregon Employment Dept.

Newspaper (which one?) _____ Other

The Housing Authority of Jackson County is committed to Equal Employment Opportunity, Diversity, and compliance with the Americans with Disabilities Act. Our commitment includes providing a respectful working environment that is free from discrimination and harassment in the workplace. This commitment is made by the HAJC in accordance with applicable Federal, state and Local Laws.

EDUCATION AND FORMAL TRAINING

High School attended: _____ Location: _____

Graduated? Yes No If no, highest grade completed: _____ GED certificate? Yes No

SCHOOLS ATTENDED AFTER HIGH SCHOOL OR SPECIAL TRAINING RECEIVED

Business/Vocation Schools and/or College/University – Name and Location	From Mo/Yr	To Mo/Yr	Type of Degree or Certificate	Qtr Hrs Completed	Sem Hrs Completed

Other certificates or degrees granted or **applicable registration or license numbers:** _____

If you are applying for a position requiring typing or shorthand, you **must** complete this certification:
 I hereby certify that I can type or take shorthand at the following speed: Net typing speed _____
 Net shorthand speed _____

SKILLS

Please indicate briefly any **related** skills that would further qualify you for this position. They need not be a result of past employment.

If you are applying for a classification requiring bilingual abilities, please complete this section.

	FLUENT	GOOD	FAIR
SPEAK			
READ			
WRITE			

EMPLOYMENT HISTORY – List below your work experience, paid or unpaid (volunteer work), beginning with your most recent job. Go back at least 10 years if you have worked that long. Give special attention to experience relating to the job for which you are applying. Incomplete descriptions may result in a low rating.

DATES FROM/TO _____ TOTAL TIME _____ years _____ months

NAME AND ADDRESS OF EMPLOYER _____

SUPERVISOR NAME & TITLE _____ Phone Number _____

RATE OF PAY START _____ FINISH _____ (MONTHLY RATES PLEASE)

REASON FOR LEAVING _____

YOUR TITLE _____ DUTIES (be specific) _____

May we contact this employer?

CERTIFICATE OF APPLICANT

1. I hereby certify that all statements made in this application are true and complete to the best of my knowledge. I understand that any falsification, misrepresentation or omission of fact in this application or in any other required documents, as well as any misleading statements or omissions, may be cause of denial of employment or immediate termination, regardless of how or when discovered.
2. I understand that the Housing Authority of Jackson County may conduct a criminal background investigation, check my driving record, or contact my present or past employers if necessary.
3. I authorize the investigation of all matters which the Housing Authority of Jackson County deems relevant to my qualifications for employment, including all statements contained in this application and employment history. I release the Housing Authority of Jackson County as well as any other agency, school or company contacted from any liability or damage which may result from obtaining the information requested.
4. I have read and understand the above statements.

SIGNATURE _____ DATE _____

ADDRESS _____ CITY _____ STATE _____

PHONE _____ MESSAGE PHONE _____

EMAIL ADDRESS _____

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

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

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

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



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