SOPHIE TRETTEVICK
INDIAN HEALTH CENTER
MAKAH TRIBE

APPLICATION FOR TEMPORARY EMPLOYMENT ROSTER

GENERAL INFORMATION

Social Security Number: _____ Male ____ Female ____

Full Name: _____
(Please Print)

Full Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone #: _____ Best time to call: _____

Email Address: _____ Date of Birth: _____

Do you have a valid Driver's License? _____NO _____YES _____
Driver's License Number State Expiration

DEPARTMENT INTERESTED IN:

- ☐ CUSTODIAN – Night Shift
- ☐ CHR/DRIVER
- ☐ ADMIN/CLERICAL
- ☐ GROUNDSKEEPER
- ☐ MAINTENANCE
- ☐ MEDICAL/DENTAL
- ☐ Other: _____

LIST YOUR SPECIAL SKILLS/EXPERIENCE:

_____

_____

_____

_____

_____

AVAILABILITY

If you are under 18 years of age, can you provide required proof of eligibility to work? ☐Yes ☐No

Are you a citizen of the United States? ☐Yes ☐No
Proof of citizenship will be required upon employment.

Have you ever been convicted of a misdemeanor or felony within the past ten (10) years? ☐Yes ☐No
(Answering yes will not automatically disqualify you for employment.)

If "YES" list the dates: _____

- ☐ I am an enrolled Indian residing on the Reservation
- ☐ I am an enrolled Indian residing off the Reservation
- ☐ I am a Local Resident and I reside on the Reservation
- ☐ I am not a Local Resident and I do not reside on the Reservation

E Signature: _____ Date: _____

SOPHIE TRETTEVICK
INDIAN HEALTH CENTER
MAKAH TRIBE

AUTHORIZATION TO RELEASE CRIMINAL BACKGROUND HISTORY

A. Requested by:

_____

Human Resources Date

B. Department:

- □ Medical
- □ Dental
- □ Administration
- □ Community Health
- □ Behavioral Health/Wellness
- □ Makah Recovery Services
- □ Volunteer/Student

Position Title: _____

C. Applicant of Inquiry:

Applicant Name: _____

Please Print **Last Name** **First Name** **Middle**

Alias/Maiden Name(s): _____

Date of Birth: _____ **Sex:** _____ **Race:** _____

E Sig: _____

Applicant Signature **Date**

D. Makah Tribal Court

Charges and Classifications:
Charge Detail(s)

Offense(s): _____

Classification: _____

Sentence: _____

Amended Charge: _____

Verified by: _____

Name **Title**

Date: _____

WASHINGTON STATE PATROL

Identification and Background Check Section
PO Box 42633
Olympia WA 98504-2633
(360) 534-2000
http://watch.wsp.wa.gov

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

☐ **$32 Fee — Conviction Criminal History Record Information Based on Name and Date of Birth**
- For an $11 fee and an immediate response using a credit card, access our web site listed above.

☐ **$58 Fee — Conviction Criminal History Record Information Based on Fingerprints**
- A full set of fingerprints on a fingerprint card is required for processing.

☐ **$10 Fee per Notary Seal — Notary Letter(s) in Addition to Criminal History Record Check**
- Requesting _____ Notarized Letter(s)

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints. Applicant may be advised of inquiry.

SUBJECT INFORMATION: **(Please type or print clearly)**

Applicant's Name _____
Last First Middle

Alias/Maiden Name/Other Names Used _____

Date of Birth _____
Month/Day/Year

REQUESTOR INFORMATION: **(Please type or print clearly)**

Name Sophie Trettevick Indian Health Center - Makah Tribe

Address PO Box 410

Neah Bay WA 98357
City State ZIP Code

Contact Phone Number (360) 477-6463

How would you like to receive your results? **(Please select only one)**

☐ Mailed (It may take 7 to 14 business days for response, when mailed.)

☒ WSP Portal*

Portal Account # _____

Portal Username _____

*For results to be sent through WSP Portal requestor must have pre-exisiting WSP Portal account. To inquire on establishing an account contact us at CRDapplicantfollowup@wsp.wa.gov

* Background checks with notary letters will be mailed to the requestor.