UNM HOSPITAL

Employee Name: _____

Employee ID Number: _____
(office use only)

New Hire Survey

To assist us in compiling accurate information to fulfill governmental requirements, please answer the following questions. This questionnaire will be kept confidential, and will be destroyed after data entry.

ETHNIC OR RACIAL IDENTITY (*Please check only one*)

☐ **HISPANIC OR LATINO** A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin regardless of race

☐ **WHITE** (Not Hispanic or Latino) A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **AMERICAN INDIAN OR ALASKAN NATIVE** (Not Hispanic or Latino) A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

☐ **ASIAN** (Not Hispanic or Latino) A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER** (Not Hispanic or Latino) A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK OR AFRICAN AMERICAN** (Not Hispanic or Latino) A person having origins in any of the black racial groups of Africa.

☐ **TWO OR MORE RACES** (Not Hispanic or Latino) All persons who identify with more than one of the above five races.

VETERAN SELF-IDENTIFICATION FOR AFFIRMATIVE ACTION PURPOSE

UNM Hospital is a Government contractor subject to section 503 of the Rehabilitation Act of 1973, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; and the Veterans Employment Opportunities Act of 1998, which requires Government contractors to take affirmative action to employ and advance in employment qualified individuals with disabilities, protected veterans, disabled veterans and veterans of the Vietnam era covered by the Act. If you have a disability, or are a protected veteran, a disabled veteran or are a veteran of the Vietnam era covered by the Act, please tell us. This information will assist us in placing you in an appropriate position and/or in making accommodations for your disability.

Please check appropriate box below (**definitions are located on the next page**):

☐ **Veteran**
☐ **Disabled Veteran**
☐ **Qualified Disabled Veteran**
☐ **Recently Separated Veteran**
☐ **Veteran of the Vietnam Era**
☐ **Other Protected Veteran**
☐ **Armed Forces Service Medal Veteran**
☐ **I am not a Veteran**

SEX

☐ **MALE** ☐ **FEMALE**

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UNM HOSPITAL

DEFINITIONS OF DISABLED VETERANS, RECENTLY SEPARATED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER PROTECTED VETERANS

A "Veteran" is defined as:

- A person who served in the active military, naval or air services of the United States, and who was discharged or released therefrom under conditions other than dishonorable.

A "Disabled Veteran" is defined as:

- A Veteran of the U.S. Military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or a person who was discharged or released from active duty because of a service connected disability.

A "Qualified Disabled Veteran" is defined as:

- A disabled veteran who has the ability to perform the essential functions of the employment position with or without reasonable accommodation.

A "Recently Separated Veteran" is defined as:

- Any veteran during the three-year period beginning on the date of such veteran's discharged or release from active duty in the U.S. Military, ground, naval or air service.

A "Veteran of the Vietnam Era" is defined as:

- A person who (a) served on active duty for a period of more than 180 days and was discharged or released therefrom with other than a dishonorable discharge so long as any part of such active duty occurred (I) in the Republic of Vietnam between February 28, 1961 and May 7. 1975 or (II) between August 5, 1964 and May 7, 1975 in all other cases; or (b) was discharged or released from active duty for a service-connected disability if any part of such active duty was performed (I) in the Republic of Vietnam between February 28, 1961 and May 7, 1975 or (II) between August 5, 1964 and May 7, 1975 in all other cases.

An "Other Protected Veteran" is defined as:

- A veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized, under the laws administered by the Department of Defense.

An "Armed Forces Service Medal Veteran" is defined as:

- Any veteran who, while serving on active duty in the U.S. Military, ground, naval or air service, participated in a United States Military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 FR 1209).

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UNM HOSPITAL

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

Signature: _____ **Today's Date:** _____

Revised 101923

HEALTH CARE AUTHORITY

HOSPITAL

Children, Youth & Families Department
STATE OF NEW MEXICO

BACKGROUND CHECK REGISTRATION

First Name: _____

Last Name: _____

Date of Birth (mm/dd/yyyy): _____ **Social Security Number:** _____

Place of Birth (US, State, or Country if not born in US): _____

Country of Citizenship: _____

Sex: □ Male □ Female

Race: □ Asian or Pacific Islander □ Black □ White (including Latino)
□ American Indian or Alaskan Native □ Unknown

Weight: _____lbs. **Height:** ____ft. ____in. **Hair Color:** _____ **Eye Color:** _____

Street Address: _____

City/State/Zip: _____

Phone: _____ **Email:** _____

ID Document: □ State Issued Driver's License: □ License #_____ Exp. Date _____
□ State Issued Identification Card: □ ID #_____ Exp. Date _____
□ Passport _____ □ VISA_____ □ U.S. Armed Forces_____
Exp. Date _____ Exp. Date _____ Exp. Date _____

Applicant Acknowledgment

Pursuant to NMSA 1978, Sec. 29-10-6(A) of the N.M. Arrest Record Information Act, I hereby appoint the N.M. Department of Health Care Authority (DOH) and/or Children, Youth & Families Dept. (CYFD) as an authorized agent for me for the purposes of inspection (and/or obtaining copies) of any New Mexico arrest fingerprint card supported record information maintained by the Department of Public Safety and the Federal Bureau of Investigations, including information concerning felony or misdemeanor arrests. To the custodian of records in question, I hereby direct you to release such information to the Authorized Agent as described above.

I am authorizing the release of said records solely for the purpose of compliance with the Caregivers Criminal History Screening Act, NMSA 1978, Sec. 20-17-1 to 5; the Children's & Juvenile Facility Criminal Records Screening Act, NMSA 1978, Sec. 32A-15-1 to 4; and Sec. 307, Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pilot Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities or Providers. It is understood that the confidentiality of said records will be maintained in accordance with applicable law.

This authorization also constitutes, with respect to the criminal history record, permission for DOH and CYFD, following an attempt to obtain clarifying information from the applicant or caregiver, to attribute, as a rebuttable presumption, disqualifying conviction status to any arrest for crimes that would constitute a disqualifying conviction and for which the arrest appearing on the nationwide criminal history record lacks a clear disposition. All documents submitted to the DOH and CYFD become their sole property and are not returnable.

_____ _____/_____/_____

Applicant's Signature **Date**

UNMH USE ONLY

DOH Background Check Number_____

CYFD Identogo Registration Number_____

HOSPITAL

Criminal Conviction Certification Form

You are a selected finalist for a position at UNMH.

In order to continue with the recruitment process, you must answer the following questions and certify your answers by checking the boxes below.

For the questions below, "crime" means any and all felonies and misdemeanors, but it does not include traffic or parking offenses for which the sole penalty is a fine. "Convicted" means you were found guilty by a judge or jury, you pled guilty, or you pled nolo contendere ("no contest"), regardless of the penalty or sentence imposed.

Have you ever been convicted of a crime, regardless of whether the conviction was later set aside or expunged?

Yes □ No □
If yes, list circumstances and dates.

_____

Are any charges currently pending against you for any crime?

Yes □ No □
If yes, please explain.

_____

□ I certify that all statements made on this form are true and accurate and that I have not omitted any material information or provided false misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

□ I authorize UNM Hospital to use the information and statements contained in this document to determine my qualifications for employment. I understand that a conviction is not an automatic bar to employment and each case will be considered on an individual basis. I understand that a comprehensive background check may be conducted to determine my eligibility for hire or continued employment.

□ I release UNM Hospital, and other persons or entities, from any claims that might be based on the Hospitals' decision to conduct a background check.

_____ _____
Signature Date

_____
Print Name

Last Updated: 03/16/2026