



STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

HEALTH EDUCATION CONSULTANT
APPLICATION PACKAGE

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INSTRUCTIONS FOR COMPLETING EXAMINATION APPLICATION

Read the following instructions carefully before completing your Application. After completing the application on-line, please print and submit a hard copy containing your signature. All questions **must** be answered completely and accurately. You may be disqualified for any false or misleading statements or for omitting information. The information you furnish will be used to determine your eligibility in this examination. During the course of the examination, you may be requested to provide additional information regarding your preference in work location and conditions of employment. Prior to appointment you may be required to provide information on your medical background.

Social Security Number—Providing this information is voluntary in accordance with the Privacy Act of 1974 (PS 93-579). However, if a Social Security number is not provided, the Department of Public Health may be hampered in processing this examination as quickly as possible to fill existing vacancies.

Item 2—Employment History/discharges — These questions must be answered by all applicants. You must answer “Yes” to (2a) if you have ever, because of poor performance or misconduct, been fired from a job, let go, or had a work contract terminated. You must answer “Yes” to (2b) if you have ever quit a job after being informed that you were under suspicion of misconduct or poor performance or after being informed you could receive disciplinary action. You must answer “Yes” to (2c) if you were ever advised that you would be rejected, released, or not hired permanently after a trial period. Explain any “Yes” answers in Item 6. Include the facts in brief, the grounds for any action taken against you, and the circumstances under which you left the position.

Item 6 – Explanations — Use this space to explain the details of any response that requires additional information. Be thorough, and attach additional sheet(s) if needed.

Item 7 — Education — You must include a copy of official transcripts or degree at the time of application. Your application must contain a complete record of your training and educational background. If more space is needed, attach additional sheet(s).

Signature —Your signature, and the date you signed the Application is required. If the Application is not signed, it will be rejected.

Item 8 — Experience — **State employees must list the specific department(s) for which they worked and indicate the specific civil service class title(s) held.** If more space is needed, attach additional sheet(s).

Veterans’ Preference: Will be awarded in this examination, pursuant to Government Code Section 18973.1, effective January 1, 2014, as follows:

1. Any veteran, widow or widower of a veteran, or spouse of a 100 percent disabled veteran, who achieves a passing score in an entrance examination, shall be ranked in the top rank of the resulting eligibility list. Any veteran who has been dishonorably discharged or released is not eligible for veterans’ preference.
2. An entrance examination is defined, under the law, as any open competitive examination.
3. Veterans’ Preference is not granted once a person achieves permanent civil service status.

NOTE: Your completed Application and other examination-related information submitted to the Department of Public Health becomes confidential information and the property of the State of California as provided by Government Code Section 18934. This application and other confidential information **will not be returned**; therefore, we recommend that you keep a copy of your completed Application for your personal records.

Discrimination on the basis of race, color, creed, national origin, ancestry, gender, marital status, disability, religious or political affiliation, age, or sexual orientation is prohibited.

**EXAMINATION APPLICATION
HEALTH EDUCATION CONSULTANT**

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SEE INSTRUCTIONS ON PRECEDING PAGE

| | | | |
|--------------------------|----------|---------|------------------------------|
| APPLICANT'S NAME (Last) | (First) | (M.I.) | SOCIAL SECURITY NUMBER |
| MAILING ADDRESS (Number) | (Street) | | WORK TELEPHONE NUMBER () |
| (City) | (County) | (State) | HOME TELEPHONE NUMBER () |

EXAMINATION(S) FOR WHICH YOU ARE APPLYING – CHECK ONE OR MORE CLASSIFICATIONS

HEALTH EDUCATION CONSULTANT I

HEALTH EDUCATION CONSULTANT II

ANSWER THE FOLLOWING QUESTIONS:

1. Are you now employed by the State of California? (If "YES", fill in the information below.) _____ YES NO
Department: _____
2. Have you ever: (If "YES", give details in Item 6 and refer to the Instructions for further details.)
 - a. Been dismissed or fired from a position for any reason? _____ YES NO
 - b. Resigned from or quit a position while under investigation or after being informed discipline would be taken against you, or during an appeal from a disciplinary action? _____ YES NO
 - c. Been rejected or told you would not receive permanent or continued employment during any type of probationary or trial period on the job? _____ YES NO
3. In addition to English, list any other languages you speak, read, or write fluently: _____
4. Do you possess a valid California Driver License? (If "YES", fill in the information below.) _____ YES NO
License # _____ Class: _____ Restrictions: _____
5. Have you ever been convicted by any court of a felony? _____ YES NO

6. EXPLANATIONS – Use this space to explain the details of any response to the above questions that requires additional information. Attach additional sheet(s) if needed.

7. EDUCATION REQUIREMENT– Both the Health Education Consultant I and Health Education Consultant II require possession of a Master's Degree with specialization in Public or Community Health Education awarded on completion of a program of study accredited by the Council on Education for Public Health sanctioned by the American Public Health Association.

- A. Do you have a Master's Degree with specialization in Public Health Education?
 Yes No
- B. Do you have a Master's Degree with specialization in Community Health Education?
 Yes No
- C. Was your degree awarded on completion of a program of study accredited by the Council on Education for Public Health sanctioned by the American Public Health Association?* www.ceph.org Yes No

Accredited School _____ Date Degree Awarded Mo _____ Year _____

***If your degree was received from a School of Public Health that is no longer accredited, please submit transcripts and a letter of verification from the school with your application indicating its accreditation at the time that your degree was awarded.**

D. In which of the following concentrations is your Master of Public Health Degree?

- | | |
|---|---|
| <input type="checkbox"/> Behavioral and Community Health Sciences | <input type="checkbox"/> Health Education |
| <input type="checkbox"/> Behavioral Health Sciences | <input type="checkbox"/> Health Education and Behavioral Sciences |
| <input type="checkbox"/> Behavioral Science and Health Education | <input type="checkbox"/> Health Promotion |
| <input type="checkbox"/> Community Health Education | <input type="checkbox"/> Health Promotion and Disease Prevention |
| <input type="checkbox"/> Community Health Intervention | <input type="checkbox"/> Health Promotion Education and Behavior |
| <input type="checkbox"/> Community Health Sciences | <input type="checkbox"/> Health Promotion Sciences |
| <input type="checkbox"/> Community Health Studies | <input type="checkbox"/> Health Science |
| <input type="checkbox"/> Disease Prevention and Health Promotion | <input type="checkbox"/> Population and Family Health |
| <input type="checkbox"/> Family and Community Health | <input type="checkbox"/> Prevention and Community Health |
| <input type="checkbox"/> Health Behavior | <input type="checkbox"/> Public Health Education |
| <input type="checkbox"/> Health Behavior and Health Education | <input type="checkbox"/> Social and Behavioral Aspects of Public Health |
| <input type="checkbox"/> Health Behavior and Health Promotion | <input type="checkbox"/> Social and Behavioral Health |
| <input type="checkbox"/> Health Behavior and Risk Reduction | <input type="checkbox"/> Social and Behavioral Sciences |
| <input type="checkbox"/> Health Communication | <input type="checkbox"/> Social Science and Behavior |

E. If your area of concentration is in any of the following, attach a copy of your transcript listing the title of each graduate work course taken and semester/quarter units received.

- | | |
|--|--|
| <input type="checkbox"/> Environmental Health | <input type="checkbox"/> Maternal and Child Health |
| <input type="checkbox"/> International/Population Health | <input type="checkbox"/> Other _____ |

**EXAMINATION APPLICATION
HEALTH EDUCATION CONSULTANT**

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8. EXPERIENCE REQUIREMENT— *In evaluating the amount of experience you have (paid or voluntary), all part-time and intermittent experience will be converted to full-time equivalency. Full-time is defined as 40 hours per week.*

HEALTH EDUCATION CONSULTANT I – No experience is required for the Health Education Consultant I. If you have relevant experience, please feel free to include. However, if you have no relevant experience, you may proceed directly to the training and experience questionnaire on page 4 .

HEALTH EDUCATION CONSULTANT II – In addition to the required education, the Health Education Consultant II requires either one year of experience performing the duties of a Health Education Consultant I (Range B) in California state service; **or** two years of post master’s experience in planning, directing, and conducting public health education programs. *(Experience gained in California state service applied toward this pattern must include one year performing duties comparable to the Health Education Consultant I (Range B).)*

Begin with your most recent job where you gained relevant experience AFTER obtaining your Master’s Degree. List each job separately.

| | | |
|-------------------------------|-----------------------------|--|
| FROM (M/D/Y) | TO (M/D/Y) | JOB TITLE/CLASSIFICATION (Include Range or Level, if applicable) |
| HOURS PER WEEK | TOTAL WORKED (Years/Months) | COMPANY/STATE AGENCY NAME |
| SALARY EARNED \$ _____ PER | ADDRESS | |
| DUTIES PERFORMED | | |

REASON FOR LEAVING

| | | |
|-------------------------------|-----------------------------|--|
| FROM (M/D/Y) | TO (M/D/Y) | JOB TITLE/CLASSIFICATION (Include Range or Level, if applicable) |
| HOURS PER WEEK | TOTAL WORKED (Years/Months) | COMPANY/STATE AGENCY NAME |
| SALARY EARNED \$ _____ PER | ADDRESS | |
| DUTIES PERFORMED | | |

REASON FOR LEAVING

**EXAMINATION APPLICATION
HEALTH EDUCATION CONSULTANT**

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| | | |
|-------------------------|-----------------------------|--|
| FROM (M/D/Y) | TO (M/D/Y) | JOB TITLE/CLASSIFICATION (Include Range or Level, if applicable) |
| HOURS PER WEEK | TOTAL WORKED (Years/Months) | COMPANY/STATE AGENCY NAME |
| SALARY EARNED \$ PER | ADDRESS | |
| DUTIES PERFORMED | | |

REASON FOR LEAVING

CERTIFICATION--IMPORTANT--PLEASE READ BEFORE SIGNING--If not signed, this application may be rejected.

I certify under penalty of perjury that the information I have entered on this application is true and complete to the best of my knowledge. I further understand that any false, incomplete, or incorrect statements may result in my disqualification from the examination process or dismissal from employment with the State of California. I authorize the employers and educational institutions identified on this application to release any information they may have concerning my employment or education to the State of California.

| | |
|-----------------------|-------------|
| APPLICANT'S SIGNATURE | DATE SIGNED |
|-----------------------|-------------|

APPLICANTS--DO NOT USE THE SPACE BELOW--FOR PERSONNEL USE ONLY

APPLICANTS – DO NOT USE THE SPACE BELOW - FOR PERSONNEL USE ONLY

| | | | | |
|---|---|--------------------------|-----------------|--------------------|
| ACCEPTED <input type="checkbox"/> HEC I <input type="checkbox"/> HEC II | REJECTED <input type="checkbox"/> HEC I <input type="checkbox"/> HEC II | STAFF | TOTAL POINTS | SCORED BY |
| | EDUCATION | EXPERIENCE (HEC II only) | OTHER | DATE PROCESSED |
| | | | CONVERTED SCORE | DATE SCORE ENTERED |

Please proceed to the Training and Experience questionnaire that follows of page 4.

HEALTH EDUCATION CONSULTANT**EVALUATION OF TRAINING AND EXPERIENCE QUESTIONNAIRE**

PAGE 4

The following items are a self assessment used to evaluate your level of knowledge and experience related to the job requirements of Health Education Consultants. Responses to this questionnaire will be used to determine your final ranking on the employment list.

| Using the measurement scale provided, please indicate ratings for both knowledge and experience | | Knowledge | | | Experience | | | |
|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|-----------------------------|
| | | No | Some | Extensive | No | Some (under 1 year) | Moderate (1 – 3 years) | Extensive (3 plus years) |
| 1 | Respond to health information questions/requests from the public | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Conduct public health presentation(s) to the community | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Conduct presentation(s) to public health professionals | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Formulate appropriate and measurable program objectives | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Design comprehensive program work plan(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Coordinate community-wide health education program(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 | Collaborate with professional and community partners in the provision of health education services | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | Utilize health information retrieval systems | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 | Conduct literature reviews and prepare findings | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 | Gather health related data | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 | Conduct needs assessment or community planning process | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 | Develop proposals for funding and requests for application | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 | Review proposals and applications for funding | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 | Negotiate contracts with statewide and local grantees | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 | Provide contract monitoring of statewide and local contracts | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 | Prepare grant proposals/applications for funding | <input type="checkbox"/> | <input type="checkbox"/> |
| 17 | Plan and conduct skill-building workshop(s) or training(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 | Provide technical assistance and consultation in health education to health professionals | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 | Provide technical assistance and consultation in health education to the community | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 | Design/select effective health education materials for dissemination | <input type="checkbox"/> | <input type="checkbox"/> |
| 21 | Involve and mobilize community group(s) around health issues | <input type="checkbox"/> | <input type="checkbox"/> |
| 22 | Design media/public education campaign(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 23 | Conduct media/public education campaign(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 24 | Design program evaluation activities | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 | Conduct program evaluation activities | <input type="checkbox"/> | <input type="checkbox"/> |
| 26 | Interpret data and needs for health education resources | <input type="checkbox"/> | <input type="checkbox"/> |
| 27 | Prepare report(s) of program findings for publication | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby certify and understand that the information provided in this self rated questionnaire of training and experience is an accurate assessment and contains no willful misrepresentation or falsification. I further understand that this information may be verified and that if it is discovered I have made any false representations, I will be removed from the eligibility list resulting from this examination, and if employed by the State of California, possibly dismissed from civil service.

Signature _____

Date _____

**HEALTH EDUCATION CONSULTANT
CONDITIONS OF EMPLOYMENT**

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If you are successful in your examination your name will be placed on the active employment list and certified to fill vacancies according to the conditions you specify on this form. If you are unwilling to accept work or do not reply promptly to communications your name will be placed on the inactive list.

Type of Employment Desired: *(Check as many as apply)*

- Permanent Limited Term
 Full Time Part Time (regular hours less than 40)
-

Locations in which you are willing to work:

- 0100 Alameda
 0700 Contra Costa County
-

Signature

Date

It is your responsibility to notify the California Department of Public Health, Selection and Certification Unit, of any changes in your address or availability for employment. All correspondence must include your examination title, identification number, and Social Security number. Mail notification of changes to:

California Department of Public Health
MS 1700-1702
PO Box 997378
Sacramento, CA 95899-7378
Attention: Selection and Certification Unit

HEALTH EDUCATION CONSULTANT**EQUAL EMPLOYMENT OPPORTUNITY**
(For Examination Use Only)

APPLICANT: To assist the State of California in its commitment to Equal Employment Opportunity, applicants are asked to voluntarily provide the following information. This questionnaire will be separated from the application package prior to scoring of the examination and will not be used in any employment decisions. Government Code Section 19705 authorizes the State Personnel Board to retain this information for research and statistical purposes.

SOCIAL SECURITY NUMBER _____

| | |
|---|---|
| AGE <input type="checkbox"/> (1) UNDER 21 <input type="checkbox"/> (3) 21 – 39 <input type="checkbox"/> (6) 40 – 69 <input type="checkbox"/> (7) 70 AND OVER | GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
|---|---|

Ethnic Category (Please check the box that best describes your race/ethnicity.):

(7) **AMERICAN INDIAN OR ALASKAN NATIVE**-- Persons having origins in any of the tribal peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

ENTER TRIBAL IDENTIFICATION OR AFFILIATION _____

(2) **ASIAN** -- Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent. This includes China, Japan, and Korea.

(1) **BLACK**-- Persons having origins in any of the black racial groups of Africa.

(8) **FILIPINO**--Persons having origins in any of the original peoples of the Philippine Islands.

(4) **HISPANIC**--Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

(6) **PACIFIC ISLANDERS**--Persons having origins in the Pacific Islands, such as Samoa.

(5) **WHITE**-- Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Check if:

(3) **OTHER (Specify)** _____

(Y) **DISABLED**--A person with a disability is an individual who: (1) has a physical or mental impairment that substantially limits one or more life activities, such as walking, speaking, breathing, performing manual tasks, seeing, hearing, learning, caring for oneself or working, . . . ; (2) has a record of such an impairment; (3) is regarded as having such an impairment.

MILITARY-- A military veteran; a widow or widower of a veteran; or a spouse of a 100% disabled veteran.

How did you learn of this Examination?

BROCHURE TELEPHONE JOB LINE WORD OF MOUTH INTERNET

ADVERTISEMENT IN _____ EXAMINATION BULLETIN LOCATED AT _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

This concludes the application and examination process for Health Education Consultant I and Health Education Consultant II. Please print this entire document, sign Page 3 (the application), Page 4 (the questionnaire), and Page 5 (the conditions of employment) and mail to:

California Department of Public Health
MS 1700-1702
PO Box 997378
Sacramento, CA 95899-7378
Attention: Selection and Certification Unit