Print Form

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 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 — You must include a complete list of your paid work experience **that relates to the qualification requirements.** The work experience you list will be used to determine if you meet the minimum qualifications. List all relevant jobs regardless of duration, including part-time and military service, during the last five years. **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).

Veteran's Preference Points are not being granted in this examination since it does not qualify as an entrance examination under the law.

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.

STATE OF CALIFORNIA – DEPARTMENT OF PUBLIC HEALTH

EXAMINATION APPLICATION
HEALTH EDUCATION CONSULTANT

CDPH-HEC 678 Page 1

SEE INSTRUCTIONS ON PRECEDING PAGE

APPLICANT'S NAME *(Last)* *(First)* *(M.I.)*	SOCIAL SECURITY NUMBER
MAILING ADDRESS *(Number)* *(Street)* E-MAIL ADDRESS	WORK TELEPHONE NUMBER ( )
(City) *(County)* *(State)* *(Zip Code)*	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?* (http://www.ceph.org/i4a/pages/index.cfm?pageid=3344) ☐ 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?

- ☐ Behavioral and Community Health Sciences
- ☐ Behavioral Health Sciences
- ☐ Behavioral Science and Health Education
- ☐ Community Health Education
- ☐ Community Health Intervention
- ☐ Community Health Sciences
- ☐ Community Health Studies
- ☐ Disease Prevention and Health Promotion
- ☐ Family and Community Health
- ☐ Health Behavior
- ☐ Health Behavior and Health Education
- ☐ Health Behavior and Health Promotion
- ☐ Health Behavior and Risk Reduction
- ☐ Health Communication
- ☐ Health Education
- ☐ Health Education and Behavioral Sciences
- ☐ Health Promotion
- ☐ Health Promotion and Disease Prevention
- ☐ Health Promotion Education and Behavior
- ☐ Health Promotion Sciences
- ☐ Health Science
- ☐ Population and Family Health
- ☐ Prevention and Community Health
- ☐ Public Health Education
- ☐ Social and Behavioral Aspects of Public Health
- ☐ Social and Behavioral Health
- ☐ Social and Behavioral Sciences
- ☐ 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.

- ☐ Environmental Health
- ☐ International/Population Health
- ☐ Maternal and Child Health
- ☐ Other

EXAMINATION APPLICATION
HEALTH EDUCATION CONSULTANT

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

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 ☐ HEC I ☐ HEC II	REJECTED ☐ HEC I ☐ 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 on page 4.

HEALTH EDUCATION CONSULTANT
EVALUATION OF TRAINING AND EXPERIENCE QUESTIONNAIRE

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. Reponses 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	☐	☐	☐	☐	☐	☐	☐
2	Conduct public health presentation(s) to the community	☐	☐	☐	☐	☐	☐	☐
3	Conduct presentation(s) to public health professionals	☐	☐	☐	☐	☐	☐	☐
4	Formulate appropriate and measurable program objectives	☐	☐	☐	☐	☐	☐	☐
5	Design comprehensive program work plan(s)	☐	☐	☐	☐	☐	☐	☐
6	Coordinate community-wide health education program(s)	☐	☐	☐	☐	☐	☐	☐
7	Collaborate with professional and community partners in the provision of health education services	☐	☐	☐	☐	☐	☐	☐
8	Utilize health information retrieval systems	☐	☐	☐	☐	☐	☐	☐
9	Conduct literature reviews and prepare findings	☐	☐	☐	☐	☐	☐	☐
10	Gather health related data	☐	☐	☐	☐	☐	☐	☐
11	Conduct needs assessment or community planning process	☐	☐	☐	☐	☐	☐	☐
12	Develop proposals for funding and requests for application	☐	☐	☐	☐	☐	☐	☐
13	Review proposals and applications for funding	☐	☐	☐	☐	☐	☐	☐
14	Negotiate contracts with statewide and local grantees	☐	☐	☐	☐	☐	☐	☐
15	Provide contract monitoring of statewide and local contracts	☐	☐	☐	☐	☐	☐	☐
16	Prepare grant proposals/applications for funding	☐	☐	☐	☐	☐	☐	☐
17	Plan and conduct skill-building workshop(s) or training(s)	☐	☐	☐	☐	☐	☐	☐
18	Provide technical assistance and consultation in health education to health professionals	☐	☐	☐	☐	☐	☐	☐
19	Provide technical assistance and consultation in health education to the community	☐	☐	☐	☐	☐	☐	☐
20	Design/select effective health education materials for dissemination	☐	☐	☐	☐	☐	☐	☐
21	Involve and mobilize community group(s) around health issues	☐	☐	☐	☐	☐	☐	☐
22	Design media/public education campaign(s)	☐	☐	☐	☐	☐	☐	☐
23	Conduct media/public education campaign(s)	☐	☐	☐	☐	☐	☐	☐
24	Design program evaluation activities	☐	☐	☐	☐	☐	☐	☐
25	Conduct program evaluation activities	☐	☐	☐	☐	☐	☐	☐
26	Interpret data and needs for health education resources	☐	☐	☐	☐	☐	☐	☐
27	Prepare report(s) of program findings for publication	☐	☐	☐	☐	☐	☐	☐

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 _____

Your name will be placed on an 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

☐ 3400 Sacramento

_____ ☐

Signature Date

It is your responsibility to notify the California Department of Public Health of any changes in your address or availability for employment. All correspondence must include your examination title, identification number provided on your notice of eligibility, 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: Certification

STATE OF CALIFORNIA – DEPARTMENT OF PUBLIC HEALTH

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

☐ (1) UNDER 21 ☐ (3) 21 – 39 ☐ (6) 40 – 69 ☐ (7) 70 AND OVER

GENDER

☐ MALE ☐ 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 Section