



# Commonwealth Healthcare Corporation

Commonwealth of the Northern Mariana Islands

P. O. Box 500409, Saipan, MP 96950

Website: [www.chcc.gov.mp](http://www.chcc.gov.mp)



## HUMAN RESOURCES

### EXAMINATION ANNOUNCEMENT NO. 20-174

POSITION: **RADIOLOGY & X-RAY  
TECHNICIAN** OPENING DATE: **07/03/2020**

NO. OF VACANCIES: **1** CLOSING DATE: **07/24/2020**

SALARY: **\$22.43 P/H - \$22.43 P/AH**

*The salary given will be determined by the qualifications of the appointee.*

LOCATION: Commonwealth Health Center, Saipan  
Commonwealth Healthcare Corporation

#### DUTIES:

Takes x-rays and CAT scans or administers nonradioactive materials into patient's blood stream for diagnostic purposes. Reviews and evaluates developed x-rays, video tapes, or computer generated information to determine if images are satisfactory for diagnostic purposes. Operates radiologic or magnetic imaging equipment to produce images of the body. Uses radiation safety measures and protection devices to comply with regulations and to ensure safety of patients and staff. Positions imaging equipment and adjusts controls to set exposure time and distance, according to specification of examination.

#### QUALIFICATION REQUIREMENTS:

Associate of Science degree in radiologic Technology from a recognized/accredited school of Radiology or foreign equivalent and two years of experience. CNMI Professionals License required for all U.S. and foreign workers.

#### CONDITIONAL REQUIREMENTS:

This position is a Full-Time employment status at 40 hours per week with a shift schedule of eight hours per day, Monday through Sunday with flexible day(s) off per week. Employment start date will begin on September 16, 2020 through September 15, 2023. Eligible for overtime pay at "rate x 1.5 per hour" after completing a 40 hour work week per week for this position.

#### *Note(s):*

- *Three-fourths 20 CFR 655, Subpart E: "Workers will be offered employment for a total number of work hours equal to at least three fourths of the workdays of the total period that begins with the first workday after the arrival of the worker at the place of employment or the advertised contractual first date of need, whichever is later, and ends on the expiration date specified in the work contract or in its extensions, if any."*
- *Transportation and Subsistence 20 CFR 655, Subpart E: "If the worker completes 50 percent of the work contract period, the employer will provide, reimburse, or advance payment for the worker's transportation and subsistence from the place of recruitment to the place of work. Upon completion of the work contract or where the worker is dismissed earlier, the employer will provide or pay for the worker's reasonable costs of return transportation and subsistence back home or to the place the worker originally departed to work, except reported a worker's voluntary abandonment of employment. The amount of transportation payment or reimbursement will be equal to the most economical and reasonable common carrier for the distances involved."*

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CHCC is an equal opportunity employer. We consider all applicants for all positions without regard to race, color, religion, sex, disability, age, mental or veteran status, the presence of a non-job related medical condition or disability, or any legal protected status.



**OTHERS:**

This position is paid on a bi-weekly basis (2-week period). CHCC adheres to all applicable deductions such as C.N.M.I. Tax, Federal Tax, Medicare and Social Security.

*Note: Education and training claimed in Employment Application must be substantiated by diploma, certificate or license. Failure to provide complete application form or the required documents will result in automatic disqualification.*

**INTERESTED PERSONS SHOULD SEND THEIR CURRENT APPLICATION FORMS TO:**

Office of Human Resources

Commonwealth Healthcare Corporation

1 Lower Navy Hill Road, Navy Hill, Saipan, MP, 96950

Operation Hours: Monday Through Friday 7:30 AM – 4:30 PM and CLOSED on weekends/holidays.

*Employment Application Forms will be available 24/7 at the employer's hospital facility's Main Cashier Office (entrance/exit point for all)*

E-mail: [humanresources@dph.gov.mp](mailto:humanresources@dph.gov.mp)

Direct Line: (670) 236-8205/8210/8729/8202

Trunk Line: (670) 234-8950 ext. 3580/3581/3583

Fax Line: (670) 233-8756

/vdlg





CW-1 Application for Temporary Employment Certification  
 Form ETA-9142C  
 U.S. Department of Labor



**IMPORTANT:** Employers and authorized preparers must read the general instructions carefully before completing the Form ETA-9142C. A copy of the instructions can be found at <http://www.foreignlaborcert.doleta.gov/>. If you are not submitting this electronically, please complete ALL required fields/items containing an asterisk (\*) and any fields/items where a response is conditional as indicated by the section (§) symbol.

**A. Nature of CW-1 Application**

1. Type of Application (choose only one) *	<input type="checkbox"/> New employment	<input checked="" type="checkbox"/> Renewal of approved employment
2. <b>CW-1 Permit Renewal:</b> If "Renewal of approved employment" is marked in Question A.1, enter the date on which the CW-1 visa status of the nonimmigrant worker(s) will expire. §	9/15/2020	
3. <b>Long-Term Worker:</b> Is the employer seeking to employ a long-term worker who was previously issued a CW-1 visa or otherwise granted CW-1 status, as defined in 20 CFR 655.402? *	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
4. <b>Cap-Exempt Worker:</b> Will any of the CW-1 workers employed under this application be <u>exempt</u> from the statutory numerical limit, or "cap," on the total number of foreign nationals who may be issued a CW-1 visa or otherwise granted CW-1 status? *	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
5. <b>Emergency Situation:</b> Is the employer requesting to waive the requirement to obtain a valid PWD prior to the filing of this application due to an emergency situation, as set forth in 20 CFR 655.422? *	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>FOR EMERGENCY SITUATIONS ONLY</b> If "Yes" is marked in question A.5, mark questions 6 and 7 below and include the required items.		
6. Is a statement justifying the employer's emergency situation attached to this application? §	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	
7. Is a completed Form ETA-9141C, <i>Application for Prevailing Wage Determination</i> (PWD application), attached to this application? If the employer has submitted its PWD application for processing, select "No" and enter the PWD case number in E.3. §	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	

**B. Employer Information**

1. Legal Business Name *		
Commonwealth Healthcare Corporation		
2. Trade Name/Doing Business As (DBA), if applicable §		
N/A		
3. Address 1 *		
1 Lower Navy Hill Road, Navy Hill		
4. Address 2 (apartment/suite/floor and number) §		
P. O. Box 500409		
5. City *	6. State *	7. Postal Code *
Saipan	Northern Mariana Islar	96950
8. Country *	9. Province §	
United States Of America	N/A	
10. Telephone Number *	11. Extension §	
16702368202	3554	
12. Federal Employer Identification Number (FEIN from IRS) *	13. NAICS Code *	
66-0774364	62211	
14. Type of Employer (Choose only one) *	<input checked="" type="checkbox"/> Individual Employer <input type="checkbox"/> Job Contractor – Joint Employer	
<b>FOR JOB CONTRACTORS ONLY</b> If "Job Contractor – Joint Employer" is marked in question B.14, mark questions 15 and 16 below and include the required items.		
15. A completed <b>Appendix A</b> identifying the employer-client is attached to this application. §		<input type="checkbox"/>
16. An executed contract or other agreement between the job contractor and the employer-client establishing a bona fide relationship to the workers sought under this application is attached. §		<input type="checkbox"/>

CW-1 Application for Temporary Employment Certification  
 Form ETA-9142C  
 U.S. Department of Labor



**C. Employer Point of Contact Information**

The information contained in this section must be that of an employee of the employer who is authorized to act on behalf of the employer in labor certification matters. The information in this Section must be different from the agent or attorney information listed in Section D, unless the attorney is an employee of the employer.

1. Contact's Last (family) Name *		2. First (given) Name *		3. Middle Name(s) §	
Muna		Esther		Lizama	
4. Contact's Job Title *					
Chief Executive Officer					
5. Address 1 *					
1 Lower Navy Hill Road, Navy Hill					
6. Address 2 (apartment/suite/floor and number) §					
P. O. Box 500409					
7. City *			8. State *		9. Postal Code *
Saipan			Northern Mariana Is		96950
10. Country *			11. Province §		
United States Of America			N/A		
12. Telephone Number *		13. Extension §	14. Business Email Address *		
16702368202		3554	chccimmigration@gmail.com		

**D. Attorney or Agent Information (If applicable)**

1. Indicate the type of representation for the employer in the filing of this application. * Complete the remainder of this section if "Attorney" or "Agent" is marked.				<input type="checkbox"/> Attorney <input type="checkbox"/> Agent <input checked="" type="checkbox"/> None	
2. Attorney or Agent's Last (family) Name §		3. First (given) Name §		4. Middle Name(s) §	
5. Address 1 §					
6. Address 2 (apartment/suite/floor and number) §					
7. City §			8. State §		9. Postal Code §
10. Country §			11. Province §		
12. Telephone Number §		13. Extension §	14. Law Firm/Business Email Address §		
15. Law Firm/Business Name §			16. Law Firm/Business FEIN §		
<b>FOR ATTORNEY USE ONLY</b>					
<b>If "Attorney" is marked in question D.1, complete questions 17 – 19 below.</b>					
17. State Bar Number(s) §			18. State of highest state court where attorney is in good standing §		
19. Name of the highest state court where attorney is in good standing §					
<b>FOR AGENT USE ONLY</b>					
<b>If "Agent" is marked in question D.1, complete question 20 below and include the required attachment.</b>					
20. A copy of the current agreement or other documentation demonstrating the agent's authority to represent the employer is attached to this application. §					<input type="checkbox"/>

CW-1 Application for Temporary Employment Certification  
 Form ETA-9142C  
 U.S. Department of Labor



**E. Job Opportunity Information**

**a. Occupational Classification and PWD**

1. SOC Occupational Code * 29-2034.00	2. SOC Occupation Title * Radiologic Technologists
3. If "No" is marked to question A.5, enter the PWD case number obtained from the U.S. Department of Labor for this job opportunity. *	P-500-19360-216506

**b. Job Offer and Minimum Requirements**

1. Job Title * Radiology & X-ray Technician							
2. Workers Needed * 2		Period of Intended Employment					
3. Begin Date: * 9/16/2020				4. End Date: * 9/15/2023			
5. Job Duties – Description of the specific services or labor to be performed. * <i>(All job duties must be disclosed on this form. The response must begin in the form space. One separate attachment will be accepted to fully complete the response.)</i> Takes x-rays and CAT scans or administers nonradioactive materials into patient's blood stream for diagnostic purposes. Reviews and evaluates developed x-rays, video tapes, or computer generated information to determine if images are satisfactory for diagnostic purposes. Operates radiologic or magnetic imaging equipment to produce images of the body. Uses radiation safety measures and protection devices to comply with regulations and to ensure safety of patients and staff. Positions imaging equipment and adjusts controls to set exposure time and distance, according to specification of examination.							
6. Anticipated days and hours of work per week <i>(an entry is required for each box below)</i> *						7. Hourly work schedule *	
40	a. Total Hours	8	c. Monday	8	e. Wednesday	8	g. Friday
0	b. Sunday	8	d. Tuesday	8	f. Thursday	0	h. Saturday
						a. 7 : 30	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM
						b. 4 : 30	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM
8. Education: minimum U.S. diploma/degree required. *							
<input type="checkbox"/> None <input type="checkbox"/> High School/GED <input checked="" type="checkbox"/> Associate's <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate (PhD) <input type="checkbox"/> Other degree (JD, MD, etc.)							
9. Training: number of <u>months</u> required. *		0		10. Work Experience: number of <u>months</u> required. *		24	
11. Supervision: does this position supervise the work of other employees? *		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11a. If "Yes" to question 11, enter the number of employees worker will supervise.§		0	
12. Special Requirements - List specific skills, licenses/certifications, field(s) of training, and requirements of the job. * Please See Addendum							

CW-1 Application for Temporary Employment Certification  
 Form ETA-9142C  
 U.S. Department of Labor



**c. Place of Employment and Wage Information**

1. Worksite Address *		
1 Lower Navy Hill Road, Navy Hill		
2. Worksite Address § (apartment/suite/floor and number)		
P. O. Box 500409		
3. City *	4. State *	5. Postal Code *
Saipan	Northern Mariana Islar	96950
6. Basic Wage Rate Paid *		6a. Overtime Wage Rate Paid §
From: \$ 22 . 43 * To: \$ 22 . 43		From: \$ 33 . 65 To: \$ 33 . 65
7. Per (Choose only one) *		7a. Additional conditions about the wage rate to be paid. § Fringe benefits - paid time off & holidays. Optional-medical & dental insurance
<input checked="" type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Piece Rate		
8. Frequency of Pay. * <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Biweekly <input type="checkbox"/> Other (specify): _____		
9. Will work be performed at worksite locations other than the one identified above? *		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10. If "Yes" is marked in question E.c.9, a completed <b>Appendix B</b> is attached to this application. §		<input checked="" type="checkbox"/>

**d. Other Material Terms and Conditions of the Job Offer**

1. <b>I have read and agree to provide</b> the following terms and conditions with this job offer as fully explained in Form ETA-9142C – General Instructions and at 20 CFR 655, Subpart E. *		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>▪ <b>Three-Fourths Guarantee:</b> Workers will be offered employment for a total number of work hours equal to at least three-fourths of the workdays of the total period that begins with the first workday after the arrival of the worker at the place of employment or the advertised contractual first date of need, whichever is later, and ends on the expiration date specified in the work contract or in its extensions, if any.</li> <li>▪ <b>Transportation and Subsistence:</b> If the worker completes 50 percent of the work contract period, the employer will provide, reimburse, or advance payment for the worker's transportation and subsistence from the place of recruitment to the place of work. Upon completion of the work contract or where the worker is dismissed earlier, the employer will provide or pay for the worker's reasonable costs of return transportation and subsistence back home or to the place the worker originally departed to work, except where the worker will not return due to subsequent employment with another employer or where the employer has appropriately reported a worker's voluntary abandonment of employment. The amount of transportation payment or reimbursement will be equal to the most economical and reasonable common carrier for the distances involved.</li> </ul>		
2. <b>Daily Transportation:</b> Workers will be provided with daily transportation to and from the worksite in compliance with all applicable Federal and Commonwealth laws and regulations. *		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A
3. <b>Overtime Available:</b> Overtime hours will be available to the worker under this job offer and payable for every hour worked at the rate disclosed in this application. *		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> N/A
4. <b>On-the-Job Training Available:</b> Workers will be provided with on-the-job training to perform the duties assigned. *		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A
5. <b>Employer-Provided Tools and Equipment:</b> Workers will be provided, without charge or deposit charge, all tools, supplies, and equipment required to perform the duties assigned. *		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A
6. <b>Board, Lodging, or Other Facilities:</b> Workers will be provided with board, lodging, or other facilities and/or the employer will assist workers in securing board, lodging, or other facilities. *		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A
7. <b>Deductions from Pay:</b> State all deduction(s) from pay and, if known, the amount(s). *		
CNMI Tax, Federal Tax, Medicare and Social Security		



CW-1 Application for Temporary Employment Certification  
 Form ETA-9142C  
 U.S. Department of Labor



**e. Recruitment Information**

1. Explain how prospective U.S. applicants may be considered for employment under this job opportunity, including verifiable methods of contacting the employer, and the days and hours applicants can apply for the job. \*  
 Please See Addendum

2. Telephone Number to Apply * +16702368202	3. Email Address to Apply * humanresources@dph.gov.mp
4. Website address (URL) to Apply * www.chcc.gov.mp	

**F. Declaration of Employer and Attorney/Agent**

In accordance with Federal regulations, the employer(s) must attest to abide by certain terms, assurances, and obligations as a condition for receiving a temporary labor certification from the U.S. Department of Labor. Applications that fail to attach Appendix C will not be certified by the Department.

1. Please confirm that you have read and agree to all the applicable terms, assurances, and obligations contained in <b>Appendix C</b> and have attached a signed and dated copy of Appendix C with this application. *	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. Please confirm that the <u>employer-client</u> identified in Appendix A has read and agrees to all the applicable terms, assurances, and obligations contained in <b>Appendix C</b> and has attached a separate signed and dated copy of Appendix C with this application. *	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

**G. Preparer**

Complete this section if the preparer of this application is a person other than the one identified in either Section C (employer point of contact) or Section D (attorney or agent) of this application.

1. Last (family) Name § Deleon Guerrero	2. First (given) Name § Vanessa	3. Middle Initial § B.
4. Law Firm/Business FEIN § 66-0774364	5. Law Firm/Business Name § Commonwealth Healthcare Corporation	
6. Law Firm/Business Email Address § vanessa.deleonguerrero@dph.gov.mp		

**Public Burden Statement (1205-0534)**

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 1 hour and 50 minutes to complete the form and its appendices, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the needed data, and completing and reviewing the collection of information. The burden estimate is as follows: 9142C - 45 minutes, Appendix A - 15 minutes, Appendix B - 20 minutes, Appendix C - 20 minutes, and recordkeeping - 10 minutes. The obligation to respond to this data collection is required to obtain/retain benefits (Northern Mariana Islands U.S. Workforce Act of 2018, 48 U.S.C. 1806 et seq.). Please send comments regarding this burden estimate or any other aspect of this information collection to the U.S. Department of Labor \* Employment and Training Administration \* Office of Foreign Labor Certification \* 200 Constitution Ave., NW \* Box PPII 12-200 \* Washington, DC \* 20210 or by email to [ETA.OFLC.Forms@dol.gov](mailto:ETA.OFLC.Forms@dol.gov). **Please do not send the completed application to this address.**

CW-1 Application for Temporary Employment Certification  
ETA Form 9142C  
U.S. Department of Labor



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**ADDENDUM**  
Section E.b.12: Special Requirements

Associate of Science degree in radiologic Technology from a recognized/accredited school of Radiology or foreign equivalent and two years of experience. CNMI Professionals License required equally for all U.S. and foreign workers.

CW-1 Application for Temporary Employment Certification  
ETA Form 9142C  
U.S. Department of Labor



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**ADDENDUM**  
ADDENDUM SECTION E.e.1: Recruitment Information

Job vacancy announcements are posted externally at the CNMI Department of Labor's (DOL) official website [marlanastlabor.net](http://marlanastlabor.net); and Internally at the employer's official website [www.chcc.gov.mp](http://www.chcc.gov.mp) to individuals who are interested in applying for certain positions. Applicants are also encouraged to apply in-person, through CNMI DOL JVA website, employer's official website, telephone inquiries at (670) 236-8202/ 8205/ 8210/ 8729; 234-8950 ext. 3580; 3581; 3583 or at e-mail address [humanresources@dph.gov.mp](mailto:humanresources@dph.gov.mp); 3RNet global website or job fairs in which the employer participates in (if any). The employer's Human Resources Office is open from Mondays through Fridays, 7:30 AM to 4:30 PM and CLOSED on weekends/holidays. Employment Application forms will be available 24/7 at the employer's hospital facilities Main Cashier Office (entrance/ext point for all).



CW-1 Application for Temporary Employment Certification  
 Form ETA-9142C - Appendix B  
 U.S. Department of Labor

1. City *	2. Postal/ZIP Code *	3. Additional Place of Employment Information § (Address—e.g., street address, area, town, village, geographic identification)	4. Additional Work Itinerary Information §				Basic Wage Rate (in \$)		Per
			Crew ID	Total Workers	Begin Date	End Date	From:	To:	
Tinian	96952	alth Center P. O. Box 520446 Tinian,		2	9/16/2020	9/15/2023	\$22.43	\$22.43	Hour

**Public Burden Statement (1205-0534)**

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 1 hour and 50 minutes to complete the form and its appendices, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the needed data, and completing and reviewing the collection of information. The burden estimate is as follows: 9142C - 45 minutes, Appendix A - 15 minutes, Appendix B - 20 minutes, Appendix C - 20 minutes, and recordkeeping - 10 minutes. The obligation to respond to this data collection is required to obtain/retain benefits (Northern Mariana Islands U.S. Workforce Act of 2018, 48 U.S.C. 1806 et seq.). Please send comments regarding this burden estimate or any other aspect of this information collection to the U.S. Department of Labor \* Employment and Training Administration \* Office of Foreign Labor Certification \* 200 Constitution Ave., NW \* Box PPII 12-200 \* Washington, DC \* 20210 or by email to [ETA\\_OFLC.Forms@dol.gov](mailto:ETA_OFLC.Forms@dol.gov). Please do not send the completed application to this address.