

# Care Home Health Agency

## Application for Employment

<b>PERSONAL DATA</b>													
Date Application Completed		OFFICE USE ONLY			OFFICE USE ONLY								
Last		Date of Interview			Date of Hire								
Social Security Number		Home Phone ( ) ( )		Other Number ( ) ( )		Pager / Cellular Number ( ) ( )							
Address (If less than one year provide your previous address)			City		State		Zip Code		Length of Residence				
Previous Address			City		State		Zip Code		Length of Residence				
<b>JOB INTERESTS</b>													
Position Applying For:			How were you referred to us?			Date Available for Work?			Anticipated Wage				
Please check the specialty area(s) that best match (as) your experience / education and interested													
<input type="checkbox"/> Homecare		<input type="checkbox"/> Medical / Surgical		<input type="checkbox"/> IV Therapy		<input type="checkbox"/> Intermittent Care		<input type="checkbox"/> Private Duty					
<input type="checkbox"/> Hospice		<input type="checkbox"/> Rehabilitation		<input type="checkbox"/> Pediatrics/Maternal Child		<input type="checkbox"/> Supplemental Staffing		<input type="checkbox"/> Residential Care					
<input type="checkbox"/> Nursing Home		<input type="checkbox"/> Hospital		<input type="checkbox"/> Geriatric		<input type="checkbox"/> Psychiatric		<input type="checkbox"/> Homemaking					
Please indicate your availability or interests below													
<b>Work Status</b> <input type="checkbox"/> Full Time (32 hours per week average) <input type="checkbox"/> Part Time (less than 32 hours per week average)			<b>Shifts Available</b> <input type="checkbox"/> 7am – 3 pm <input type="checkbox"/> 11pm – 7 am <input type="checkbox"/> 3pm – 11pm <input type="checkbox"/> Visits Only			<b>Days Available</b> <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday							
<b>EDUCATION</b>													
Circle the Highest level of education completed			1 2 3 4 5 6 7 8 9 10 11 12   High School Diploma   Associate   Bachelors   Masters										
Name of College or Undergraduate Education / School					Degree				Year Graduated				
Name of College or Undergraduate Education / School					Degree				Year Graduated				
<b>LICENSE / CERTIFICATIONS / EXAMINATIONS</b>													
Type of License		State of Issue		Expiration Date		License Number		Any restrictions or pending actions against license ?					
CPR Expiration				Last Physical Examination				Last TB / Chest X-ray					
<b>GENERAL INFORMATION</b>													
Are you legally authorized to work in the USA			<input type="checkbox"/> Yes <input type="checkbox"/> No		If you become an employee of this Agency you will be required to provide documentation proving your eligibility to work in the USA								
Have you ever been convicted of a felony or a misdemeanor crime?			<input type="checkbox"/> Yes <input type="checkbox"/> No		This does not apply if the conviction has been expunged, is contained in a sealed record, or was a juvenile conviction.								
If yes, state the basis for each conviction and the date of the conviction:													
Have you ever been employed by this Agency or one of its subsidiaries			<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give location and dates:								
In case of emergency, notify				Phone				Relationship					
Personal References													
Please furnish three references with complete address. Do not list former employers or relatives. The individuals you list should have known you for at least one year													
<b>Name</b>		<b>Address</b> (Include city, state and zip)				<b>Phone Number</b>		<b>Business</b>		<b>Years Known</b>			
1.													
2.													
3.													

## WORK HISTORY

Company Name (present or most recent employer)	Employment Dates		
	From:		To:

Company Address	City	State	Wage	Per Hour	Annual
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Describe your Job Responsibilities and Duties

Supervisor's Name	Telephone Number	May We Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Reason for Leaving?

Company Name	Employment Dates		
	From:		To:

Company Address	City	State	Wage	Per Hour	Annual
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Describe your Job Responsibilities and Duties

Supervisor's Name	Telephone Number	May We Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Reason for Leaving?

Company Name	Employment Dates		
	From:		To:

Company Address	City	State	Wage	Per Hour	Annual
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Describe your Job Responsibilities and Duties

Supervisor's Name	Telephone Number	May We Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Reason for Leaving?

Company Name	Employment Dates		
	From:		To:

Company Address	City	State	Wage	Per Hour	Annual
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Describe your Job Responsibilities and Duties

Supervisor's Name	Telephone Number	May We Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Reason for Leaving?

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, Care Home Health Agency, LLC is an EQUAL OPPORTUNITY EMPLOYER and WILL NOT DISCRIMINATE AGAINST RACE, COLOR, SEX, CREED, NATIONAL ORIGIN OR COMMUNICABLE DISEASE AS DEFINED IN SECTION 504 OF TITLE VI. In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation Care Home Health Agency, LLC. WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF HANDICAP. In accordance with the Age Discrimination Act of 1975 and its implementing regulation, Care Home Health Agency, LLC. WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF AGE in the provision of services, unless age is a factor necessary to the normal operation or the achievement of any statutory objective. In accordance with the Americans with Disabilities Act of 1992 (42 USC §12101) and its implementing regulations, (private employers with more than 25 agency personnel), Care Home Health Agency, LLC. WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF DISABILITY. A disability is a physical or mental impairment that substantially limits a major life activity, or for which there is a record of impairment or which causes the individual to be regarded as impaired.

The information that I have given is true and accurate to the best of my knowledge

Signature of Applicant	Date
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# CARE HOME HEALTH AGENCY

## *Applicant Authorization*

PLEASE READ BEFORE SIGNING

If you have any questions regarding the following statements, please ask prior to signing.

Care Home Health Agency does not discriminate in hiring or employment on the basis of race, color, religion, age, disability, veteran status, or status within any group protected by federal, state, or local law. No questions on this application are intended to secure information to be used for any such discriminatory purpose.

This application will be given every consideration, but our receipt of it does not imply that you will be offered employment.

By signing your name below, you authorize investigation of all statements contained herein and the reference and employers listed to give you any and all information concerning your previous employment and any pertinent information they may have, personal or otherwise, and release Care Home Health Agency from any liability for any damage that may result from the utilization of such information.

By signing your name below, you certify that all statements made by you on this application are true and complete to the best of your knowledge and that you understand that misrepresentations or omissions may be cause for rejection, or may be cause for subsequent dismissal if you are hired or prosecution.

By signing your name below, you understand that nothing contained in the application or in the interview process is intended to create an employment contract between you (the applicant) and Care Home Health Agency. Should this application result in your employment, you have a right to terminate your employment at any time and for any reason and Care Home Health Agency retain a similar right. You further understand that no representative of Care Home Health Agency other than {Nursing Supervisor/Administrative Staff} has any authority to enter into any agreement with you for any specified period of time or to guarantee some other personal move or benefit. You further understand this entire statement applies to the period prior to and after you may be employed.

I hereby acknowledge that I have read, understand, and agree to the above statements.

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Signature of Applicant

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Date



**Care Home Health Agency**

**REFERENCE VERIFICATION FORM**

Employee Name: \_\_\_\_\_

SS#: \_\_\_\_\_ Title: \_\_\_\_\_

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Title: \_\_\_\_\_

Employed from: \_\_\_\_\_ to: \_\_\_\_\_

**DO NOT FILL OUT BELOW:**

**FOR OFFICE USE ONLY**

<b>Attendance:</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
<b>Job Performance:</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
<b>Attitude</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>

Eligible for Rehire: Yes \_\_\_ No \_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Agency Staff completing reference call: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Spoke With: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_