

APPLICATION FOR EMPLOYMENT HOME HEALTH

PERSONAL INFORMATION

Name (Last name First)		Social Security No.	
Present Address	City	State	Zip
Are you 18 years or older <input type="checkbox"/> Yes <input type="checkbox"/> No	Day phone	Evening phone	

DESIRED EMPLOYMENT

Position applied for	Date you can start	Salary desired
Are you employed now? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, may we make an inquiry of your present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who referred you to this company?	Are you applying for	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

LICENSURE/CERTIFICATION

License Type	License/Certification No.	State	Expiration Date
CPR Expiration Date	Last TB/CRX Date		

EDUCATION

School Level	Name and Location of School	# Years Attended	Did you Graduate?	Subjects Studied
<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> CNA				
College				
Trade, Business Or Correspondence School				

GENERAL INFORMATION

Please list any other work related information you think would be helpful to us in considering you for employment, such as foreign language, additional work experience, volunteer work, activities, accomplishments, publications etc.

Special training

Special Skills

FORMER EMPLOYERS

List your last three employers, starting with the most recent one first.

Name of present or last employer				
Address		City	State	Zip
Starting date	Leaving date		Job title	
Weekly starting salary	Weekly final salary		May we contact your supervisor?	Yes No
Name of supervisor		Title	Phone	
Description of work				
Reason for leaving _____				

Name of employer				
Address		City	State	Zip
Starting date	Leaving date		Job title	
Weekly starting salary	Weekly final salary		May we contact your supervisor?	Yes No
Name of supervisor		Title	Phone	
Description of work				
Reason for leaving _____				

Name of employer				
Address		City	State	Zip
Starting date	Leaving date		Job title	
Weekly starting salary	Weekly final salary		May we contact your supervisor?	Yes No
Name of supervisor		Title	Phone	
Description of work				
Reason for leaving _____				

PERSONAL REFERENCES

Below, give the names of three persons you are not related to whom you have known for at least one year.

Name	Address	Relationship	Phone #	Years known
1				
2				
3				

AUTHORIZATION

Are you legally authorized to work in the USA? Yes No
(Should you become employed by Sound Options Home Health, you will be required to provide documentation proving that your eligibility to work in the USA).

Have you ever been convicted of or are presently charged with a felony or misdemeanor crime? Yes No

Are you currently or have you in the past used illegal drugs? Yes No

If yes to above, what crime and dates of conviction or charge _____

(This does not apply if there was a juvenile conviction. A criminal conviction will not necessarily bar you from employment. We will consider the nature of the crime, the time that has expired since the occurrence, and any rehabilitation you have undergone).

I authorize Sound Options Home Health to obtain any relevant information (including extensive local and national criminal background checks, social security verification credit history and motor vehicle investigations) needed to make an employment decision. I authorize Sound Options Home Health to disclose this application along with any information about me obtained through reference checks or during the course of the interview process for state, federal contractual, or accreditation audits purposes. I also authorize Sound Options Home Health to disclose any of my performance appraisals, disciplinary records or skills tests for the same purposes as above. I release Sound Options Home Health from any individual or entity providing information to Sound Options Home Health from all liability for any damages from the disclosure of the information.

I understand and agree that nothing contained in this employment application or in granting an interview creates an employment contract between Sound Options Home Health and me for either employment or for the providing of any benefits. No promises regarding employment have been made to me. If I am offered employment, I understand that it is conditional upon a clear criminal background check and that the employment can be terminable "at will", and that I have a right to terminate my employment at any time and that Sound Options Home Health also retains a similar right to terminate my employment at any time.

I understand that should I become employed by Sound Options Home Health, my work assignments, schedules and work locations are subject to change according to the needs of the business and the clients of Sound Options Home Health.

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that if employed, falsified statements on this application shall be considered grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed to you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

Signature _____

Date _____

Pursuant to Title VII of the Civil Rights Act of 1964 (42 U.S.C. Et Seq) and 45 C.F.R. part 80, section 504 of the Rehabilitation Act of 1973, as amended (29 U/S/C. 794) and 45 C.F.R. Part 84, and the Age Discrimination Act of 1975 (42 U/S/C/ 6101 Et Seq) and 45 C.F.R. Part 91, Sound Options Home Health adheres to an equal opportunity policy for all persons seeking admission as clients or seeking employment , and for all persons employed by the agency. Sound Options Home Health dose not discriminate because of age, race, color, religion, military status, marital status, gender preference, sex, national origin or disability.