CONFIDENTIAL DOCUMENT

EQUAL OPPORTUNITY EMPLOYER

______________________________ ____________________

Name Date

Grace Home Healthcare Inc.

216 E. Main St. Suite 5

Albert Lea MN 56007

Phone: 507-369-5370

gracehomehealthcaresm@gmail.org

APPLICANT INFORMATION

Last Name		First		M.I.			
Street Address				Apt. #/Unit			
City		State		Zip Code			
Phone		Email Address					
Date Available		Social Security No.					
Position Applied For				Desired Wage			
Are you a citezen of the United States	YES	NO	If no, are you authorized to work in the U.S.		YES	NO	
Have you worked for this company before	YES	NO	If so, when?				
Do you have friends or relatives employed here	YES	NO	If so, who?				
Have you ever been found guilty by a court of law of abusing, neglecting, mistreating, or misappropriating the property of	YES	NO	If yes, explain				
	YES	NO					

AVAILABILITY (Please mark all available time frames for each individual day. Ex: Friday: 8am -5pm)

SUNDAY	MONDAY	TUESDAY	WEDNESDAY

THURSDAY	FRIDAY	SATURDAY

EDUCATION

High School							
From		To		Did you graduate?	YES	NO	Degree
College							
From		To		Did you graduate?	YES	NO	Degree
Other							
From		To		Did you graduate?	YES	NO	Degree

REFERENCES - Please list three professional references.

Full Name		Realationship	
Company		Phone	
Address			
Full Name		Realationship	
Company		Phone	
Address			
Full Name		Realationship	
Company		Phone	
Address			

PREVIOUS EMPLOYMENT

Company					Phone		
Address					Supervisor		
Job Title				Starting Salary	$	Ending Salary	$
Res onsibiti es							
From		To		Reason for leaving			
May we contact your previous supervisor for a reference			YES	NO			
Company					Phone		
Address					Supervisor		
Job Title				Starting Salary	$	Ending Salary	$
Res onsibiti es							
From		To		Reason for leaving			
May we contact your previous supervisor for a reference			YES	NO			
Company					Phone		
Address					Supervisor		
Job Title				Starting Salary	$	Ending Salary	$
Res onsibiti es							
From		To		Reason for leaving			
May we contact your previous supervisor for a reference			YES	NO			

How did you hear about us?

HOME HEALTH EXPERIENCE

RN		LPN		HHA		PCA	

Hours desired	Live in		Hourly		Over night		On-Call	
Fill in or check all that apply	Full Time		Part Time		Week Ends			

List all medical conditions and devices you have encountered and used.

DISCLAIMER AND SIGNATURE

I hereby authorize Grace Home Healthcare Inc. and/or their authorized agents to gather information regarding the following: All records, including: criminal, credit, driving, drug and/or education; written or verbal information from previous employers, including, but not limited to; concerns regarding my performance during employment, my reason for ending employment or and other information pertinent to the functions of my job.

I understand that all inquiries on this form are used for identification perposes only in order to conduct a background check and are asked for legitimate, non-discriminatory reasons. Responses to gender, age and race inquiries are voluntary and choosing not to respond will not preclude hire or promotion. I hearby release Grace Home Healthcare Inc. employees, former employees and other references from liability and understand there is

I understand that submission of false information on this or any other employment form/interview may result in non-selection or in termination if hired. The following is my complete legal name and all information is true and correct to the best of my knowledge. This information is used for verification purposes ONLY.

Signature Date

NOTES: