**EMPLOYMENT APPLICATION**

Abiding Grace Home Health Care LLC

1200 Woodruff Road Suite A 3

Greenville, South Carolina 29607

PHONE: (864) 321-2116

EMAIL: catherine@abidinggracehealthcare.com

**ABIDING GRACE HOME HEALTH CARE** is an equal opportunity employer. This application will not be used for limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Should an applicant need reasonable accommodation in the application process, he or she should contact a company representative.

*Please fill out all sections of the application:*

**Applicant Information**

**Applicant Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City/State/ZIP:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Number of years at this address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daytime phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Application:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

**Who should be contacted if you are involved in an emergency?**

**Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City/State/ZIP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daytime phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Position**

***Position(s) applying for:*** RN \_\_\_\_ LPN \_\_\_\_ CNA\_\_\_\_\_CAREGIVER\_\_\_\_\_\_COMPANION\_\_\_\_\_\_

How did you hear about this position?

What days are you available for work?

What hours or shift are you available for work?

If needed, are you available to work overtime?

On what date can you start working if you are hired?

Do you have reliable transportation to and from work?

|  |  |
| --- | --- |
| Salary desired: |  |
|  | |

**Personal Information**

|  |  |  |
| --- | --- | --- |
| Have you ever applied to or worked for ABIDING GRACE HOME HEALTH CARE |  |  |
| before? | Yes | No |
| If yes, when? |  |  |
|  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have any friends, relatives, or acquaintances working for ABIDING GRACE HOME HEALTH CARE?  If yes, state name & relationship: | |  | Yes No |  |
| Are you 18 years of age or older? | |  | Yes | No |
| Are you a U.S. citizen or approved to work in the United States? |  | Yes | No |
| What document can you provide as proof of citizenship or legal status? |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Will you consent to a mandatory controlled substance test? | Yes | No |
| Do you have any condition which would require job accommodations? | Yes | No |
| If yes, please describe accommodations required below. |  |  |
|  |  |  |

Have you ever been convicted of a criminal offense (felony or misdemeanor)? Yes No

If yes, please state the nature of the crime(s), when and where convicted and disposition of the case:

|  |  |
| --- | --- |
|  |  |
|  |  |
|  | |

*(Note: No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The date of the offense, the nature of the offense, including any significant details that affect the description of the event, and the surrounding circumstances and the relevance of the offense to the position(s) applied for may, however, be considered.)*

# **Job Skills/Qualifications**

Please list below the skills and qualifications you possess for the position for which you are applying:

*(Note: ABIDING GRACE HOME HEALTH CARE LLC complies with the ADA and considers reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. )*

**Education and Training**

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Name

Location (City, State)

Year Graduated

Degree Earne

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**College/Un**

Name

Location (City, State)

Year Graduated

Degree Earne

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**V**

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**d**

**Training**

Name

Location (City, State)

Year Graduated

Degree Earne

d

**Military:**

Are you a member of the Armed Services?

What branch of the military did you enlist?

What was your military rank when discharged?

How many years did you serve in the military?

What military skills do you possess that would be an asset for this position?

**Previous Employment**

**Employer Name:**

Job Title: Supervisor Name:

Employer Address:

City, State and Zip Code: Employer Telephone:

Dates Employed:

Reason for leaving:

**Employer Name:**

Job Title:

Supervisor Name:

Employer Address:

City, State and Zip Code: Employer Telephone:

Dates Employed:

Reason for leaving:

**Employer Name:**

Job Title:

Supervisor Name:

Employer Address:

City, State and Zip Code: Employer Telephone:

Dates Employed:

Reason for leaving:

**Employer Name:**

Job Title:

Supervisor Name:

Employer Address:

City, State and Zip Code: Employer Telephone:

Dates Employed:

Reason for leaving:

**References**

List any two non-relatives who would be willing to provide a reference for you.

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide any other information that you believe should be considered, including whether you are bound by any agreement with any current employer:

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CERTIFICATION**

I certify that the information provided on this application is truthful and accurate. I understand that providing false or misleading information will be the basis for rejection of my application, or if employment commences, immediate termination.

I authorize Abiding Grace Home Health Care LLC to contact former employers and educational organizations regarding my employment and education. I authorize my former employers and educational organizations to fully and freely communicate information regarding my previous employment, attendance, and grades. I authorize those persons designated as references to fully and freely communicate information regarding my previous employment and education.

If an employment relationship is created, I understand that unless I am offered a specific written contract of employment signed on behalf of the organization by its Owner, the employment relationship will be "at-will." In other words, the relationship will be entirely voluntary in nature, and either I or my employer will be able to terminate the employment relationship at any time and without cause. With appropriate notice, I will have the full and complete discretion to end the employment relationship when I choose and for reasons of my choice. Similarly, my employer will have the right. Moreover, no agent, representative, or employee of Abiding Grace Home Health Care LLC, except in a specific written contract of employment signed on behalf of the organization by its Owner, has the power to alter or vary the voluntary nature of the employment relationship.

I HAVE CAREFULLY READ THE ABOVE CERTIFICATION AND I UNDERSTAND AND AGREE TO ITS TERMS.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT FULL NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT SIGNATURE DATE