

**PLEASE COMPLETE THE FOLLOWING INFORMATION AND RETURN WITH APPLICATION**

**EEO REPORTING AND PERSONNEL RESEARCH**      Your SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Note: The information requested in this section is not used to evaluate your application. This information is needed to satisfy **Equal Employment Opportunity** reporting and personnel research requirements.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ DOB: / /

Former State of S.C. Employee Y \_\_\_ N \_\_\_

Race (check one) \_\_\_ Black \_\_\_ White \_\_\_ Other \_\_\_ Specify \_\_\_\_\_

Sex: F \_\_\_ M \_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_

Number of Children \_\_\_\_\_ How long have you lived in S.C.? \_\_\_\_\_ Position(s) applied for \_\_\_\_\_

Minimum salary you will accept \$ \_\_\_\_\_ US Citizenship \_\_\_ Y Other \_\_\_\_\_

**EMPLOYEE MEDICAL HISTORY**

Put a checkmark beside all items that apply to you.

\_\_\_ Diabetes

\_\_\_ Epilepsy

\_\_\_ Heart Disease

\_\_\_ Arthritis

\_\_\_ Varicose Veins

\_\_\_ Hearing Problems

\_\_\_ High Blood Pressure

\_\_\_ Back Problems

\_\_\_ Allergies

\_\_\_ Contact Lens

\_\_\_ Smoker \_\_\_ Non-Smoker

Have you had a problem in the past with alcohol or drugs? \_\_\_ Y \_\_\_ N

If yes explain: \_\_\_\_\_

Please list all Medications you are taking at the present time and for what condition.

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

**GENERAL INFORMATION**

Do you have any relatives employed BY **Quality Care Services, Inc**? Y \_\_\_ N \_\_\_ List names and relationship.

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

Have you ever been forced to resign from any job? Y \_\_\_ N \_\_\_

Explain:

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

Have you been convicted of a crime other than a minor traffic violation? Y \_\_\_ N \_\_\_

A yes answer to this question will not necessarily deny you employment. The nature, severity, and date of the offense in relation to position for which you are applying are considered, If yes, please complete the following:

<u>CHARGE</u>	<u>WERE CONVICTED</u>	<u>DATE</u>	<u>DISPOSITION OR CURRENT STATUS</u>
_____	_____	_____	_____
_____	_____	_____	_____

Will being hired by **Quality Care Service, Inc.** result in you being dually employed? Y \_\_\_ N \_\_\_

If yes give the name of other employment and position.

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

All statements on this form must be true and accurate; any misrepresentation or omission of facts may result in you being disqualified or discharged. A routine inquiry or investigation may be made during our initial or subsequent processing and will provide information applicable to this job for which you are applying. Upon written request, additional information as to the nature and extent of the inquiry, if one is made, will be provided. The information on this form will be treated as confidential and will be available for official use only.

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONTRACT OF AGREEMENT

I \_\_\_\_\_, ON THIS DATE OF \_\_\_\_\_

Do Hereby agree to the arrangement and assignment set forth by this contract for employment, with **Quality Care Services, Inc.**, do not operate as a Inpatient/Outpatient Hospital Services, Laboratory/ X-Ray Services, Skilled Nursing Facility Services, Screening for Early Discovery of Physical and Mental defects or chronic conditions, and Physician Services. My position with **Quality Care Services, Inc.**, is:

\_\_\_\_\_.

I agree not to be employed by **Quality Care Services, Inc.**, clients (current/former), parties responsible or the client or client's family, for a period of five (5) years from the date of resigning or termination of employment. Any form of work (i.e., FT or PT work, freelance, free will, OJT, etc...) if asked to leave the client's location. I will leave immediately, at **Quality Care Services, Inc.**, request.

If hired by **Quality Care Services, Inc.**, it is my understanding that I will be in on a 90-day trial period.

\_\_\_\_\_  
Employee

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# Quality Care Services, Inc.

## Availability Sheet

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

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM
Areas willing to travel to:						
Notes:						