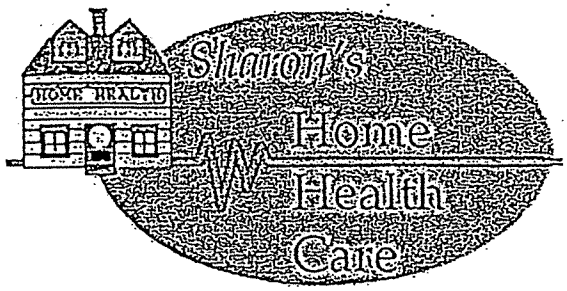

116 N LITTLE HORN
PO BOX 189
MOORCROFT, WY 82721

POSITION APPLYING FOR:_____DATE:_____.

PERSONAL

_____.
LAST NAME FIRST NAME M SOCIAL SECURITY#

_____.
PRESENT ADDRESS CITY STATE ZIP CODE

_____.
HOME PHONE# CELL PHONE# DATE OF BIRTH

CAN WE CALL YOU AT WORK? YES NO
WORK PHONE #_____.

CAN YOU AT TIME OF EMPLOYMENT, SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES? YES NO

VERIFICATION AND COMPLETION OF THE I-9 FORM MUST BE SUBMITTED NO LATER THAN 3 BUSINESS DAYS AFTER DATE OF HIRE. COPY OF DRIVER'S LICENSE, SOCIAL SECURITY CARD OR BIRTH CERTIFICATE.

NUMBER OF HOURS PER WEEK DESIRED?_____.
DATE AVAILABLE TO WORK:_____.

WILL YOU TRAVEL IF THE JOB REQUIRES? YES NO

HAVE YOU EVER BEEN DISCHARGED OR ASKED TO RESIGN FROM A POSITION?
YES NO
IF YES PLEASE EXPLAIN:_____.

ARE THERE ANY OTHER EXPERIENCES, SKILLS OR TRAINING WHICH MAKE YOU PARTICULARLY SUITED TO WORK FOR SHARON'S?

_____.
_____.

LIST ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO CONSIDER:

_____.
_____.
_____.

ACKNOWLEDGEMENT

IN SIGNING THIS APPLICATION, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE QUESTIONS ASKED IN THIS APPLICATION AND THAT ALL ANSWERS GIVEN BY ME ARE TRUE, ACCURATE AND COMPLETE. I ALSO UNDERSTAND THAT OMISSION, CONCEALMENT OR MISREPRESENTATION OF ANY FACT ON THIS APPLICATION OR DURING ANY INTERVIEW FOR EMPLOYMENT MAY JEOPORDIZE MY CHANCES FOR EMPLOYMENT AND BE CAUSE FOR MY IMMEDIATE DISMISSAL FROM EMPLOYMENT.

I GIVE SHARON'S HOME HEALTH CARE PERMISSION TO USE ANY INFORMATION IN THIS APPLICATION TO ENABLE IT AND ITS AGENTS TO VERIFY THE INFORMATION CONTAINED IN THIS APPLICATION AND I AUTHORIZE PRESENT AND FORMER EMPLOYERS, EDUCATIONAL INSTITUTIONS I HAVE ATTENDED, CREDIT AGENCIES, ALL REFERENCES AND ANY OTHER PERSONS TO ANSWER ALL QUESTIONS ASKED BY SHARON'S HOME HEALTH CARE WITH REGARD TO ANY OF THE SUBJECTS COVERED BY THIS APPLICATION. I ALSO UNDERSTAND THAT IN CONNECTION WITH MY APPLICATION FOR EMPLOYMENT OR MY EMPLOYMENT SHARON'S HOME HEALTH CARE MAY CONDUCT A CRIMINAL BACKGROUND INVESTIGATION AND THAT EMPLOYMENT WITH SHARON'S HOME HEALTH CARE MAY BE CONTINGENT ON THE RESULT OF SUCH INVESTIGATION. I RELEASE SHARON'S HOME HEALTH CARE, IT'S AGENTS AND ALL AFFILIATED ENTITIES, AS WELL AS ANY PERSONS OR INSTITUTION THAT PROVIDE THE SHARON'S HOME HEALTH CARE, WITH ANY INFORMATION ABOUT ME, FROM ANY AND ALL LIABILITY WHATSOEVER RESULTING FROM ANY SUCH INVESTIGATION OR THE DISCLOSURE OF SUCH INFORMATION.

IN CONSIDERATION OF MY EMPLOYMENT BY SHARON'S HOME HEALTH CARE, I AGREE BY ALL SHARON'S HOME HEALTH CARE RULES AND REGULATIONS, WHICH I UNDERSTAND ARE SUBJECT TO CHANGE BY SHARON'S HOME HEALTH CARE, AT ANY TIME FOR ANY REASON WITHOUT PRIOR NOTICE. I ALSO UNDERSTAND THAT IF EMPLOYED, I WILL BE AN EMPLOYEE AT WILL AND EMPLOYED FOR NO DEFINITE PERIOD OF TIME. I UNDERSTAND THAT EITHER SHARON'S HOME HEALTH CARE OR I CAN TERMINATE MY EMPLOYMENT AT ANY TIME, WITH OR WITHOUT CAUSE AND WITH OR WITHOUT ADVANCE NOTICE. I FURTHER UNDERSTAND THAT NO COMMUNICATION, WHETHER ORAL OR WRITTEN, BY ANY REPRESENTATIVE OF SHARON'S HOME HEALTH CARE, AT ANY TIME, CAN CONSTITUTE A CONTRACT OF EMPLOYMENT. NO REPRESENTATIVE OR AGENT OF SHARON'S HOME HEALTH CARE, OTHER THAN THE DIRECTOR OF HUMAN RESOURCES BY EITHER WRITTEN OR MUTUALLY SIGNED AGREEMENT, HAS THE AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING.

IN ADDITION, I UNDERSTAND THAT SHARON'S HOME HEALTH CARE AND ALL COMPENSATION AND BENEFIT PLAN ADMINISTRATORS HAVE THE MAXIMUM DISCRETION PERMITTED BY LAW TO ADMINISTER, INTERPRET, MODIFY, DISCONTINUE, ENHANCE OR OTHERWISE ADMINISTER, INTERPRET OR CHANGE ALL POLICIES, PROCEDURES, BENEFITS OR OTHER TERMS AND CONDITIONS OF EMPLOYMENT.

I AM WILLING TO SUBMIT TO A PHYSICAL EXAMINATION, INCLUDING THE ANALYSIS FOR THE DETECTION OF THE USE OF UNLAWFUL DRUGS OR SUBSTANCES IN ACCORDANCE WITH APPLICABLE LAWS. IF I RECEIVE AN OFFER OF EMPLOYMENT AT THE REQUEST OF SHARON'S HOME HEALTH CARE, AND IF ONE IS GIVEN, I AGREE THAT MY CONTINUED EMPLOYMENT MAY BE CONTINGENT ON THE RESULTS.

I HAVE READ THE ABOVE STATEMENT AND FULLY UNDERSTAND IT.

APPLICANT SIGNATURE DATE

EDUCATION

	SCHOOL	YEARS COMPLETED	DIPLOMA/DEGREE	COURSE OF STUDY/SKILLS
HIGH SCHOOL				
COLLEGE UNIVERSITY				
GRADUATE PROFESSIONAL				
TRADE SCHOOL				

EMPLOYMENT HISTORY

COMPANY NAME:____.
DATES EMPLOYED:____.
PHONE NUMBER:________________ADDRESS_______________________.
RESPONSIBILITIES:____.
REASON FOR LEAVING:____.
BEGINNING PAY:___________ENDING PAY:___________.

COMPANY NAME:____.
DATES EMPLOYED:____.
PHONE NUMBER:________________ADDRESS_______________________.
RESPONSIBILITIES:____.
REASON FOR LEAVING:____.
BEGINNING PAY:___________ENDING PAY:___________.

COMPANY NAME:____.
DATES EMPLOYED:____.
PHONE NUMBER:________________ADDRESS_______________________.
RESPONSIBILITIES:____.
REASON FOR LEAVING:____.
BEGINNING PAY:___________ENDING PAY:___________.

COMPANY NAME:____.
DATES EMPLOYED:____.
PHONE NUMBER:________________ADDRESS_______________________.
RESPONSIBILITIES:____.
REASON FOR LEAVING:____.
BEGINNING PAY:___________ENDING PAY:___________.

APPLICANT

TO AID IN OUR RECRUITMENT PROGRAM AND REMAIN WITHIN OUR FEDERAL AND STATE RECORD KEEPING GUIDELINES, WE WOULD APPRECIATE YOUR COMPLIANCE IN COMPLETING THE VOLUNTARY INFORMATION BELOW.

SHARON'S KEEPS THIS CONFIDENTIAL INFORMATION SEPARATE FROM YOUR APPLICATION. THE INFORMATION WILL NOT AFFECT YOUR CONSIDERATION FOR EMPLOYMENT.

NAME:_____.
SOCIAL SECURITY #_____.

POSITION:_____DATE:_____.

PLEASE CHECK THE APPROPRIATE DESIGNATION

WHITE: _____.

BLACK: _____.

ASIAN/PACIFIC ISLANDER: _____.
PERSONS HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLE OF THE FAR EAST, SOUTHEAST ASIA, PACIFIC ISLANDS OR INDIA.

AMERICAN INDIAN/ALASKAN NATIVE: _____.
PERSONS HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLE OF NORTH AMERICA, AND WHO MAINTAIN CULTURAL IDENTIFICATION THROUGH TRIBAL AFFILIATION OR COMMUNITY RECOGNITION.

HISPANIC: _____.
PERSONS OF MEXICAN, PUERTO RICAN, CUBAN, CENTREL OR SOUTH AMERICAN OR OTHER SPANISH CULTURE OR ORIGIN REGARDLESS OF RACE.

MALE: _____.
FEMALE: _____.

PROFESSIONAL REFERENCES

NAME:_____ADDRESS_____.

PHONE:_____OCCUPATION:_____.

NAME:_____ADDRESS_____.

PHONE:_____OCCUPATION:_____.

NAME:_____ADDRESS_____.

PHONE:_____OCCUPATION:_____.

PERSONAL REFERENCES

NAME:_____ADDRESS_____.

PHONE:_____OCCUPATION:_____.

NAME:_____ADDRESS_____.

PHONE:_____OCCUPATION:_____.

NAME:_____ADDRESS_____.

PHONE:_____OCCUPATION:_____.