



## **JOB APPLICATION**

**Allied Home Health Services, Inc. & Allied Hospice, LLC**  
500 N Poplar Ave, Broken Arrow,  
Oklahoma 74012  
PH:918-742-4269

Allied Home Health Services, Inc. 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 of the sections below:*

### **Applicant Information**

***Applicant Name:***

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***Address:***

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***City, State and Zip Code:***

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***Telephone Number:***

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***Email:***

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***Date of Application:***

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**Employment Position**

**Position(s) applying for:** \_\_\_\_\_

How did you hear about this position? \_\_\_\_\_

What days are you available for work? \_\_\_\_\_

What hours or shift are you available for work? \_\_\_\_\_

What date would you be available to start working? \_\_\_\_\_

Do you have reliable transportation to and from work? \_\_\_\_\_

**Personal Information**

Have you ever applied to or worked for Allied Home Health Services, Inc. before? If yes, when?  
Yes      No      Date: \_\_\_\_\_

Do you have any friends, relatives, or acquaintances working for Allied Home Health Services, Inc. If yes, state name & relationship: Yes      No

\_\_\_\_\_

What documents can you provide as proof of citizenship or legal status?

\_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

**Job Skills/Qualifications**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(Note: Allied Home Health Services, Inc. and Allied Hospice, LLC. complies with the ADA and considers reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. It is possible that a hire may be tested*

on skill/agility and may be subject to a medical examination conducted by a medical professional.)

**Education and Training**

**High School**

Name	Location (City, State)	Year Graduated	Degree Earned

**College/University**

Name	Location (City, State)	Year Graduated	Degree Earned

**Vocational School/Specialized Training**

Name	Location (City, State)	Year Graduated	Degree Earned

**Military:**

Are you a member of the Armed Services? Yes      No

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: \_\_\_\_\_

**Additional Space if needed:**

**References**

Please provide 2 personal and professional reference(s) below:

Reference	Contact Information	Relationship	Years Known

**AT-WILL EMPLOYMENT**

The relationship between you and Allied Home Health Services, Inc. and Allied Hospice, LLC. is referred to as "employment at will." This means that your employment can be terminated at any time for any reason, with or without cause, with or without notice, by you or the Allied Home Health Services, Inc. and Allied Hospice, LLC. No representative of Allied Home Health Services, Inc. Or Allied Hospice, LLC. has authority to enter into any agreement contrary to the foregoing "employment at will" relationship. You understand that your employment is "at will," and that you acknowledge that no oral or written statements or representations regarding your employment can alter your at-will employment status, except for a written statement signed by you and either our Executive Vice-President, Chief Operations Officer, or the Company's President.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_