



Job Application Form

Personal Data

Today's Date: _____

Last Name: _____ First Name: _____ Middle: _____

Email Address: _____ SSN: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____

Emergency Contact Information

Name of Emergency Contact: _____ Relation: _____

Emergency Telephone Number: _____

Job Information

Position (Job Class) Applying for:

☐ RN ☐ LPN/LVN ☐ CNA ☐ PCA ☐ HHA ☐ Companion ☐ Other: _____

Date Available: _____

Previous Facility Types Worked: Check All That Apply:

☐ Hospital ☐ Hospice ☐ Nursing Home/Rehab ☐ Home Care ☐ Private Duty ☐ Assisted Living

Language Skills: Other than English, please check any other languages you speak –

☐ Spanish ☐ French ☐ German ☐ Other: _____

Check the type of assignment you are available for:

☐ Full-time ☐ Part-time ☐ PRN/On-call ☐ Live-In

Check the days of the week you are available to work:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Holidays available to work: _____

Name of High School/GED: _____ City: _____ State: _____

Graduation Date: _____

License Type: _____ License/Certification #: _____ State: _____

Expiration Date: _____

Has your professional license ever been suspended, revoked or under investigation?

☐ Yes ☐ No If Yes, Please explain: _____



Certifications

Check all applicable certifications and enter expiration date:

- CPR Expiration Date: _____
- First Aid Expiration Date: _____
- Other Expiration Date: _____

Work Experience

List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.

1. **Facility/Employer Name:** _____
 - Address: _____
 - City/State/Zip: _____
 - Country: _____
 - Unit: _____
 - Number of Beds in Unit: _____
 - In Hospital: _____
 - Describe duties and specialty areas: _____
 - Pay Rate/Salary: Hourly _____ Yearly _____
 - Reason for leaving: _____
 - Are your employment records listed under another name?
 - No
 - Yes - if yes, what name? _____
 - Date Employed
 - From: _____ To: _____
 - Title: _____
 - Name of Current Immediate Supervisor: _____
 - Telephone #: _____
 - May We Contact: Yes No – If no, why? _____
 - If this was a travel assignment, name of agency: _____
 - Supervisory Experience: Yes No – How often? _____



Facility/Employer Name: _____

- Address: _____
- City/State/Zip: _____
- Country: _____
- Unit: _____
- Number of Beds in Unit: _____
- In Hospital: _____
- Describe duties and specialty areas: _____
- Pay Rate/Salary: Hourly _____ Yearly _____
- Reason for leaving: _____
- Are your employment records listed under another name?
 - No
 - Yes - if yes, what name? _____
- Date Employed
 - From: _____ To: _____
- Title: _____
- Name of Current Immediate Supervisor: _____
- Telephone #: _____
- May We Contact: Yes No – If no, why? _____
- If this was a travel assignment, name of agency: _____
- Supervisory Experience: Yes No – How often? _____



Additional Information

1. Are you legally authorized to work in the USA?
 - ☐ Yes
 - ☐ No
2. Have you ever been convicted of a felony?
 - ☐ Yes
 - ☐ No
3. Can you pass a pre-employment drug test?
 - ☐ Yes
 - ☐ No
4. How were you referred to S&S Home Health Care?
 - ☐ Newspaper
 - ☐ Trade Publication
 - ☐ Job Fair/Open House
 - ☐ Internet Site
 - ☐ Company Employee – Name: _____

I understand that I must report all accidents to my immediate supervisor and to S&S Home Health Care – No MATTER HOW SLIGHT.

- Yes

I also understand that I must wear all required personal protection equipment (PPE).

- Yes

The penalty for not wearing PPE is disciplinary action, up to and including termination.

Signature: _____



ACKNOWLEDGMENT (Please read carefully and sign)

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 the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I give S&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. I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by S&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, S&S Home Health Care may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release S&S Home Health Care, its agents, and all affiliated entities, as well as any person or situation that provides 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 and of my being considered for employment by S&S Home Health Care, I agree to abide by all rules and regulations, which I understand are subject to change 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 S&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 S&S Home Health Care, at any time, can constitute a contract of employment. No representative or agent of S&S Home Health Care, 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.

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 the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I understand that S&S Home Health Care is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies S&S Home Health Care against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature _____ Date _____



Name of Candidate: _____ **Potential Position:** _____

Current/Previous Employer: _____ **Type of Business:** _____

Supervisor/Person Contacted: _____ **Position or Title of Person Contacted:**

Telephone Number of Person Contacted: _____ **Date:** _____

Release of Information Name: _____ **Signature:** _____ **Date:** _____

1. I'd like to verify the following information (a) Dates of employment: From _____ to _____. If not correct, dates are from: _____ to _____. (b) Part time or Full time: _____. (c) Salary: He/she started \$_____ per _____. Is that correct? Yes or No. If NO, correct salary: _____. (d) He/she said they held the following position: _____. Is that correct? Yes or No. (e) Do you have an RN supervisor? Yes or No _____ RN Name: _____.
2. Why did he/she leave your company? _____
3. Given the following categories, how would you rate his/her overall work performance:
Above Average _____ Average _____ Below Average _____
4. If given the opportunity to rehire this person, would you do so? Yes _____ or No _____

Reference Check Performed by: _____ **Date:** _____

Company Employee Receiving Information Name: _____ **Date:** _____