Age Line Home Health & Activity Center

EMPLOYMENT FORMS

4350 Rocky River Drive
Cleveland, Ohio 44135
Phone: (216)941-9990
Fax: (216) 941-6127

APPLICANT NAME _____

POSITION APPLYING FOR _____

DATE _____

Please complete and sign all forms in the PRE·EMPLOYMENT FORMS section. Complete and sign forms in the FEDERAUSTATE FORMS section as instructed in each individual form.

Submit the following additional documentation as applicable:

- o Proof of Employment Eligibility (SS Card and visa or proof of citizenship)
- o Licenses/Certifications
- o CPRIAED/First-Aid Certification
- o Driver's License
- o Proof of Auto Liability Insurance
- o Resume (if available)
- o Recent Criminal History Check From the Illinois State Police (if available)
- o Results of a Recent Physical Examination (if available)
- o Results of a Recent TB Exam (if available)
- o Results of Vaccination (if available)
- o Results of a Recent Drug Screening (if available)

Age Line Home Health & Activity Center

PRE-EMPLOYMENT FORMS

CONTENTS

- ☐ APPLICATION FOR EMPLOYMENT
- ☐ EMERGENCY CONTACT
- ☐ EMPLOYEE REFERENCE
- ☐ EMPLOYEE REFERENCE
- ☐ DRIVER CERTIFICATION
- ☐ CONFIDENTIALITY AGREEMENT
- ☐ PROOF OF RESIDENCE
- ☐ HIRE SHEET

INSTRUCTIONS

- ☐ Print – do not write.
- ☐ Answer each question. If a question does not apply, write N/A.
- ☐ Complete and sign all forms.

Age Line Home Health & Activity Center

APPLICATION FOR EMPLOYMENT

AGE LINE HOME HEALTH & ACTIVITY CENTER is an equal opportunity employer and does not discriminate against any applicant or employee because of race,
color, sex, religion, marital status, age, national origin, disability, veteran status, citizenship, or other protected status.

PERSONAL INFROMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

DOB____/____/____

ADDRESS _____ CITY _____ STATE____ ZIP_____

HOME PHONE (____)_____ - _____ CELL PHONE(____)_____ - _____ E-MAIL_____

NEW EMPLOYMENT

POSITION DESIRED_____ SALARY DESIRED_____

DATE AVAILABLE____/____/____ HAVE YOU EVER APPLIED FOR EMPLOYMENT WITH US? ☐ YES ☐ NO

If YES, month and year: _____/20____ Location:_____

HOW WERE YOU REFERRED? _ Company Employee _ Employment Agency _ Career Website (specify): _ Other (specify):_____

ADDITIONAL INFORMATION

ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.? _ YES _ NO

ARE YOU OVER 18 YEARS OF AGE? _ YES _ NO

CAN YOU TRAVEL IF REQUIRED? _ YES _ NO

ARE YOU ABLE TO WORK A NIGHT SHIFT, OVERTIME OR WEEKENDS IF NEEDED? _ YES _ NO

HAVE YOU EVER BEEN CONVICTED OF A CRIME? _ YES _ NO (conviction will not necessarily disqualify applicant from the job applied for)

HAVE YOU BEEN EXCLUDED FROM PARTICIPATING IN FEDERAL HEALTH CARE PROGRAMS? _ YES _ NO

EDUCATION

NAME OF SCHOOL_____ LOCATION_____

LAST YEAR COMPLETED_____ MAJOR DEGREE EARNED_____

HIGH SCHOOL_____ COLLEGE / TECH SCHOOL_____

ADVANCED DEGREE_____

LICENSE VERIFICATION (Up to 3 professional licenses can be provided)

DRIVER'S LICENSE_____ STATE_____ EXPIRATION DATE____/____/____

HAS YOUR LICENSE EVER BEEN REVOKED OR SUSPENDED? _ YES _ NO

TYPE OF LICENSE/CERTIFICATION _ RN _ LPN/LVN _ PT _ OT _ SLP _ MSW _ HHA/I _ Other (specify):_____

LICENSE/CERTIFICATION #_____ STATE_____ EXPIRATION DATE____/____/____

HAS YOUR LICENSE EVER BEEN REVOKED OR SUSPENDED? _ YES _ NO

TYPE OF LICENSE/CERTIFICATION _ RN _ LPN/LVN _ PT _ OT _ SLP _ MSW _ HHA/I _ Other (specify):_____

LICENSE/CERTIFICATION #_____ STATE_____ EXPIRATION DATE____/____/____

HAS YOUR LICENSE EVER BEEN REVOKED OR SUSPENDED _ YES _ NO

TYPE OF LICENSE/CERTIFICATION _ RN _ LPN/LVN _ PT _ OT _ SLP _ MSW _ HHA _ Other (specify):_____

LICENSE/CERTIFICATION #_____ STATE_____ EXPIRATION DATE____/____/____

HAS YOUR LICENSE EVER BEEN REVOKED OR SUSPENDED _ YES _ NO

APPLICATION FOR EMPLOYMENT *CONTINUED*

EMPLOYMENT HISTORY (Starting with the most recent)

COMPANY NAME__________ EMPLOYMENT START___/___/___ EMPLOYMENT END DATE___/___/___
ADDRESS__________
SUPERVISOR'S NAME__________ PHONE (____) ____ - ____
JOB TITLE__________ START PAY RATE______ END PAY RATE______
DESCRIPTION OF DUTIES__________ REASON FOR LEAVING__________

COMPANY NAME__________ EMPLOYMENT START___/___/___ EMPLOYMENT END DATE___/___/___
ADDRESS__________
SUPERVISOR'S NAME__________ PHONE (____) ____ - ____
JOB TITLE__________ START PAY RATE______ END PAY RATE______
DESCRIPTION OF DUTIES__________ REASON FOR LEAVING__________

COMPANY NAME__________ EMPLOYMENT START___/___/___ EMPLOYMENT END DATE___/___/___
ADDRESS__________
SUPERVISOR'S NAME__________ PHONE (____) ____ - ____
JOB TITLE__________ START PAY RATE______ END PAY RATE______
DESCRIPTION OF DUTIES__________ REASON FOR LEAVING__________

COMPANY NAME__________ EMPLOYMENT START___/___/___ EMPLOYMENT END DATE___/___/___
ADDRESS__________
SUPERVISOR'S NAME__________ PHONE (____) ____ - ____
JOB TITLE__________ START PAY RATE______ END PAY RATE______
DESCRIPTION OF DUTIES__________ REASON FOR LEAVING__________

PROVIDE ADDITIONAL INFORMATION THAT YOU THINK WOULD BE HELPFUL TO US IN EVALUATING YOUR APPLICATION

I hereby authorize AGE LINE HOME HEALTH & ACTIVITY CENTER to fully investigate my record and work qualifications and verify licensure/certification before or during my employment, and to facilitate such investigation. All employment is contingent upon successful completion of all background checks as well as physical examination and/or drug/alcohol screen. I so hereby authorize any persons having knowledge thereof to give such information to National Home Health Services upon request.

I certify that all statements made by me on this application for employment and accompanying resume are true and correct. I acknowledge that misrepresentation, falsification or omission of facts may be grounds for rejection of my application; or if discovered after I am employed, such misrepresentation, falsification or omission may result in termination of my employment.

I understand that if employed by the AGE LINE HOME HEALTH & ACTIVITY CENTER, such employment is not for any definite period but is at will and may be terminated by either party at any period of time and without prior notice.

I understand that any offer of employment is conditioned on my ability to establish eligibility under the Immigration Reform and Control Act of 1986.

I certify that I have read the job description for the position for which I have applied.

PRINTED NAME ____________________

SIGNATURE ____________________ DATE ___/___/___

Age Line Home Health & Activity Center

APPLICATION FOR EMPLOYMENT *CONTINUED*

EMERGENCY CONTACT INFORMATION

PERSONAL INFROMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

DOB____/____/____

EMERGENCY CONTACT #1

NAME: _____

ADDRESS: _____

HOME PHONE: (____)____ - _____

BUSINESS PHONE: (____)____ - _____

RELATIONSHIP: _____

EMERGENCY CONTACT #2

NAME: _____

ADDRESS: _____

HOME PHONE: (____)____ - _____

BUSINESS PHONE: (____)____ - _____

RELATIONSHIP: _____

Age Line Home Health & Activity Center

APPLICATION FOR EMPLOYMENT *CONTINUED*

EMPLOYEE REFERENCE

I, _____, have applied for employment with AGE LINE HOME HEALTH & ACTIVITY CENTER. I authorize them to collect any information concerning my qualifications and past performance. Further, I hereby release the company or person completing this form of any and all liability in supplying the requested information.

_____ SIGNATURE

____/____/_____ DATE

REFERENCE INFORMATION (Applicant list your reference in this section)

NAME OF YOUR REFERENCE_____ **TITLE**_____

COMPANY_____

POSITION OF YOUR REFERENCE_____

ADDRESS_____

PHONE (____) ____ - _____ FAX (____) ____ - _____

APPLICANT DO NOT WRITE BELOW THIS LINE

EMPLOYMENT REFERENCE

POSITION HELD_____ WOULD YOU REHIRE? ☐ YES ☐ NO

IF NO, WHY NOT?_____

CHECK APPROPRIATE RATING:

QUALITY OF WORK?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
ATTENDANCE / DEPENDABILITY?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
COOPERATION / ATTITUDE?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
COMMON SENSE?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
FOLLOWS DIRECSTIONS (Verbal & Written)?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
LEADERSHIP (If Applicable)?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE

ADDITIONAL COMMENTS:

_____ SIGNATURE

____/____/_____ DATE

Age Line Home Health & Activity Center

APPLICATION FOR EMPLOYMENT *CONTINUED*

EMPLOYEE REFERENCE

I, _____, have applied for employment with AGE LINE HOME HEALTH & ACTIVITY CENTER I authorize them to collect any information concerning my qualifications and past performance. Further, I hereby release the company or person completing this form of any and all liability in supplying the requested information.

_____ SIGNATURE

_____/_____/_____ DATE

REFERENCE INFORMATION (Applicant list your reference in this section)

NAME OF YOUR REFERENCE_____ **TITLE**_____

COMPANY_____

POSITION OF YOUR REFERENCE_____

ADDRESS_____

PHONE (____) ____ - _____ FAX (____) ____ - _____

APPLICANT DO NOT WRITE BELOW THIS LINE

EMPLOYMENT REFERENCE

POSITION HELD_____ WOULD YOU REHIRE? ☐ YES ☐ NO

IF NO, WHY NOT?_____

CHECK APPROPRIATE RATING:

QUALITY OF WORK?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
ATTENDANCE / DEPENDABILITY?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
COOPERATION / ATTITUDE?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
COMMON SENSE?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
FOLLOWS DIRECSTIONS (Verbal & Written)?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE
LEADERSHIP (If Applicable)?	☐ ABOVE AVERAGE	☐ AVERAGE	☐ BELOW AVERAGE

ADDITIONAL COMMENTS:

_____ SIGNATURE

_____/_____/_____ DATE

Age Line Home Health & Activity Center

APPLICATION FOR EMPLOYMENT *CONTINUED*

DRIVER CERTIFICATION

Each employee who uses an automobile to conduct AGE LINE HOME HEALTH & ACTIVITY CENTER business is required, as a condition of employment, to complete and sign this form in order to certify that s/he has: (1) a valid driver's license and (2)
automobile insurance coverage at or above the minimum levels specified below. If you do not own an automobile but have a valid driver's license, you may be authorized to drive a rental vehicle or agency-owned vehicle on company business with prior approval from your supervisor.

Please complete all information on this form to avoid being prohibited from driving on AGE LINE HOME HEALTH & ACTIVITY CENTER business.

PERSONAL INFROMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

DOB____/____/____

DRIVER'S LICENSE INFORMATION

☐ I do not drive, and I agree not to drive a rental or personal auto, even for brief periods, while on Age Line Home Health & Activity Center business. (Skip to signature line If checking this box)

☐ I do not have a valid driver's license.
☐ I have a valid driver's license issued by the state of _____
Driver's License #: _____ Expiration Date: _____
☐ No Restrictions ☐ Restrictions: Specify _____

AUTO LIABILITY INSURANCE COVERAGE

☐ I do not have a personal automobile
☐ I have auto liability insurance provided through policy number: _____
Issued by _____, in the state of _____
I certify that: (1) the above information is accurate and correct; (2) I will not drive on AGE LINE HOME HEALTH & ACTIVITY CENTER
business without meeting all of the requirements for license and liability coverage; (3) I will notify my immediate supervisor in the event that (a) my driver's license or (b) my liability insurance coverage is no longer in effect; (4) I will abide by the AGE LINE HOME HEALTH & ACTIVITY CENTER policy on *Driving on Company Business*; and (5) I understand that falsification of
information provided on this form is grounds for termination of my employment..

SIGNATURE _____ ____/____/____ DATE

Age Line Home Health & Activity Center
APPLICATION FOR EMPLOYMENT *CONTINUED*

CONFIDENTIALITY AGREEMENT

I hereby acknowledge that in the course of my employment, AGE LINE HOME HEALTH & ACTIVITY CENTER will make available to me confidential data and information. Such electronic verbal and/or written information may consist of, but is not limited to: patient health information; OASIS assessment information; lists of the names and addresses of patients/customers/employees; patients' family histories; information relating to the organization's financial and/or contractual relations with customers; referral sources; administrative manuals; computer generated listings and documents; telephone conversations; directives and policies relating to the internal operations of the organization; and various documents containing information relating to the organization's recruiting, training, operating and soliciting functions. I understand that access to such information is only being made available to me in order that I may perform the duties for which I have been employed I specifically agree that:

1. During the course of my employment I will use such information only in connection with my employment and will not disclose the same to any other person or the general public, except those individuals who are directed to communicate such information at the appropriate time.

2. I will not copy and/or remove any such materials from the organization's premises except as needed to perform the duties for which I am employed.

3. I will ensure the security of such information throughout the day at the close of each day, and in preparation for transport.

4. Following my employment with the organization, I will immediately return to the organization all such materials and all other agency property in my possession.

5. Following my employment with the organization, I will not directly or indirectly:
   a. Disclose, solicit, use, or permit any other person to have access to the organization's materials;
   b. Cause any other individual to breach their confidentiality with the organization or solicit any employee to leave the organization's employ.
   c. Solicit or induce any client of the organization to terminate the relationships the client has with the organization.

6. I understand that any breach of confidentiality as stated herein will entitle the organization to injunctive relief, in addition to disciplinary action, up to and including dismissal.

7. I will abide by the provisions of the "Confidentiality of Information" employment policy.

SIGNATURE _____ DATE ____/____/_____

Age Line Home Health & Activity Center
APPLICATION FOR EMPLOYMENT *CONTINUED*

PROOF OF RESIDENCE

How long have you lived in Ohio? _____

List your last three addresses: _____

Please provide a copy of your most recent utillity bill or rental agreement.

Age Line Home Health & Activity Center
FEDERAL / STATE FORMS

CONTENTS

- ☐ I-9 (EMPLOYMENT ELIGIBILITY VERIFICATION)
- ☐ W-4

INSTRUCTIONS

- ☐ Print – do not write.
- ☐ I-9: Complete Section 1 only, sign and date.
- ☐ W-4: Complete the bottom portion, questions 1 through 7. Sign and date.