EMPLOYMENT APPLICATION

Thank you for your interest in joining our care team.
All fields marked * are required. Please print clearly or type directly into this form.

✓ Applicant Information

FULL NAME *

DATE *

STREET ADDRESS *

CITY *

STATE *

ZIP *

PHONE NUMBER *

EMAIL ADDRESS *

DATE AVAILABLE *

POSITION APPLIED FOR *

DESIRED SALARY *

SSN (LAST 4 DIGITS) *

Eligibility Questions

Are you legally eligible to work in the United States? *

◯ Yes ◯ No

Have you ever worked for Thriving Well at Home before? *

◯ Yes ◯ No

IF YES, WHEN?

Have you ever been convicted of a felony? *

◯ Yes ◯ No

IF YES, PLEASE EXPLAIN

Education

High School

SCHOOL NAME

CITY / STATE

FROM

TO

DID YOU GRADUATE?

DIPLOMA / GED

College / University (add additional sheets if needed)

SCHOOL NAME

CITY / STATE

FROM

TO

DID YOU GRADUATE?

DEGREE / MAJOR

Certifications & Licenses (CNA, CPR, etc.)

CERTIFICATION / LICENSE

ISSUING BODY

EXPIRATION DATE

CERTIFICATION / LICENSE

ISSUING BODY

EXPIRATION DATE

Professional References

Please list three professional references. Do not include family members.

Reference 1

FULL NAME

RELATIONSHIP

PHONE

COMPANY / EMPLOYER

EMAIL

Reference 2

FULL NAME

RELATIONSHIP

PHONE

COMPANY / EMPLOYER

EMAIL

Reference 3

FULL NAME	RELATIONSHIP	PHONE

COMPANY / EMPLOYER	EMAIL

Previous Employment

Please list your last three employers, starting with the most recent.

Employer 1 (Most Recent)

COMPANY NAME | PHONE | FROM | TO

STREET ADDRESS | CITY | STATE | ZIP

SUPERVISOR NAME | JOB TITLE | STARTING PAY

KEY RESPONSIBILITIES

REASON FOR LEAVING

May we contact this supervisor? ○ Yes ○ No

Employer 2

COMPANY NAME | PHONE | FROM | TO

STREET ADDRESS | CITY | STATE | ZIP

SUPERVISOR NAME | JOB TITLE | STARTING PAY

KEY RESPONSIBILITIES

REASON FOR LEAVING

May we contact this supervisor? ○ Yes ○ No

Employer 3

COMPANY NAME | PHONE | FROM | TO

STREET ADDRESS | CITY | STATE | ZIP

SUPERVISOR NAME

JOB TITLE

STARTING PAY

KEY RESPONSIBILITIES

REASON FOR LEAVING

May we contact this supervisor?

Yes No

Military Service (if applicable)

BRANCH OF SERVICE

FROM

TO

RANK AT DISCHARGE

TYPE OF DISCHARGE

IF OTHER THAN HONORABLE, EXPLAIN

Disclaimer & Signature

I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release from employment.

APPLICANT SIGNATURE *

DATE *

SWORN DISCLOSURE STATEMENT

Thriving Well at Home

I understand Section 32.1-162.9:1 of the Code of Virginia requires that any applicant for employment with a licensed home care organization provide the Commissioner's representative with a sworn statement or affirmation disclosing: (1) whether the applicant has a criminal conviction or is the subject of any pending criminal charges within or outside the Commonwealth of Virginia, and (2) whether the applicant has been the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth of Virginia. Such conviction may be relevant if job-related but does not bar you from employment. Further dissemination of the information provided on this form is prohibited other than to the Commissioner's representative or a federal or state authority or court as required by law. Required by Virginia Code 12VAC5-381-110.

FULL NAME *

DATE OF BIRTH *

SSN (LAST 4 DIGITS) *

CURRENT ADDRESS *

1 Have you had any criminal convictions or any pending criminal charges, whether within or outside the Commonwealth of Virginia?

○ **Yes** ○ **No**

IF YES, PLEASE EXPLAIN IN DETAIL:

2 Have you ever been excluded from participating in any federally funded healthcare program?

○ **Yes** ○ **No**

IF YES, PLEASE EXPLAIN IN DETAIL:

3 Have you ever been the subject of a founded complaint of child or elder abuse or neglect, whether within or outside the Commonwealth of Virginia?

○ **Yes** ○ **No**

IF YES, PLEASE EXPLAIN IN DETAIL:

I understand that failure to disclose accurate and complete information may result in disqualification from employment or association with the home care organization. I further understand that any false statements made herein may be punishable under applicable state and federal laws. Any person making a materially false statement when providing such sworn statement or affirmation is guilty upon conviction of a **Class 1 Misdemeanor**.

By signing below, I swear or affirm that the information provided in this disclosure statement is true and correct. I give permission to Thriving Well at Home to obtain a criminal record report from the Virginia Department of State Police.

PRINTED NAME *

DATE *

APPLICANT SIGNATURE *

FOR OFFICE USE ONLY — Sworn Statement Received By:

STAFF SIGNATURE

DATE RECEIVED