



# Sochi Home Health Agency Job Application

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Have you lived in the state of Ohio for the past five (5) years?  Yes  No

Do you have auto (car) insurance?  Yes  No

Do you have any severe allergies?  Cat  Dog  Smoke  None  Other: \_\_\_\_\_

Which certifications do you have?  BLS (CPR/AED)  CPR  First Aid

License(s) or certification(s): \_\_\_\_\_

Special skills/training: \_\_\_\_\_

Honors & awards: \_\_\_\_\_

Have you previously been employed by Sochi Home Health Agency?  Yes  No

- If yes, please list your dates of employment (month & year): \_\_\_\_\_ to \_\_\_\_\_

Are any of your relatives employed by Sochi Home Health Agency?  Yes  No

- If yes, who? \_\_\_\_\_

How did you hear about Sochi Home Health Agency? \_\_\_\_\_

**Military Service**

U.S. Military Service:  Active  Veteran  None

Branch: \_\_\_\_\_ Service dates: \_\_\_\_\_ to \_\_\_\_\_

**Employment Desired**

Position:  RN  LPN  HHA/CNA/STNA  Other: \_\_\_\_\_

Date available to start: \_\_\_\_\_ Pay desired: \_\_\_\_\_  Hourly  Salary

Employment desired:  Full-time  Part-time  PRN Shift(s) desired:  Days  Evenings  Nights

How far are you willing to travel? \_\_\_\_\_  Miles  Minutes

Timeframe(s) available to work each day:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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## **Criminal History**

*All employees are required to undergo a background check, in accordance with law/regulations. Convictions will not necessarily disqualify an applicant for employment.*

Have you ever been convicted of a felony or misdemeanor?  Yes  No

If yes, state the nature of the crime and the date of conviction: \_\_\_\_\_

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Are there any felony or misdemeanor charges currently pending against you?  Yes  No

If yes, state the nature of the charges: \_\_\_\_\_

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## **Emergency Contact Information**

*Please list who we should contact in the event of an accident or medical emergency.*

1. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## **Employment Record**

*Please list your last five (5) employers, beginning with your most recent employer. Include medical, non-medical, summer, or temporary jobs.*

Company: _____	Dates of employment: _____	to _____
Address: _____		
City: _____	State: _____	Phone: _____
Job Title: _____	Supervisor: _____	
Job duties/responsibilities: _____		
Reason for leaving: _____		

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Company: _____ Dates of employment: _____ to _____ Address: _____ City: _____ State: _____ Phone: _____ Job Title: _____ Supervisor: _____ Job duties/responsibilities: _____ Reason for leaving: _____
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## Sochi Home Health Agency Job Application

I certify that all the information provided by me on this application is true and complete. I understand that if any false information, omissions, or misrepresentations are discovered, my application may be rejected and, if I am employed, my employment may be terminated at any time.

In consideration of my employment, I agree to conform to the rules and regulations of Sochi Home Health Agency, LLC and I agree that my employment and compensations can be terminated with cause and with or without notice at any time, at the option of Sochi Home Health Agency, LLC.

I also understand and agree that the terms and condition of my employment may be changed with or without cause and with or without notice, at any time by Sochi Home Health Agency, LLC. I understand that no one other than the Administrator or his or her appointed representative, and only in writing and signed by the Administrator, has any authority to enter into any agreement for the employment for any specific period of time or to make any agreement contrary to the foregoing.

I expressly authorize, without reservation, the employer, its representatives, employees, or agents to contact and obtain information from all references. Employers, public agencies, licensing authorities, and educational institutions to otherwise verify the accuracy of all information provided by me in the application, resume, or job interview. I hereby waive any and all rights and claims I may have regarding the employer, its agents, employees, or representatives for the seeking, gathering, and using such information in the employment process and all other persons, corporations, and organizations for furnishing such information about me.

I understand that the employer does not unlawfully discriminate in employment and no questions on this application are used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by applicable local, state, or federal law.

I understand that if hired, Sochi Home Health Agency is required by law to ask me to provide proof of identify and proof of legal authority to work in the United States.

**Do not sign this form until you have read and fully understand the above application statement.**

I, \_\_\_\_\_, certify that I have read, fully understand, and accept all terms of the above application statement.

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

# Sochi Home Health Agency Employment Verification Form

The applicant named below has applied for employment with our agency. Please verify employment, employment dates, position held, and who their RN Supervisor was at the time of employment. In accordance with OAC 173-39-02.11, any section marked with an asterisk (\*) is required for this form to be used for employment purposes.

**Please fax the completed form to 937-732-5049.**

\*Applicant's Name: \_\_\_\_\_ \*Date of Application: \_\_\_\_\_

I hereby authorize the following information to be released by all my previous employers.

\*Applicant's Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_



## To be Completed by Previous Employer



\*Company Name: \_\_\_\_\_

\*Street Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

\*Position Held: \_\_\_\_\_ Would you rehire this individual?  Yes  No

\*Was this position supervised by an RN?  Yes  No \*Name of RN: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Comments: \_\_\_\_\_

### Form Completed By:

\*Name: \_\_\_\_\_ \*Date: \_\_\_\_\_

\*Job Title: \_\_\_\_\_

**30 W. Rahn Road, Suite 17, Dayton, OH 45429**  
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**sochihomehealth.com**