



## EMPLOYMENT APPLICATION

**INSTRUCTIONS:** If you need help filling out this application form or for any phase of the employment process, please notify the person who gave you this form and every reasonable effort will be made to meet your needs in a reasonable amount of time.

- Please read "Applicant Note" below.
- Complete all pages of this application.
- Print clearly. Incomplete or illegible applications may not be accepted.
- If more space is needed to complete any question, use comments section on the back.
- Application will be valid for 60 days.

**APPLICANT NOTE:** This application form is intended for use in evaluating your qualifications for employment with us, a privately owned and operated Home Care business. This is not an employment contract. Please answer all appropriate questions completely and accurately. False or misleading statements during the interview and on this form are grounds for terminating the application process or, if discovered after employment begins, terminating employment. All qualified applicants will receive consideration and will be treated throughout their employment without regard to race, color, religion, sex, national origin, age, disability, or any other protected class status under applicable law. Additional testing for the presence of illegal drugs in your body may be required prior to employment.

### PERSONAL INFORMATION

Today's Date: \_\_\_\_\_

Positions(s) Applied For: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Current Address: \_\_\_\_\_  
Street City State Zip Code

Previous Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact(s): \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Phone

\_\_\_\_\_  
Name Phone

Professional License # \_\_\_\_\_ State Issued \_\_\_\_\_ Exp Date \_\_\_\_\_

Valid Driver's License #: \_\_\_\_\_ State Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Make & Model of Vehicle: \_\_\_\_\_ Year of vehicle: \_\_\_\_\_

Auto Ins Co: \_\_\_\_\_ Policy # \_\_\_\_\_ Exp Date: \_\_\_\_\_

Have you ever submitted an application here before? **Yes / No** If yes, when? \_\_\_\_\_

Have you ever been employed here before? **Yes / No** If yes, when? \_\_\_\_\_

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

Have you have been given a copy of the job description for the position for which you have applied to review. **Yes / No**  
Are you able to perform the essential functions of the job for which you are applying with or without a reasonable accommodation? **Yes / No**

Why are you interested in employment with us? \_\_\_\_\_

Desired pay rate \_\_\_\_\_

### **AVAILABILITY**

Due to the nature of the business, no guarantee can be made as to the schedule or the amount of hours worked.

What date are you available to begin work? \_\_\_\_\_

Please complete all areas of availability:

\_\_\_\_\_ Mornings \_\_\_\_\_ Afternoon \_\_\_\_\_ Evenings \_\_\_\_\_ Overnights \_\_\_\_\_ Weekdays \_\_\_\_\_ Weekends

Please indicate the days of the week as well as the earliest and latest times that you are available for work.

		<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>
Shift	From:							
	To:							

### **PREFERENCES**

Please indicate the counties in which you are willing to work:

\_\_\_ Gwinnett County \_\_\_ Dekalb County \_\_\_ Walton County \_\_\_ Rockdale County \_\_\_ Newton County

	Companionship	Housekeeping (dust/vacuum)	Errands/Shopping/Transportation*
	Meal Preparation	Laundry/Ironing	Personal Care
	Activities (games/crafts)	Medication Reminders	Dementia/Alzheimer's Care

For Nursing Applicants\* Please indicate the types of Skilled services you are able to provide:

	*Intramuscular injections	*Glucose Monitoring	*Wound Care/Dressing Change
	*Vent Management	*Tube Feeding	*Urinary Catheter insertion
	IV therapy/Injections	*Medication Reminders	*Dementia/Alzheimer's Care

Are you willing to provide service to a client with pets? Yes / No If yes, : \_\_\_\_\_ Cats \_\_\_\_\_ Dogs

Are you willing to provide service to a client that smokes tobacco ? Yes / No

### **JOB RELATED SKILLS**

Describe any training or life skills you have that apply to caring for a senior and/or disabled person:

Describe any work history you have that would apply to caring for a senior and/or disabled person:

What do you like (or think you would like) most about working with older adults and/or disabled person?

What do you like (or think you would like) least about working with older adults and/or disabled person?

What personal rewards do you get from working with seniors and/or a disabled person?

### **EDUCATION \***

Please circle highest grade completed:

Grade School: 6 7 8      High School: 9 10 11 12      College: 13 14 15 16 16+

School Type	School Name	City, State	Major/Subject	# Yrs Attended	Graduate
High School					Y / N
Vocational/Technical					Y / N
College/University					Y / N

\*For employment our minimum education requirement is either a GED or High School diploma

### **WORK HISTORY**

Your application will not be considered unless all questions in this section are answered. Since we will make every effort to contact previous employers, the correct telephone numbers of past employers are essential.

#### **MOST RECENT EMPLOYER**

Are you currently working for this employer? **Yes / No**    If yes, may we contact? **Yes / No**

Company Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Job Title \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Duties \_\_\_\_\_

\$ \_\_\_\_\_ per \_\_\_\_\_  
Salary (Hour, Week, Month) \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

#### **SECOND MOST RECENT EMPLOYER**

Company Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Job Title \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Duties \_\_\_\_\_

\$ \_\_\_\_\_ per \_\_\_\_\_  
Salary (Hour, Week, Month) \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

#### **THIRD MOST RECENT EMPLOYER**

Company Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Job Title \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Duties \_\_\_\_\_

\$ \_\_\_\_\_ per \_\_\_\_\_  
 Salary (Hour, Week, Month) Reason for Leaving \_\_\_\_\_

# **SECURITY**

\*\*\*\*\*Please be sure to complete the attached Authorization to do a criminal and motor vehicle background check.

As a condition of employment all employees must be "Bondable" & "Insurable". Are you at least 19 years of age?

**Yes / No**

List states *and* counties of residence for the past seven years:

Have you had any moving traffic violations? **Yes / No** If yes, please describe: \_\_\_\_\_

Have you been charged/convicted of a felony and/or misdemeanor/or served time **Yes / No** If yes, please describe:

	<u>Incident</u>	<u>City/State</u>	<u>Charge</u>
1)	_____	_____	_____
2)	_____	_____	_____

Have you ever been a charged perpetrator and/or accused of abuse or neglect of others? **Yes or No**

Have you ever appeared on any abuse registry? **Yes or No.**

# **REFERENCES (Do not include relatives)**

Please complete all six references. Your application will not be considered unless six references are provided. Since we will contact these references, please notify them in advance. If we are unable to reach all 4 references, you will be asked to provide additional references.

Full Name	Phone Number	Best Time of Day to Call	Relationship	Number of Years Known
1)	H W			
2)	H W			
3)	H W			
4)	H W			

## APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

American Health Care Management, LLC dba Guiding Star Home Care/Extended Angels Home Care requires, as a condition of employment, and/or continued employment, that all applicants consent to and authorize a verification of the information submitted on their application or resume. **Please read this statement carefully.**

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledge that this Company may now, or at any time while I am employed, conduct a verification of my education, employment history, three (3) years of drug, alcohol and accident history from all Departments of Transportation (DOT)-regulated employers, and motor vehicle records. In addition this company may contact personal references, require that I provide a urine specimen to be tested for the presences of drugs and/ or alcohol, and receive any criminal history record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any state, and/or information as deemed necessary to fulfill the job requirements. I understand that use of illegal drugs is prohibited during employment. I am willing to submit to drug testing to detect use of illegal drugs prior to and during employment.

I authorize American Health Care Management, LLC dba Guiding Star Home Care/Extended Angels Home Care and any of its agents and/or employees to disclose verbally and in writing the results of this verification process to the designated authorized representative of the Company. The results will be used to determine employment eligibility under this Company's employment policies.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide American Health Care Management, LLC dba Guiding Star Home Care/Extended Angels with all information that may be requested, and I hereby release all of the persons and agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge this Company, its agent, and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint files with any agency arising for the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if the employment was denied based on information obtained by my prospective employer, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report.

I understand that this application is not a contract of employment. My employment is contingent upon confirmation of credentials and successful completion of drug test or criminal background check. I also understand that if hired, regardless of any oral presentations to the contrary, the employment relationship between *American HealthCare Management, LLC, dba Guiding Star Home Care/Extended Angels Home Care*, and myself is terminable at-will, so that both the company and I remain free to choose to end out work relationship at any time for any or no reason. Any changes in this employment relationship must be made in writing. My signature below acknowledges that I have read, understand, and agree to the above disclosure. I also understand that due to the nature of the business, no amount of work can be guaranteed.

**Please provide all requested information and provide address for the last seven – (4) years**

\_\_\_\_\_  
(Applicant's Name,Printed-Last, First, Middle)

\_\_\_\_\_  
Maiden or Other Name(s) Used

\_\_\_\_\_  
(Current Address Street, City, State, Zip)

\_\_\_\_\_  
(How Long)

\_\_\_\_\_  
(Previous Address Street, City, State, Zip)

\_\_\_\_\_  
(How Long)

(Date of Birth-for confirmation of ID only) \_\_\_\_\_ Social Security Number \_\_\_\_\_

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE