|  |  |
| --- | --- |
| Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Personal Data | Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Last Name First Name** **Middle** | | | | | **SSN** |
| Home Address City State ZIP | | | | | |
| Home Phone Cell Phone DOB: | | | | | |
|  | | | | | |
| Emergency Contact Information | | | | | |
| Name of Emergency Contact | | Relation | Emergency Telephone Number | | |

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| --- |
| **Job Information** |

Position (Job Class) Applying for:

In-Home Aide  Sitter  Companion  Other \_\_\_\_\_\_\_\_\_\_\_ Date Available: \_\_\_\_\_\_\_\_\_\_

**Previous Facility Types Worked: Check All That Apply –**

Hospital  Hospice  Nursing Home  Rehab  Private Duty  Assisted Living / Residential Treatment

|  |  |
| --- | --- |
| 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  Contract  Travel |

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

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

**Work Experience**

|  |  |
| --- | --- |
| **Facility/Employer Name** | **Date Employed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_\_\_\_\_\_To: \_\_\_\_\_\_\_** |
| **Address** | **Title** |
| **City/State/Zip** |
| **Name of Current Immediate Supervisor Telephone #:** | |
| **Pay Rate/Salary: Hourly \_\_\_\_\_\_\_\_ Yearly \_\_\_\_\_\_\_\_\_\_\_** | **Reason for leaving:** |
| **Are your employment records listed under another name?** | **No  Yes If yes, what name?** |
| **Facility/Employer Name** | **Date Employed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_\_\_\_\_\_To: \_\_\_\_\_\_\_** |
| **Address** | **Title** |
| **City/State/Zip** |
| **Name of Current Immediate Supervisor Telephone #:** | |
| **Pay Rate/Salary: Hourly \_\_\_\_\_\_\_\_ Yearly \_\_\_\_\_\_\_\_\_\_\_** | **Reason for leaving:** |
| **Are your employment records listed under another name?** | **No  Yes If yes, what name?** |
| **Facility/Employer Name** | **Date Employed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_\_\_\_\_\_To: \_\_\_\_\_\_\_** |
| **Address** | **Title** |
| **City/State/Zip** |
| **Name of Current Immediate Supervisor Telephone #:** | |
| **Pay Rate/Salary: Hourly \_\_\_\_\_\_\_\_ Yearly \_\_\_\_\_\_\_\_\_\_\_** | **Reason for leaving:** |
| **Are your employment records listed under another name?** | **No  Yes If yes, what name?** |

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| --- |
| I understand that **I must** report all accidents to my immediate supervisor **and** to Touch of Healing Hands Home Care, LLC - - 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 Touch of Healing Hands Home Care, LLC 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 Touch of Healing Hands Home Care, LLC 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, Touch of Healing Hands Home Care, LLC may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Touch of Healing Hands Home Care, LLC, 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 Touch of Healing Hands Home Care, LLC, 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 Touch of Healing Hands Home Care, LLC 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 Touch of Healing Hands Home Care, LLC, at any time, can constitute a contract of employment. No representative or agent of Touch of Healing Hands Home Care, LLC, 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 Touch of Healing Hands Home Care, LLC 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 Touch of Healing Hands Home Care, LLC 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |