

# SELECT

## Home Health Services, Inc.

Select the best for your health!

### *Employment Application*

In accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, and the Age Discrimination Act of 1975 and their implementing regulations, **Select Home Health Services, Inc.** will not discriminate against any person on the basis of race, color, creed, national origin, religion, sex, marital status, sexual preference, disability, handicap, HIV or age in: admission, treatment, participation in its programs, services and activities, or in employment.

<b>Application Check Off</b> (to be completed by applicant except I-9)		
<input type="checkbox"/> Application with resume	<input type="checkbox"/> Auto Insurance (copy)	<input type="checkbox"/> Form W-4
<input type="checkbox"/> Verification of Employment	<input type="checkbox"/> Professional License (copy)	<input type="checkbox"/> Indiana Form WH-4
<input type="checkbox"/> Physical Exam (copy)	<input type="checkbox"/> CPR Certification (copy)	<input type="checkbox"/> Form I-9 (office to complete)
<input type="checkbox"/> Drivers License (copy)	<input type="checkbox"/> TB Test/X-Ray (copy)	

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

Personal Data			
Last Name	First Name	Middle	SSN
Home Address	City	State	Zip
Home Phone	Cell Phone	Email	

Emergency Contact Information		
Name of Emergency Contact	Relation	Emergency Telephone Number

Educational Information	Highest Grade Completed (1-12 and/or post HS)
Type of program	Institution
Degree, Certification, or Certificate	Year Completed
Type of program	Institution
Degree, Certification, or Certificate	Year Completed

**Job Information**

Position (Job Class) Applying for:

- RN  
  LPN  
  PT  
  OT  
  ST  
  PTA  
  OTA  
  MSW  
  HHA  
  Admin  
  Other \_\_\_\_\_

**Work Experience/Skills**

Please check the areas you have a minimum of 1 year experience and are clinically competent to work:

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Burn        | <input type="checkbox"/> ENT              | <input type="checkbox"/> Pediatrics    | <input type="checkbox"/> Detox/Drug Rehab |
| <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Outpatient Rehab | <input type="checkbox"/> Cardiac Heart | <input type="checkbox"/> Psychiatry       |
| <input type="checkbox"/> Dialysis    | <input type="checkbox"/> Geriatric        | <input type="checkbox"/> Neurology     | <input type="checkbox"/> Operating Room   |
| <input type="checkbox"/> Oncology    | <input type="checkbox"/> CCU              | <input type="checkbox"/> Med/Surgery   | <input type="checkbox"/> Emergency Room   |
| <input type="checkbox"/> Other       | <input type="checkbox"/> Other            | <input type="checkbox"/> Other         | <input type="checkbox"/> Other            |





**Additional Information:**

- 1. Can you provide proof that you are at least 18 years of age?  Yes  No
- 2. Are you legally authorized to work in the USA?  Yes  No
- 3. Have you ever been convicted of a crime?  Yes  No
- 4. Can you pass a pre-employment drug test?  Yes  No
- 5. How were you referred to Select Home Health Services, Inc.?  
 Newspaper  Trade Publication  Job Fair/Open House  Internet Site  
 Company Employee – Name: \_\_\_\_\_

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