

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.

Application Check Off (to be completed by applicant except I-9)						
☐ Application with resume	☐ Auto Insurance (copy)	□ Form W-4				
□ Verification of Employment	□ Professional License (сору)	□ Indiana Form WH-4				
☐ Physical Exam (copy)	☐ CPR Certification (copy	☐ Form I-9 (office to complete)				
□ Drivers License (copy)	□ TB Test/X-Ray (copy)					

			Todayda Pater				
			Today's Date:				
Personal Data							
Last Name	First Name	Midd	le SSN				
Home Address	City	State	Zip				
Home Phone	Cell Phone	9	Email				
Emergency Contact Info	Prmation Relation	l e	marganay Talanhana Number				
Name of Emergency Contact	Relation		mergency Telephone Number				
	<u> </u>						
Educational Information	Highest Grade Completed	(1-12 and/or post HS)					
Type of program	·	Institu	ition				
Degree, Certification, or Certificate		Year C	Completed				
Type of program		Institu	ition				
Degree, Certification, or Certificate		Year (Completed				
		<u> </u>					
Job Information							
Position (Job Class) Applying for	or:						
□RN □LPN □PT □	OT ST PTA C	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:							
Burn	☐ ENT	Pediatrics	☐ Detox/Drug Rehab				
Orthopedics	Outpatient Rehab	Cardiac Heart	Psychiatry				
☐ Dialysis	☐ Geriatric	☐ Neurology	☐ Operating Room				
Oncology	□ ccu	☐ Med/Surgery	☐ Emergency Room				
☐ Other	☐ Other	Other	☐ Other				
							

	s Worked: Check All That Apply ☐ Hospice ☐ Nursing Home ☐ Rehab	☐ Private Dut	y Assisted Living / Residential Treatment		
☐ Home Healt	h				
License Type	License/Certification #	State	Expiration Date		
License Type	License/Certification #	State	Expiration Date		
Language Skills: Other than English, please check any other languages you speak –		Check the type of assignment you are available for:			
☐ Spanish ☐	French German Other:	☐ Full-time	☐ Part-time ☐ Contract ☐ PRN		
Check the day	s of the week you are available to work:				
☐ Monday	☐ Tuesday ☐ Wednesday ☐ Thu	rsday 🗌 Fr	riday 🗌 Saturday 🔲 Sunday		
☐ Holidays a	vailable to work:				
Has your professional license ever been suspended, revoked or under investigation? Yes No If Yes, Please explain:					
Certifications: Check all applicable certifications and enter expiration date:					
☐ ACLS	Expiration Date:	¬	Funitation Date:		
☐ BCLS	Expiration Date:		Expiration Date:		
☐ CPR	Expiration Date:	Other	Expiration Date:		
Work Experience: List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.					
Facility/Employer	Name	Date Emplo	yed		
Address		From:	To:		
City/State/Zip	Country	Name of Cu	rrent Immediate Supervisor		
Describe duties a	nd specialty areas:	Telephone #	#:		
Reason for leaving	g:				
Pay Rate/Salary: Hourly Yearly		If this was a	a travel assignment, name of agency:		
May We Contact: Yes No – If no, why?					
	nent records listed under another name?	Supervisory	y Experience:		
□ No □ Yes	If yes, what name?				

Facility/Employer Name		Date Employed			
		From:	То:		
Address		Title			
City/State/Zip	Country	Name of 0	Current Immediate Supervisor		
Describe duties and specialty areas:		Telephon	ne #:		
Reason for leaving:		<u> </u>			
Dov Dota/Colomy, Havely Veetly		If this was a travel assignment, name of agency:			
Pay Rate/Salary: Hourly Yearly	y				
May Wa Cantact:	whv2	•			
May We Contact: ☐ Yes ☐ No – If no	, wny?				
Are your employment records listed under	another name?	Supervisory Experience: Yes No – How often?			
☐ No ☐ Yes If yes, what name?					
,		<u> </u>			
Facility/Employer Name		Date Employed			
		From: To:			
Address		Title			
City/State/Zip	Country	Name of 0	Current Immediate Supervisor		
		<u> </u>			
Describe duties and specialty areas:		Telephon	Telephone #:		
Reason for leaving:					
		If 4h!	o a traval againment many of annual		
Pay Rate/Salary: Hourly Yearly	y	it this was	s a travel assignment, name of agency:		
	,				
May We Contact: ☐ Yes ☐ No – If no	, why?				
	•				
Are your employment records listed under	another name?	Superviso	sory Experience:	ten?	
☐ No ☐ Yes If yes, what name?					
		<u> </u>			
References (non-relative or former employer)					
Name	Relationship		Phone Number	-	
-					
Name	Relationship		Phone Number	1	
Name	Relationship		Phone Number	1	
				1	
Please list any other work related information you think would be helpful to us in considering you for employment, such as					
specialized training, certifications, additional work experience, etc.					

Additional Information: Can you provide proof that you are at least 18 years of age? Yes Are you legally authorized to work in the USA? Yes 2. No Have you ever been convicted of a crime? Yes 3. No Can you pass a pre-employment drug test? 4. Yes No How were you referred to Select Home Health Services, Inc.? 5. 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 _____