SELECT
Home Health Services, Inc.
Select the best for your health!

SELECT
Senior Care
Select the best for your care!

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, this agency 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 (copy)	□ Indiana Form WH-4
□ Physical Exam (copy)	□ CPR Certification (copy	□ Form I-9 (office to complete)
□ Drivers License (copy)	□ TB Test/X-Ray (copy)	

121 Penn Street, Westfield, IN 46074 Phone: (317) 804-8996 Fax: 317-804-7837 Email: info@selecthhs.com

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:

☐ 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
_____	_____	_____	_____

Previous Types Worked: Check All That Apply
☐ Hospital ☐ Hospice ☐ Nursing Home ☐ Rehab ☐ Private Duty ☐ Assisted Living / Residential Treatment

☐ Home Health ☐ Other: _____

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 days of the week you are available to work:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

☐ Holidays available 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:** _____

☐ **BCLS** **Expiration Date:** _____

☐ **CPR** **Expiration Date:** _____

☐ **IV** **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 Employed** **From:** _____ **To:** _____
Address	**Title**
City/State/Zip **Country**	**Name of Current Immediate Supervisor**
Describe duties and specialty areas:	**Telephone #:**
Reason for leaving:	
Pay Rate/Salary: Hourly _____ **Yearly** _____	**If this was a travel assignment, name of agency:**
May We Contact: ☐ **Yes** ☐ **No – If no, why?**	
Are your employment records listed under another name? ☐ **No** ☐ **Yes If yes, what name?**	**Supervisory Experience:** ☐ **Yes** ☐ **No – How often?**

Facility/Employer Name	**Date Employed** **From: _____ To: _____**
Address	**Title**
City/State/Zip Country	**Name of Current Immediate Supervisor**
Describe duties and specialty areas:	**Telephone #:**
Reason for leaving:	
Pay Rate/Salary: Hourly _____ Yearly _____	**If this was a travel assignment, name of agency:**
May We Contact: ☐ Yes ☐ No – If no, why?	
Are your employment records listed under another name? **☐ No ☐ Yes If yes, what name?**	**Supervisory Experience: ☐ Yes ☐ No – How often?**
Facility/Employer Name	**Date Employed** **From: _____ To: _____**
Address	**Title**
City/State/Zip Country	**Name of Current Immediate Supervisor**
Describe duties and specialty areas:	**Telephone #:**
Reason for leaving:	
Pay Rate/Salary: Hourly _____ Yearly _____	**If this was a travel assignment, name of agency:**
May We Contact: ☐ Yes ☐ No – If no, why?	
Are your employment records listed under another name? **☐ No ☐ Yes If yes, what name?**	**Supervisory Experience: ☐ Yes ☐ No – How often?**

References (non-relative or former employer)		
Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**

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:

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 _____