

# A & B Home Health Care, Inc.

## Employment Application

**NOTICE: All employees must be able to pass a criminal background check of all offenses listed in the Statement of Employability. Please refer to the Statement of Employability before completing this employment application.**

Date: \_\_\_\_\_

**PERSONAL**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Position Applied for: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Transportation:      Do you have a valid Texas Driver's License?      Yes      No  
Circle one

All persons shall have the opportunity to be considered for employment without regards to their race, color, religion, national origin, or ancestry, age, disability, sex, marital status, liability for service in the armed forces of the United States, citizenship, or any other characteristic protected by law.

Have you ever used another name for work, School or other business purpose? If so, Identify all names and dates used.

	<small>Date</small>		<small>Date</small>
--	---------------------	--	---------------------

Are you 16 years or older?      Yes      No

Identify all languages in which you are proficient:

English:	Speak	Read	Write	_____:	Speak	Read	Write
Spanish:	Speak	Read	Write	_____:	Speak	Read	Write

Have you ever had a nursing, trade, or other professional license which is issued by any governmental authority or professional organization denied, limited, suspended, revoked, or voluntarily relinquished?      Yes      No

Have you ever been reprimanded, sanctioned, disciplined or otherwise cited for misconduct by any governmental authority professional or trade organization?      Yes      No

Have you ever had any malpractice claims, suits, and settlement or arbitration proceedings involving your professional practice?      Yes      No

# A & B Home Health Care, Inc.

## Employment Application

<b>EDUCATION</b>				
<b>Public/Private School</b>				
Name of School	City	- Dates	Yes Graduated?	No Degree?
Name of School	City	- Dates	Yes Graduated?	No Degree?
<b>Vocational/Technical</b>				
Name of School	City	- Dates	Yes Graduated?	No Degree?
Name of School	City	- Dates	Yes Graduated?	No Degree?
<b>College/University</b>				
Name of School	City	- Dates	Yes Graduated?	No Degree?
Name of School	City	- Dates	Yes Graduated?	No Degree?
<b>Post Graduate</b>				
Name of School	City	- Dates	Yes Graduated?	No Degree?
Name of School	City	- Dates	Yes Graduated?	No Degree?
<b>Additional Education</b>				
Name of School	City	- Dates	Yes Graduated?	No Degree?
Name of School	City	- Dates	Yes Graduated?	No Degree?

### PROFESSIONAL LICENSING and/or CERTIFICATION

Type/Number	Organization or State Issued	Initial License Issue Date	Expiration Date

### PROFESSIONAL REFERENCES (List the names of two professional references, excluding relatives or former employers.)

NAME	ADDRESS	PHONE
NAME	ADDRESS	PHONE

# A & B Home Health Care, Inc.

## Employment Application

Have you ever been terminated from employment or asked to resign by any employer? Yes No

If yes, provide complete information on employer, location, date, and circumstances:

---

---

---

Use this space to give us other information about your personal qualities, work style, interpersonal skills, or communication skills which would assist us in placing you.

---

---

---

---

---

### WORK HISTORY

*Present Employer*

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

Address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Salary: \_\_\_\_\_

Your work name if different: \_\_\_\_\_

Dates Worked From: \_\_\_\_\_ To: \_\_\_\_\_ Hrs/Wk: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Shift: \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

May we call your present/past employer to verify work status? Yes No

If no please explain:

---

---

---

# A & B Home Health Care, Inc.

## Employment Application

Name: _____	Phone: _____
Address: _____	
Job Title: _____	Salary: _____
Your work name if different: _____	
Dates Worked From: _____	To: _____ Hrs/Wk: _____
Supervisor: _____	Shift: _____
Duties: _____	
Reason for Leaving: _____	

Name: _____	Phone: _____
Address: _____	
Job Title: _____	Salary: _____
Your work name if different: _____	
Dates Worked From: _____	To: _____ Hrs/Wk: _____
Supervisor: _____	Shift: _____
Duties: _____	
Reason for Leaving: _____	

**The following section must be completed if you are applying for a position, which requires the operation of a motor vehicle owned or leased by the company or you are required to use your own vehicle.**

Drivers License Number	State	Expiration Date
Has your driver's license ever been denied, limited, suspended and/or revoked?		YES      NO
(If YES, provide complete information on dates, action, governmental authority and current license status.)		

Accident Record (List all accidents in which you were involved as a driver during the past 3 years)			
Date	Nature	# of Fatalities	Persons Injured

# A & B Home Health Care, Inc.

## Employment Application

### ACKNOWLEDGMENT (Please read carefully and sign.)

By 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, correct, and complete. I also understand that false, misleading, incomplete, or omitted information on this application or during any interview for employment, will be cause for immediate dismissal from employment, if hired.

I authorize A & B Home Health Care, Inc., and its agents, to use any information in this application to verify the information contained herein, and I authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by A & B Home Health Care, Inc. with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment, A & B Home Health Care, Inc. may conduct a criminal background investigation and that my employment with A & B Home Health Care, Inc. is contingent on the results of such investigation. I release A & B Home Health Care, Inc., its agents, and all affiliated entities, as well as any person or institution that provides A & B Home Health Care, Inc. with 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 A & B Home Health Care, Inc., I agree to abide by all A & B Home Health Care, Inc. Policies and Procedures, which I understand are subject to change by A & B Home Health Care, Inc. at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and will be employed for no definite period of time. I understand that either A & B Home Health Care, 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 orally or written, by any representative of A & B Home Health Care, Inc. at any time, can constitute a contract of employment.

In addition, I understand that A & B Home Health Care, Inc. and all compensation and benefit administrators have the maximum discretion permitted by law to administer, interpret, modify, discontinue, enhance or otherwise administer, interpret or change all policies, procedures, benefits or other terms and conditions of employment.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

# A & B HOME HEALTH CARE, INC.

## REFERENCE CHECK

One of your associates or former employees has applied for employment with A & B Home Health Care, Inc. and has authorized this request for information about employment and performance. Information you provide will be held in strict confidence. Please complete and return this addressed reply form at your earliest convenience.

I hereby authorize this release of all information requested on this form.

\_\_\_\_\_  
Applicant Signature Date

Verifying Employer: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ SS# \_\_\_\_\_

Name Used While Employed: \_\_\_\_\_

Employment Dates: From \_\_\_\_\_ To \_\_\_\_\_ Position: \_\_\_\_\_

Check if telephone reference ( ) and sign below.

Are the Employment Dates Correct? Yes ( ) No ( )

Correct Employment Dates: \_\_\_\_\_ Eligible for Rehire? Yes ( ) No ( )

Reason for Leaving: \_\_\_\_\_

Please Evaluate the Applicant on the Following:

	Excellent	Good	Average	Poor	Not Known
Performance					
Attendance					
Cooperation					
Personal Appearance					
Judgment					
Initiative					

Comments: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
A & B Home Health Care, Inc. Representative

Date: \_\_\_\_\_

# A & B HOME HEALTH CARE, INC.

## REFERENCE CHECK

One of your associates or former employees has applied for employment with A & B Home Health Care, Inc. and has authorized this request for information about employment and performance. Information you provide will be held in strict confidence. Please complete and return this addressed reply form at your earliest convenience.

I hereby authorize this release of all information requested on this form.

\_\_\_\_\_  
Applicant Signature Date

Verifying Employer: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ SS# \_\_\_\_\_

Name Used While Employed: \_\_\_\_\_

Employment Dates: From \_\_\_\_\_ To \_\_\_\_\_ Position: \_\_\_\_\_

Check if telephone reference ( ) and sign below.

Are the Employment Dates Correct? Yes ( ) No ( )

Correct Employment Dates: \_\_\_\_\_ Eligible for Rehire? Yes ( ) No ( )

Reason for Leaving: \_\_\_\_\_

Please Evaluate the Applicant on the Following:

	Excellent	Good	Average	Poor	Not Known
Performance					
Attendance					
Cooperation					
Personal Appearance					
Judgment					
Initiative					

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

A & B Home Health Care, Inc. Representative