



Employment Application

We are an equal opportunity employer. Applicants are considered for positions without regard to race, religion, sexual orientation, national origin, age, disability, or any other category protected by applicable federal, state, or local laws.

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email _____

Gender: _____ Desired Salary: \$ _____

Position Applied for: _____

Are you a citizen of the United States? YES NO If no, are you authorized to work in the U.S.? YES NO

Have you ever worked for this company? YES NO If yes, when? _____

Emergency Contact _____ Relationship _____ Phone # () _____

Have you been referred for this position? Yes No Referred by: _____

Available Start Date: _____

CRIMINAL OFFENSES

Have you ever plead guilty or no contest to, or been convicted of any criminal offense? Yes No do not include convictions that were sealed, eradicated, erased, annulled by a court, or expunged.

If you answered yes, to the above question, please explain so individual circumstances can be considered.

Criminal convictions or arrests will not automatically disqualify an applicant from a particular job. PREMIER HEALTH GROUP will consider the nature of the crime, its seriousness, the substantial relation to the position's functions and qualifications, the number of occurrences, the applicant's age at the time of the crime, the time elapsed since the crime, the applicant's work and educational history, employment references and recommendations, and the business necessity of any exclusion when required by law.

Have you ever initiated an act of violence in the workplace? Yes No

If Yes, please provide the date(s) and explain so that individual circumstances can be considered. (A "Yes" answer will not necessarily disqualify you from employment.)

LIST ALL THE PLACES YOU HAVE LIVED IN THE LAST SEVEN (7) YEARS

Current _____ I lived there _____ Years
Street and Apt. City/State/Zip

Previous _____ I lived there _____ Years
Street and Apt. City/State/Zip

Previous _____ I lived there _____ Years
Street and Apt. City/State/Zip

Previous _____ I lived there _____ Years
Street and Apt. City/State/Zip

Education

High School: _____ Location: _____

From: _____ To: _____ Did you graduate? YES NO Diploma: _____

College: _____ Location: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

Vocational/Post graduate: _____ Location: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

Previous Employment (Last 7 years)

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:\$ _____ Ending Salary:\$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:\$ _____ Ending Salary:\$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:\$ _____ Ending Salary:\$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Have you ever been terminated or asked to resign from any job? Yes No

If Yes, how many times? _____

Has your employment ever been terminated by mutual agreement? Yes No

If Yes, how many times? _____

Have you ever been given the choice to resign rather than be terminated? Yes No

If Yes, how many times? _____

If you answered Yes to any of the above three questions, please explain the circumstances of each occasion.

List any Specialized Medical/ Nursing/ Clinical License or Credentials

Type of License	State of Issuance	Expiration Date

RESUME (Disregard/ Skip if you have provided a resume)

Name: _____

Address: _____

Phone: _____ **Email:** _____

EDUCATION

Highschool: _____ Date Completed: _____

College/ University: _____ Date Completed: _____

Other: _____ Date Completed: _____

WORK EXPERIENCE

Company: _____ From: _____ To: _____

Duties

Company: _____ From: _____ To: _____

Duties

Company: _____ From: _____ To: _____

Duties

SKILLS

EMPLOYEE REFERENCE FORM

Name of Candidate _____ have applied for employment at PREMIER HEALTH GROUP. PREMIER HEALTH GROUP is a Home Health Agency and provides services to individuals with physical disabilities, chronic illnesses and intellectual disabilities and the elderly. I have given your name as a reference on my application for employment. I hereby authorize Premier to collect information concerning my qualifications and past performance. I hereby release the company or person completing this form of any and all liability in supplying the requested information.

Candidate's Signature _____

Candidate's Signature _____

Name of Your Reference	Address of Reference
Name of Company	Phone Number
Position Held at Company	Fax Number

My Classification was RN/ LPN/ CNA/ HHA/ OTHER _____

Dates of Employment: From _____ To _____

I was terminated / resigned / still working.

Reason for Leaving: _____

Applicants Do Not Write Below this Line

Key Competencies	Excellent	Good	Fair	Poor	N/A
Knowledge					
Problem solving					
Interpersonal skills					
Communication Skills					
Punctuality					
Initiative					
Dependability					
Ability to get along with others					
Overall rating					

Duties Performed: _____

Would you rehire this individual? Yes / No Suitable to work with sick individuals? Yes / No

Comments _____

Completed by: _____ Signature: _____ Date: _____

EMPLOYEE REFERENCE FORM

Name of Candidate _____ have applied for employment at PREMIER HEALTH GROUP. PREMIER HEALTH GROUP is a Home Health Agency and provides services to individuals with physical disabilities, chronic illnesses and intellectual disabilities and the elderly. I have given your name as a reference on my application for employment. I hereby authorize Premier to collect information concerning my qualifications and past performance. I hereby release the company or person completing this form of any and all liability in supplying the requested information.

Candidate's Signature _____

Date _____

Name of Your Reference	Address of Reference
Name of Company	Phone Number
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Initiative					
Dependability					
Ability to get along with others					
Overall rating					

Duties Performed: _____

Would you rehire this individual? Yes / No Suitable to work with sick individuals? Yes / No

Comments _____

Completed by: _____ Signature: _____ Date: _____

Voluntary Self-Identification of Veteran Status

Why are you being asked to complete this form?

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active-duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans.

These classifications are defined as follows:

1. A "disabled veteran" is one of the following:
 - A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
 - A person who was discharged or released from active duty because of a service-connected disability.
2. A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
3. An "active-duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
4. An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA—the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

1. If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE

I AM NOT A PROTECTED VETERAN

I DON'T WISH TO ANSWER

2. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.
3. The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

Your Name

Date

Voluntary Self-Identification of Disability

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

- Yes, I Have A Disability, Or Have A History/Record Of Having A Disability
- No, I Don't Have A Disability, Or A History/Record Of Having A Disability
- I Don't Wish To Answer

EEO-1 Voluntary Self Identification Form

The Equal Employment Opportunity Commission (EEOC) requires all private employers with 100 or more employees as well as federal contractors and first-tier subcontractors with 50 or more employees AND contracts of at least \$50,000 complete an EEO-1 report each year. Covered employers must invite employees to self-identify gender and race for this report.

Completion of this form is voluntary and will not affect your opportunity for employment, or the terms or conditions of your employment. This form will be used for EEO-1 reporting purposes only and will be kept separate from all other personnel records only accessed by the Human Resources department. Please return completed forms to the HR department.

If you choose not to self-identify your race/ethnicity at this time, the federal government requires PREMIER HEALTH GROUP to determine this information by visual survey and/or other available information.

NAME: _____

JOB TITLE: _____

DATE COMPLETED: _____

GENDER:

(Please check one of the options below)

____ Male

____ Female

RACE/ETHNICITY:

(Please check one of the descriptions below corresponding to the ethnic group with which you identify.)

___ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

___ **White (Not Hispanic or Latino):** A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

___ **Black or African American (Not Hispanic or Latino):** A person having origins in any of the black racial groups of Africa.

___ **Native Hawaiian or Pacific Islander (Not Hispanic or Latino):** A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.

___ **Asian (Not Hispanic or Latino):** A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

___ **Native American or Alaska Native (Not Hispanic or Latino):** A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

___ **Two or more races (Not Hispanic or Latino):** All persons who identify with more than one of the above five races.

___ **I do not wish to disclose.**

Applicant Signature Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

I understand and agree that if driving is a requirement of the job for which I am applying, my employment and/or continued employment is contingent on possessing a valid driver's license for the state in which I reside and automobile liability insurance in an amount equal to the minimum required by the state where I reside.

I understand that the Company may now have, or may establish, a drug-free workplace or drug and/or alcohol testing program consistent with applicable federal, state, and local law. If the Company has such a program and I am offered a conditional offer of employment, I understand that if a pre-employment (post-offer) drug and/or alcohol test is positive, the employment offer may be withdrawn. I agree to work under the conditions requiring a drug-free workplace, consistent with applicable federal, state, and local law. I also understand that all employees of the location, pursuant to the Company's policy and federal, state, and local law, may be subject to urinalysis and/or blood screening or other medically recognized tests designed to detect the presence of alcohol or illegal or controlled drugs. If employed, I understand that the taking of alcohol and/or drug tests is a condition of continual employment and I agree to undergo alcohol and drug testing consistent with the Company's policies and applicable federal, state, and local law.

If employed by the Company, I understand and agree that the Company, to the extent permitted by federal, state, and local law, may exercise its right, without prior warning or notice, to conduct investigations of property (including, but not limited to, files, lockers, desks, vehicles, and computers) and, in certain circumstances, my personal property. I understand and agree that as a condition of employment and to the extent permitted by federal, state, and local law, I may be required to sign a confidentiality, restrictive covenant, and/or conflict of interest statement, as well as an agreement to arbitrate. I understand that as a condition of employment, I agree to accurately report services and time on timesheets I submit to the Company during the course of my employment.

I certify that all the information on this application, my résumé, or any supporting documents I may present during any interview is and will be complete and accurate to the best of my knowledge. I understand that any falsification, misrepresentation, or omission of any information may result in disqualification from consideration for employment or, if employed, disciplinary action, up to and including immediate dismissal.

THE COMPANY IS AN AT-WILL EMPLOYER AS ALLOWED BY APPLICABLE STATE LAW. THIS MEANS THAT REGARDLESS OF ANY PROVISION IN THIS APPLICATION, IF HIRED, THE COMPANY OR I MAY TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME, FOR ANY REASON, WITH OR WITHOUT CAUSE OR NOTICE. NOTHING IN THIS APPLICATION OR IN ANY DOCUMENT OR STATEMENT, WRITTEN OR ORAL, SHALL LIMIT THE RIGHT TO TERMINATE EMPLOYMENT AT-WILL. NO OFFICER, EMPLOYEE OR REPRESENTATIVE OF THE COMPANY IS AUTHORIZED TO ENTER INTO AN AGREEMENT—EXPRESS OR IMPLIED—WITH ME OR ANY APPLICANT FOR EMPLOYMENT FOR A SPECIFIED PERIOD OF TIME UNLESS SUCH AN AGREEMENT IS IN A WRITTEN CONTRACT SIGNED BY AN OFFICER OF THE COMPANY.

IF HIRED, I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY, AND I UNDERSTAND THAT THE COMPANY HAS COMPLETE DISCRETION TO MODIFY SUCH RULES AND REGULATIONS AT ANY TIME, EXCEPT THAT IT WILL NOT MODIFY ITS POLICY OF EMPLOYMENT AT-WILL.

I authorize the Company or its agents to confirm all statements contained in this application and/or résumé as it relates to the position I am seeking and to the extent permitted by federal, state, or local law. I agree to complete any requisite authorization forms for the background investigation.

I authorize and consent to, without reservation, any party or agency contacted by this employer to furnish the above-mentioned information. I hereby release, discharge, and hold harmless, to the extent permitted by federal, state, and local law, any party delivering information to the Company or its duly authorized representative pursuant to this authorization from any liability, claims, charges, or causes of action which I may have as a result of the delivery or disclosure of the above requested information. I hereby release from liability the Company and its representative for seeking such information and all other persons, corporations, or organizations furnishing such information.

If hired by this Company, I understand that I will be required to provide genuine documentation establishing my identity and eligibility to be legally employed in the United States by this Company. I also understand this Company employs only individuals who are legally eligible to work in the United States.

THIS APPLICATION WILL BE CONSIDERED ACTIVE FOR A MAXIMUM OF SIXTY (60) DAYS. IF YOU WISH TO BE CONSIDERED FOR EMPLOYMENT AFTER THAT TIME, YOU MUST REAPPLY. I CERTIFY THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE.

Signature: _____ Date: _____