



HOWARD COUNTY

Home Health
and Hospice

101 Furr Street

Fayette, MO 65248

Phone 660-248-2100 or toll free 866-748-2100;

Fax 660-248-3347 or toll free 866-348-3347

www.hchhh.org

Application for Employment

(Revised 7-18-07)

Please fill out this application to the best of your ability.

Date _____

Full Name _____ Phone Number _____

Position Applied For _____ Full Time Part Time PRN

When would you be available to start employment with us? _____

Any specialized training, apprenticeship programs or special job-related skills _____

Military History: Job Related Training _____

Personal

Have you ever been convicted of any crime (any felony or misdemeanor in any jurisdiction)? Convictions will not automatically disqualify you from employment. Yes No

If yes, please explain _____

If you are applying for a position that requires driving, do you have the appropriate license? Yes No

If you are applying for a position that requires driving, have you been ticketed for a moving violation in the last three (3) years? Yes No

If yes, please explain _____

Can you provide proof of identification and proof of eligibility to work in this country (green card, social security card, passport, etc.)? Yes No

If you are under eighteen (18) years of age, can you provide proof of eligibility to work? Yes No

Have you ever applied with us before? Yes No

If yes, when? _____

Have you ever been employed with us before? Yes No

If yes, when? _____

Can you perform the essential job functions of the position for which you are applying? Yes No

References

References must include one supervisor or coworker. Providing this information means that you give this organization permission to contact the references listed.

Name _____	Phone _____			
Relationship: <input type="checkbox"/> Friend	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Supervisor	<input type="checkbox"/> Family Member	<input type="checkbox"/> Other _____
Name _____	Phone _____			
Relationship: <input type="checkbox"/> Friend	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Supervisor	<input type="checkbox"/> Family Member	<input type="checkbox"/> Other _____
Name _____	Phone _____			
Relationship: <input type="checkbox"/> Friend	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Supervisor	<input type="checkbox"/> Family Member	<input type="checkbox"/> Other _____
Name _____	Phone _____			
Relationship: <input type="checkbox"/> Friend	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Supervisor	<input type="checkbox"/> Family Member	<input type="checkbox"/> Other _____

I have the following concerns and/or comments about potentially negative references or information that may be revealed through the Agency's background investigation regarding my previous employment information, education information, references, licensing or certification information or criminal records: _____

Applicant's Acknowledgement

I certify that the answers given in this application are true and complete to the best of my knowledge. I authorize Howard County Home Health and Hospice to investigate all statements that I have made in this application as may be necessary in reaching an employment decision.

In the event that I am employed, I understand that any false or misleading information that I knowingly provided on this application or in any interview(s) may result in termination from employment and/or legal action. I understand also that if employed by Howard County Home Health and Hospice, I am required to abide by all rules and regulations of the Agency and by any and all special agreements, written or verbal, as reached by the Agency and myself.

This application will be considered active for no more than one (1) year. After that time, applicants will be required to resubmit a separate completed application.

This applicant understands that neither this document, nor any offer of employment from this employer, constitutes an employment contract unless a specific document is executed in writing by the employer and employee.

Unless a specific document is executed in writing by the employer and employee, all employment here will be at will. Just as an employee may resign for any reason, the employer may terminate an employee for any reason.

I certify that all information on this application is accurate, true, and complete to the best of my knowledge.

Signature of applicant

Date

Employment Inquiry Release

In connection with your application for/continuing employment with Howard County Home Health and Hospice, on our behalf, EMPFACTS will make inquiries, including but not limited to, your education, professional licensing, criminal history, driving history, personal character, abilities, work habits, residency, immigration status, general reputation, performance, experience and other qualities pertinent to your qualifications for employment, including reasons for termination of past employment.

In compliance with the Fair Credit Reporting Act, you are entitled to be informed if an offer of employment is withheld because of information obtained from EMPFACTS and, in the event, upon your written request, we will provide a copy of the report we receive and the FTC notice, "A Summary of Your Rights Under the Fair Credit Reporting Act."

Please complete and sign the form which follows, authorizing, without reservation, any party, including, but not limited to, employers, law enforcement agencies, state agencies, institutions and private information bureaus or repositories, contacted by EMPFACTS to furnish any or all of the above mentioned information. Your authorization releases EMPFACTS from any and all liability for damages arising from the investigation and disclosure of the requested information. Further, it releases and discharges all liability from all companies, agencies, officers, employees and other persons who, in good faith, provide a background investigation for your application for employment. Your signature allows a photocopy or fax of this authorization to be as valid as the original.

Print Full Name _____ *Date of Birth _____
Social Security # _____ Maiden Name _____
Street Address _____ Other Names Used _____
City, State, Zip _____ Drivers License _____
High School _____ Address _____
Phone _____ Graduation Date _____
College/Trade School _____ Address _____
Phone _____ Graduation Date _____ Degree _____
Employer & Address _____
Job Title & Duties/Responsibilities _____
Dates of Employment: From _____ To _____ Supervisor _____
May we contact employer for reference <input type="checkbox"/> Yes <input type="checkbox"/> No Reason for Leaving _____
Employer & Address _____
Job Title & Duties/Responsibilities _____
Dates of Employment: From _____ To _____ Supervisor _____
May we contact employer for reference <input type="checkbox"/> Yes <input type="checkbox"/> No Reason for Leaving _____
Professional License Type _____ License Number _____ Exp. Date _____

Applicant Signature _____

*Date of birth is being requested only for the purposes of identification in obtaining accurate retrieval of records and it will not be used for discriminatory purposes.