

(Please Print in Ink)

In considering your application for employment; the facility may conduct a detailed and thorough investigation which may include but is not limited to a criminal record check, interviews or inquiries of prior employers, coworkers, acquaintances, relative or friends.

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LAST NAME	FIRST	MIDDLE	
PRESENT ADDRESS	CITY	STATE	ZIP
PERMANENT ADDRESS	CITY	STATE	ZIP

POSITION APPLIED FOR: _____

HOW DID YOU LEARN ABOUT THIS POSITION? _____

RELATIVES OR FRIENDS EMPLOYED AT _____ YES___ NO___
 HAVE YOU EVERY BEEN EMPLOYED BY THIS COMPANY YES___ NO___
 ARE YOU 18 YEARS OF AGE OR OLDER YES___ NO___
 ARE YOU A U.S. CITIZEN OR AN ALIEN LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES YES___ NO___

HOME TELEPHONE NO.. _____

CELL PHONE NO. _____

E-MAIL ADDRESS _____

DATE AVAILABLE FOR WORK _____

CHECK ALL OU WOULD CONSIDER WORKING
 FULL TIME/REGULAR _____
 FULL TIME TEMPORARY _____
 PART TIME REGULAR _____
 PART TIME TEMPORARY _____

WOULD YOU CONSIDER WORKING?
 WEEKENDS YES___ NO___
 ROTATING SHIFT YES___ NO___
 ON CALL YES___ NO___
 ANY SHIFT YES___ NO___

SHIFT AVAILABILITY
 DAYS___ EVENINGS___ NIGHTS___

LONG RANGE OCCUPATIONAL GOALS: _____

HAVE YOU EVER BEEN CONVICTED OF, OR PLEAD GUILTY TO, A CRIME OTHER THAN A MISDEMEANOR TRAFFIC VIOLATION YES___ NO___ IF YES, WHICH STATE(S) AND EXPLAIN:
 (You are not required to disclosed any sealed or expunged criminal records)

HAVE YOU EVER BEEN INVOLVED IN SUBSTANTIATED ABUSE, OR NEGLECT OF CHILDREN OR ADULTS UNDER THE LAWS OF THIS OR ANY OTHER STATE OF THE UNITED STATES YES___ NO___ IF YES, WHICH STATE(S), AND EXPLAIN:

HAVE YOU BEEN SANCTIONED, CITED, REPORTED, OR EXCLUDED FROM PARTICIPATION IN MEDICARE, MEDICAID, OR ANY OTHER HEALTHCARE RELATED LAW OR REGULATION YES___ NO___ IF YES, EXPLAIN:

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SCHOOL	NAME AND ADDRESS OF SCHOOL	COURSE OF STUDY	LAST YEAR COMPLETED				DID YOU GRADUATE	LIST DIPLOMA/DEGREE
HIGH			1	2	3	4		
COLLEGE			1	2	3	4		
COLLEGE			1	2	3	4		
OTHER			1	2	3	4		

AREAS OF SPECIALIZATION OR MAJOR INTEREST: _____

LIST OFFICE SKILLS INCLUDING COMPUTER/SOFTWARE EXPERIENCE: _____

LIST HEALTH CARE EQUIPMENT OPERATED: _____

PROFESSIONAL LICENSES

___ CURRENTLY LICENSED ___ ELIGIBLE FOR LICENSE
 ___ CURRENTLY REGISTERED ___ ELIGIBLE FOR REGISTRATION:
 TYPE: _____ STATE+ _____ LICENSE OR REGISTRATION EVER SUSPENDED, REVOKED OR ON PROBATION
 NO. _____ DATE: _____ __ YES___ NO IF YES, EXPLAIN: _____

PROFESSIONAL CERTIFICATIONS

___ CURRENTLY CERTIFIED
 ___ ELIGIBLE FOR CERTIFICATION
 TYPE: _____ STATE: _____ DATE: _____
 OTHER: _____



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PREVIOUS EMPLOYMENT BEGINNING WITH MOST RECENT EMPLOYER

JOB TITLE: _____ FROM: (MO/YR) _____ TO: (MO/YR) _____ SUPERVISOR: _____ SALARY _____

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

DUTIES: _____

REASON FOR LEAVING: _____

JOB TITLE: _____ FROM: (MO/YR) _____ TO: (MO/YR) _____ SUPERVISOR: _____ SALARY _____

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

DUTIES: _____

REASON FOR LEAVING: _____

JOB TITLE: _____ FROM: (MO/YR) _____ TO: (MO/YR) _____ SUPERVISOR: _____ SALARY _____

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

DUTIES: _____

REASON FOR LEAVING: _____

JOB TITLE: _____ FROM: (MO/YR) _____ TO: (MO/YR) _____ SUPERVISOR: _____ SALARY _____

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

DUTIES: _____

REASON FOR LEAVING: _____

JOB TITLE: _____ FROM: (MO/YR) _____ TO: (MO/YR) _____ SUPERVISOR: _____ SALARY _____

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

DUTIES: _____

REASON FOR LEAVING: _____

PLEASE IDENTIFY AND EXPLAIN ANY GAPS IN EMPLOYMENT LONGER THAN THREE (3) MONTHS



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WORK REFERENCES WHO ARE NOT RELATIVES OR PERSONAL AQUAINTANCES:

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RELATIONSHIP: _____ TITLE: _____
PHONE: _____

#2
NAME: _____ RELATIONSHIP: _____ TITLE: _____

COMPANY NAME & ADDRESS: _____ PHONE: _____

#3
NAME: _____ RELATIONSHIP: _____ TITLE: _____

COMPANY NAME & ADDRESS: _____ PHONE: _____

CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW

I hereby affirm that the information provided on this application (and accompanying resume, if any) is true and complete. I understand that any false or misleading representations or omissions made on the application of during the hiring process may disqualify me from further consideration for employment and may result in discharge even if discovered at a later date.

I understand that employment may be conditioned upon successfully passing a medical examination and that I may be required to satisfactorily complete a drug screening as a condition of employment.

I hereby authorize persons, schools, my current employer *(if applicable) and previous employers and other organizations to provide this facility and its affiliates with any requested information regarding my application or suitability for employment, and I completely release all such persons or entities from any and all liability related to the providing or use of such information.

I understand that my employment is at-will which means that I may terminate the employment relationship at any time and for any reason with or without notice, and that the facility has the same right. I understand that no one has the authority to enter into any agreement contrary to the preceding sentence, except for a written agreement signed by an administrative representative of this facility and notarized.

Our Lady of Angels Retirement Home is a drug-free workplace. Employment is contingent on pre-employment drug screening.

Date: _____ Signature: _____

HIRED? YES NO

REFERENCES CHECKED AND BY WHOM:

REFERENCE #1 DATE:
REFERENCE #2 DATE:
REFERENCE #3 DATE:

PERSONNEL NOTES (Please keep all information factual)

STARTING DATE: _____ DEPARTMENT: _____

POSITION: _____ STARTING SALARY: _____

FULL TIME ON CALL STATUS PART TIME ROTATION

INTERVIEWER'S SIGNATURE: _____

NOTIFY IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ TELEPHONE: _____