



EMPLOYEE NAME:

HOME ADDRESS / HOME PHONE NUMBER

ADDRESS:

PHONE NO:

EMERGENCY CONTACT

Please list a relative and / or friend to be contacted in the event of an emergency.

NAME:

PHONE:

ADDRESS:

NAME:

PHONE:

ADDRESS:

ARCAM HOME HEALTH CARE

An Equal Opportunity Employer
EMPLOYMENT APPLICATION

Please Print

Date: _____

Applicant Name: _____

(Last)

(First)

(Middle)

Cell: (____) _____ Home Tel.: (____) _____ Email: _____

Present Address: _____

(No.) (Street)

(City)

(State)

(Zip)

Permanent Address (if different from present address)

(No.) (Street)

(City)

(State)

(Zip)

EMPLOYMENT DESIRED

Position applying for: _____

Are you applying for:

Regular full-time work?.....Yes____ No____

Regular part-time work?.....Yes____ No____

Temporary Work, e.g. summer or holiday work?.....Yes____ No____

Per Diem work?.....Yes____ No____

What days and hours are you available for work? _____

If applying for temporary work / per diem, during what period of time will you be available?

From: _____

Are you available for work on weekends?.....Yes____ No____

Would you be available to work overtime, if necessary?....Yes____ No____

If hired, on what date can you start work? _____

PERSONAL INFORMATION

Have you ever applied to or worked for Arcam Home Health Care before? () Yes () No

If Yes, when? _____

Do you have any relatives working for Arcam Home Health Care? () Yes () No

If Yes, State name(s) and relationship: _____

Have you ever used a different name that we would need to know in verifying your employment record or education?

() Yes () No

If Yes, please indicate the name(s) and when used:

If hired, would you have a reliable means of transportation to and from work? () Yes () No

Are you at least 18 years old? () Yes () No

(If under 18, hire is subject to verification that you are of minimum legal age)

If hired, can you present evidence of your identity and legal right to work in this country? () Yes () No

Are you able to perform the functions of the job for which you are applying with or without reasonable accommodations? () Yes () No

If No, describe the functions that cannot be performed:

(Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for qualified applicants/employees to perform essential functions)

Are you currently employed? () Yes () No

If so, may we contact your current employer? () Yes () No

EMPLOYMENT HISTORY

List below all present and past employment starting with your most recent employer (last 5 years is sufficient). Account for all periods of unemployment. You must complete this section even if attaching a resume.

Name of Employer: _____

Address: _____

Type of Business: _____

Tel. No.: _____ Your Supervisor's Name: _____

Dates of Employment: _____ To: _____

Your Position and Duties: _____

Name of Employer: _____

Address: _____

Type of Business: _____

Tel. No.: _____ Your Supervisor's Name: _____

Dates of Employment: _____ To: _____

Your Position and Duties: _____

Name of Employer: _____

Address: _____

Type of Business: _____

Tel. No.: _____ Your Supervisor's Name: _____

Dates of Employment: _____ To: _____

Your Position and Duties: _____

Note: Attach additional page(s) if necessary.

EDUCATION, TRAINING AND EXPERIENCE

SCHOOL DIPLOMA	NAME AND ADDRESS	DEGREE	DID YOU GRADUATE?	NO. OF YEARS
College / University			Yes ____ No ____	
High School			Yes ____ No ____	
Vocational/ Business			Yes ____ No ____	

Please list any certificates or professional designations earned:

Do you have any other experience, training, qualifications or skills which you feel make you especially suited for work at Arcam Home Health Care? If so, please explain.

REFERENCES

List below three persons not related to you who have knowledge of your work performance within the last five years.

Name: _____

Address: _____

Position / Title: _____

Tel. No.: _____ Number of Years Acquainted: _____

Name: _____

Address: _____

Position / Title: _____

Tel. No.: _____ Number of Years Acquainted: _____

Name: _____

Address: _____

Position / Title: _____

Tel. No.: _____ Number of Years Acquainted: _____

ACKNOWLEDGEMENT

Please read carefully, Initial each paragraph and sign below.

_____ I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ I hereby authorize Arcam Home Health Care to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the company and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I agree that this company and my previous employers shall not be held liable in any respect if a job offer is not extended, is withdrawn or my employment is terminated because of false statements, omissions or answers made by me on this application. I understand that, if hired, I am obliged to comply with any and all current and subsequently adopted Arcam Home Health Care policies.

_____ In compliance with the Immigration Reform and Control Act of 1986, I understand that I will be required to provide approved documentation that verifies my right to work in the United States on my first day of employment.

_____ I understand that this application does not create a contract of employment. I understand that, if hired, employment at Arcam Home Health Care is "at will", which means that either I or the company can terminate the employment relationship at any time, with or without prior notice, and for any reason not prohibited by statute. All employment is continued on that basis. I understand that no supervisor, manager, or executive of Arcam Home Health Care, other than the President, has any authority to alter the foregoing.

I hereby acknowledge that I have read and understand the above statements.

APPLICANT'S SIGNATURE: _____ DATE: _____

PRINTED NAME: _____