Application for Friends Health Care Team

POSITION: Full-Time/ Part-Time	DATE AVAILABLE	TODAY'S DATE

PERSONAL INFORMATION

LAST NAME	FIRST NAME MIDDLE INITIAL	DATE OF BIRTH

ADDRESS:

PHONE	EMAIL ADDRESS	SOCIAL SECURITY NO.:

EMERGENCY CONTACT: NAME PHONE # RELATIONSHIP
1.
2.

If under 18 years of age, can you submit a work permit after employment? YES NO N/A

If hired, can you provide proof of your legal right to work in the US? YES NO

List memberships in professional organizations

Have you ever been employed by Friends Home Care Team? YES NO
If Yes, give dates:

WORK PREFERENCES

Do you have your own transportation? Y / N	Work Area preferred

Will you provide service for clients with pets? Y / N Will you provide service for clients that smoke? Y / N

DAY ONLY NIGHT ONLY DAY & NIGHT HOURLY LIVE IN HOURLY & LIVE IN

PROFESSIONAL LICENSES/CERTIFICATION

TYPE	STATE ISSUED	EXPIRATION DATE	LICENSE NUMBER

EDUCATIONAL BACKGROUND

	NAME & ADDRESS	GRADUATE?	COURSE/ MAJOR	DEGREE/DIPLOMA
HIGH SCHOOL				
COLLEGE				
TRADE, OR OTHER PROF. SCHOOLS				

SKILLS

TYPE? YES NO WPM____________	What languages do you speak?

COMPUTER SKILLS: M/S EXCEL POWERPOINT OTHERS_____________________________________

EMPLOYMENT HISTORY			
EMPLOYER	TELEPHONE	STARING DATE	ENDING DATE
ADDRESS		STARTING PAY	FIANL PAY
JOB TITLE & DUTY		SUPERVISOR'S NAME AND TITLE	
MAY WE CONTACT? YES NO		REASON FOR LEAVING	
EMPLOYER	TELEPHONE	STARING DATE	ENDING DATE
ADDRESS		STARTING PAY	FIANL PAY
JOB TITLE & DUTY		SUPERVISOR'S NAME AND TITLE	
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MAY WE CONTACT? YES NO		REASON FOR LEAVING	

EQUAL EMPLOYMENT OPPORTUNITY

Friends Health Care Team is an Equal Opportunity Employer. All qualified applicants will receive consideration without regard to race, color, religion, gender, gender identity, national origin, age, disability, veteran status or any other status protected under local, state or federal law.

ACKNOWLEDGEMENT

I understand that the Company abides by an employment-at-will policy, which means either, Friends Health Care Team, hereafter, "the Company" or the employee may terminate the employment relationship at any time, for any reason or for no reason, with, or without notice, nothing contained in this employment application, any employee handbook or conveyed to me during an interview is intended to create an employment contract, implicit or implied. I also understand and agree that any future changes in my title, duties, compensation, working conditions, or company benefits, policies and/or procedures will not alter this at-will agreement. This at-will agreement can only be changed or modified in writing by the President of the Company.

I understand consideration for employment with the Company will be contingent upon the results of reference and criminal background checks. I authorize the Company to investigate all information I provide on the application for employment, including previous employment, experience and educational credentials. I also give the Company permission to contact my former employer(s), all listed references or any other person who can other contacted persons to respond to any questions pertaining to the information included in this application.

CERTIFICATION

I certify that I completed the Company's application by myself and that all of the information provided herein is correct. I understand that any omission, misstatement or inclusion or false information on this application or any documents used to secure employment with Company shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

By signing below, you are accepting the terms and conditions as set forth in this application, including the certification that everything contained in the application is true and correct to the best of your knowledge.

Signature: ____ Date: ____

PRE-EMPLOYMENT REFERENCE CHECK FORM

PART I – COMPLETED BY APPLICANT

Applicant Name	Position Applying for

1. Reference Name	Relationship to Applicant	Company/School & Phone Number:

Dates of Employment (Start to End Dates)	Position(s) Held

PART II – COMPLETED BY SUPERVISOR (OR DESIGNEE)

Is the applicant's position title correct? Yes / No If no, indicate correct title___________________________________	References Check Method

What was the applicant's main task?

Eligible for Rehire? YES NO Not allowed to disclose N/A
If No/conditional please explain

PART III - EVALUATION

	Excellent	Good	Fair	Unsatisfactory
Work attitude/ ability to work with others				
Dependable/ Punctuality/ Attendance				
Initiative				
Job knowledge/technical skill				

Please explain strength and weakness ____

2. Reference Name	Relationship to Applicant	Company/School & Phone Number:

Dates of Employment (Start to End Dates)	Position(s) Held

PART II – COMPLETED BY SUPERVISOR (OR DESIGNEE)

Is the applicant's position title correct? Yes / No If no, indicate correct title___________________________________	References Check Method

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PART III - EVALUATION

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Work attitude/ ability to work with others				
Dependable/ Punctuality/ Attendance				
Initiative				
Job knowledge/technical skill				

Please explain strength and weakness ____

____

Name and Title of person conducting the reference check **Date**

CONFIDENTIALITY AGREEMENT

I hereby acknowledge that in the course of my employment, FRIENDS HEALTH CARE TEAM will make available to me confidential data and information. Such electronic verbal and/or written information may consist of, but is not limited to: patient health information; OASIS assessment information; lists of the names and addresses of patients/customers/employees; patients' family histories; information relating to the organization's financial and/or contractual relations with customers; referral sources; administrative manuals; computer generated listings and documents; telephone conversations; directives and policies relating to the internal operations of the organization; and various documents containing information relating to the organization's recruiting, training, operating and soliciting functions.

I understand that access to such information is only being made available to me in order that I may perform the duties for which I have been employed. I specifically agree that:

1. During the course of my employment I will use such information only in connection with my employment and will not disclose the same to any other person or the general public, except those individuals who are directed to communicate such information at the appropriate time.
2. I will not copy and/or remove any such materials from the organization's premises except as needed to perform the duties for which I am employed.
3. I will ensure the security of such information throughout the day at the close of each day, and in preparation for transport.
4. Following the dismissal from my employment with the organization, I will immediately return to the organization all such materials and all other agency property in my possession.
5. During and following the dismissal from my employment with the organization for two year, I will not directly or indirectly:
   a. Disclose, solicit, use, or permit any other person to have access to the organization's materials;
   b. Cause any other individual to breach their confidentiality with the organization or solicit any employee to leave the organization's employment.
   c. Solicit or induce any client of the organization to terminate the relationships the client has with the organization.
6. I understand that any breach of confidentiality as stated herein will entitle the organization to injunctive relief, in addition to disciplinary action, up to and including dismissal.
7. I will abide by the provisions of the "Confidentiality of Information" employment policy.

Print Name & Sign ____ Date______________________

SWORN STATEMENT OR AFFIRMATION
Please Print

____
Last Name **First** **Middle** **Maiden** **Social Security Number**

____
Current Mailing Address **Street, P.O. Box #, Apt. #** **City** **State** **Zip Code**

Friends Health Care Team 7535 Little River Turnpike, #310-A, Annandale, VA, 22003
Name of Licensed/Registered Approved Facility/Provider **Street, P.O. Box #, Apt. #** **City** **State** **Zip Code**

Please respond to all four (4) questions below:

1. Have you ever been convicted of or are you the subject of pending charges of any crime within the Commonwealth of Virginia?

☐ Yes (convicted in Virginia) ☐ Yes (pending in Virginia) ☐ No

If yes to convicted or pending, specify crime(s): ____

2. Have you ever been convicted of or are you the subject of pending charges of any crime outside the Commonwealth of Virginia?

☐ Yes (convicted outside Virginia) ☐ No

If yes to convicted or pending, specify crime(s) and state, or other location: _______________________________

3. Have you ever been the subject of a founded complaint of child abuse or neglect within the Commonwealth of Virginia?

☐ Yes (in Virginia) ☐ No (in Virginia)

4. Have you ever been the subject of a founded complaint of child abuse or neglect outside the Commonwealth of Virginia?

☐ Yes (outside Virginia) ☐ No (outside Virginia)

If yes or pending, specify state, or other location: ____

I hereby affirm that the information provided on this form is true and complete. I understand that the information is subject to verification and that a materially false statement or affirmation is a Class I misdemeanor.

Signature ____ Date _____________________________