



**IN-HOME
HEALTH CARE
SERVICES, INC.**

Employment Application

Today's Date _____

Name (Last, First, Middle Initial)

Social Security Number

Street Address

City, State, Zip Code

Home phone number

Cell phone number

Education History:

	Name of School and location	Years attended	Did you graduate or receive an equivalent certification	Subjects Studied
High School				
College				
Trade or Other				

Former Employers: (List below last four employers, starting with last one first)

To and From dates Month and Year	Name and address of Employer	Phone number of Employer	Hourly Salary	Position	Reason for leaving

References: (Give below the names of three persons not related to you)

Name	Address	Phone Number	Years known	Relationship

Position Desired _____ Available Start Date _____ Desired Salary _____

Are you currently employed? Yes No If yes, may we inquire of your current employer? Yes No

What days and times are you available for work? Mornings Afternoons Nights
 Monday Tuesday Wednesday Thursday Friday Saturday Sunday
 Yes No

Are you available to work every other weekend and holiday? Yes No

Are you seeking part-time (16 to 31 hours a week) or full-time (32 to 40 hours a week)? Part-time Full-time

Do you have dependable transportation? Yes No

Do you have a valid driver's license? Yes No

Do you require medical insurance coverage? Yes No

Have you ever been convicted of a felony? Yes No

If Yes, explain: _____

Do you have any restrictions while working? Yes No

If Yes, explain: _____

What experience do you have relevant to the medical field (list all subjects of special study, interest, work experience, training, skills or certification)? _____

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above may have, personally or otherwise, and release the company from all liability for any damages that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.

Signature _____ Date _____

For office use only:

Interview Notes: _____

Hire Date: _____ Part-time Full-time Starting Wage: _____