



EMPLOYMENT APPLICATION FORM

Blossom Ridge Home Health Agency does not refuse services to, or employment to, or in any other way discriminate against any person on the basis of sex, age, sexual orientation, mental or physical handicap, race, color, religion and ancestry or origin. (Title VI of the Civil Rights Act of 1964).

POSITION DESIRED

<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> MSW	<input type="checkbox"/> Speech Therapist
<input type="checkbox"/> LVN	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Others:
<input type="checkbox"/> CHHA	<input type="checkbox"/> Occupational Therapist	Please Specify:

PERSONAL INFORMATION: Please write legibly.

Last Name:	First Name:	MI:	Date:
Address:		City:	State: Zip:
Cell Phone:	Home Phone:	Email:	
		Driver's License:	
Citizenship:	If you are not a U.S. Citizen, are you authorized to work in the U.S. without restriction? <input type="checkbox"/> Yes <input type="checkbox"/> No		

EMERGENCY CONTACT INFORMATION (Optional)

Contact Person Name:	Relationship:	Phone:
Contact Person Name:	Relationship:	Phone:

PROFESSIONAL LICENSE AND CERTIFICATIONS

Type	Expiration	Number	Issued State:

Applying for: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Per Diem	Shifts Desired: <input type="checkbox"/> Weekdays <input type="checkbox"/> Weekends <input type="checkbox"/> Hourly <input type="checkbox"/> Others
Date of Start: _____ Desired Salary: _____	How did you learn about the Agency?
Have you ever been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please state why:

PROFESSIONAL WORK EXPERIENCE

1. Employer Name:	Dates Employed:	
Address:		Telephone:
Position:	Manager:	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Status:		
2. Employer Name:	Dates Employed:	
Address:		Telephone:
Position:	Manager:	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Status:		
3. Employer Name:	Dates Employed:	
Address:		Telephone:
Position:	Manager:	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Status:		
4. Employer Name:	Dates Employed:	
Address:		Telephone:
Position:	Manager:	May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Status:		



EDUCATION	
Name of School/College:	Year Graduated:
Address:	Degree Earned:
Name of School/College:	Year Graduated:
Address:	Degree Earned:

SKILLS/TRAININGS ATTENDED	
Date:	
Date:	
Date:	
Date:	
Date:	

REFERENCES (PLEASE PROVIDE AT LEAST 2 PROFESSIONAL REFERENCES IF NOT SPECIFIED ABOVE)			
Name	Relationship	Company	Contact Number

1. Are you eighteen (18) years old or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been employed at Blossom Ridge Home Health Agency? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you legally eligible for employment in the United States?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have available means of transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you able to perform the essential functions of the job for which you are applying with no limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant's Attestation Statement:

I hereby affirm that the information I have provided in this application are true and correct. I authorize investigation of all statements in this application for employment including references verification, written request for information from previous employer, requirement to supply birth certificate or other proof of authorization to work in the U.S., physical examination as may be necessary in arriving at an employment decision. In the event I have misrepresented or omitted any fact on this application, and is subsequently hired, I am fully aware that I maybe discharged from the job. I understand Blossom Ridge Home Health Agency may require physical examination, fingerprinting or background check investigation and TB testing at anytime and I agree to such procedures. I agree that the examining physician may disclose to Blossom Ridge Home Health Agency or it's representatives the results of such exams.

I hereby understand and acknowledge that, unless otherwise defined by the applicable law, any employment relationship with this organization is "AT WILL" in nature, which means that the Employer may discharge Employee at anytime with or without cause. It is further understood that this "AT WILL" employment may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized officer in the organization.

In the event of employment, I understand that false or misleading information provided in my application or interview(s) may result in my immediate termination. I also understand that I am required to abide by all rules and regulations of the employer.

Name	
Siganture	Date

Blossom Ridge Home Health Agency is an Equal Opportunity Employer (EOE)