Nurses Care inc.

(equal opportunity employer)

APPLICATION FOR EMPLOYMENT

Date:

PERSONAL INFORMATION:

NAME (last name, first name, and any other names you are known by ie: Maiden or married names) SOCIAL SECURITY #

PRESENT ADDRESS (please include city & zip code)

PERMANENT ADDRESS (please include city & zip code)

PHONE NUMBER: REFERRED BY: OHIO RESIDENT MORE THAN 5 YEARS

YES ☐ NO ☐

EMPLOYMENT DESIRED

POSITION Full time ☐ Part time ☐ DATE YOU CAN START SALARY DESIRED

IF YES, MAY WE CONTACT YOUR PRESENT EMPLOYER?

HAVE YOU EVER APPLIED TO THIS COMPANY BEFORE? WHEN?

PAST EDUCATION:

NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DIDYOU GRADUATE	SUBJECTS STUDIED
GRAMMAR:			
HIGH SCHOOL:			
COLLEGE:			
TRADE., BUSINESS OR CORRESPONDENCE :			

GENERAL:

SUBJECTS OF SPECIAL STUDY/RESEARCH WORK

APPLICATION FOR EMPLOYMENT

REFERENCES:
FORMER EMPLOYERS (LIST LAST FOUR, STARTING WITH LAST ONE FIRST)

DATES EMPLOYED	NAME OR CONTACT PERSON ADDRESS OF EMPLOYER	PHONE # SALARY	POSITION	REASON FOR LEAVING
1)				
2)				
3)				
4)				

PERSONAL REFERENCES:
(LIST PERSONS, NOT RELATED TO YOU, WHOM YOU HAVE KNOWN FOR AT LEAST ONE YEAR)

NAME	ADDRESS	PHONE#	BUSINESS	YEARS KNOWN
1)				
2)				
3)				

AUTHORIZATION:

I hereby certify that all questions are fully and correctly answered and I authorize the agency to contact my former employers and all other sources they see fit in order to verify the facts and information furnished with regard to my qualifications.

I hereby release any such employer or persons from any and all liability, whatever in nature, on account of furnishing such information. I understand that any misleading or incorrect statements may render this application void, and if employed, could cause termination.

Should I accept employment with the agency., I acknowledge that no contract of employment exists, implied or otherwise. The policies, benefits, and other programs listed in the employee booklet are provided either in compliance with applicable statutes or at the discretion of the agency. This does not imply a contract of employment. The policies, benefits, and other programs offered by the agency, inc. may be changed or eliminated at the agency.'s discretion.

Please indicate that you have read and understand the above statement by signing and dating in the space below. I understand that a policy of a probationary period of 90 days exists and if employed, the applicant may be terminated if transition is not satisfactory.

DATE:_____ SIGNATURE:_____

INTERVIEWED BY: _____ **DATE:**

REMARKS:

NURSES CARE, INC.
INTERVIEW QUESTIONAIRE

APPLICANT NAME : DATE :

1. Why are you interested in Home Health?

2. What Home Health experience have you had?

3. Describe the type of patients you have cared for recently. What types of care have you done?

4. What qualities do you feel you can give to this position?

5. On what areas of weakness would you need more orientation?

6. Are there any parts of the job description below that you cannot fulfill at this time?

   1) Do you have any previous involvement as a defendant In a professional malpractice?

   2) Have you ever had your professional license revoked, suspended or disciplinary action taken against you?

   3) Are you able to transfer up to 50 lbs?

   4) Are there any problems with pets?

   5) Do you have a valid Ohio Driver's License?

   6) Do you have your own reliable transportation?

   7) Do you have liability auto insurance of $100.000/person, $300.000/accident ?

   Also For Home Health Aides:

   1) Are you a high school graduate or G.E.D. ?

   2) Are you certified as an Aide?

7. **Availability**

   Monday through Friday

   Saturday & Sunday

Applicant's signature Date

Interviewer's signature Date

Telephone: 513-424-1141
Fax 513-424-0520
www.nursescareinc.com

WORK REFERENCE FORM

Date:

To: _____

Re: _____ SS# _____

The above named person has applied to us for a position of _____ _____ _____
And we would appreciate your assistance in providing the information requested below. Thank you.
Signature_____ _____

Dates of Employment _____ _____ Position(s) __ _____ _____
Salary _____
Reason for termination of employment _____
Eligible for rehire: Yes_____ No ___
Please rate the applicant in the following areas:

	Above Average	Average	Below Average
Attendance and Punctuality	_____	_____	_____
Quality of Work	_____	_____	_____
Motivation/Initiative	_____	_____	_____
Job Knowledge/Skills	_____	_____	_____
Willingness to Accept Direction	_____		_____
Coorperation with Others	_____	_____	

Comments

_____

Signature/Title_____ _____ _____ Date_____ __

I authorize Nurses Care, Inc. to conduct my former employers as they see fit in order to verify the facts and information furnished with regard to my qualifications. I hereby release any such employer or persons from any and all liability, whatever in nature, on account of furnishing such information. I will not hold Nurses Care, Inc. liable in any respect if I am not employed or employment is terminated as a result of any information obtained in the reference check.

Signature _____ **Date** _____

EMPLOYEE'S HEALTH QUESTIONAIRE

Name _____ Marital Status: S M W D DOB Sex

Last First Initial

Address Telephone

Position Date

Family Physician Weight

Date and Reason for Last Visit to Physician

Family History: Nervous of Mental Illness ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Check "Yes" or "No" after each question):

DISEASE OF:	Yes	No		Yes	No		Yes	No		Yes	No
Brain			Genitals			Chronic Constipation			Malaria		
Eyes			Dizziness			Black or Bloody bowel movements			Rheumatic Fever		
Ears			Frequent Headaches			Freq. or painful urination			Paralysis		
Nose			Deafness			Blood in urine			Cancer or Tumors		
Throat			Running ears			Swollen ankles			Asthma		
Heart			Freq. sore throat			High blood pressure			Hay fever		
Lungs			Freq. colds			Jaundice			Diabetes		
Stomach			Fainting spells			Hernia			Arthritis		
Intestines			Chest pains			Stomach ulcers			Rheumatism		
Liver			Shortness of breath			Pneumonia			Nervous breakdown		
Spleen			Chronic cough			Pleurisy			Painful flat feet		
Gallbladder			Coughing up blood			Kidney stones			Backaches		
Kidneys			Palpitations			Fits or convulsions			Chronic sinus		
Bladder			Allergies			Tuberculosis			Injuries		
Bone			Poor appetite			Bronchitis			Operations		
Joints	___	___	Chronic indigestion			Nephritis			**WOMEN ONLY**		
Back (spine)			Recurrent nausea						Abnormal menstrual periods		
Skin	___	___	Recurrent vomiting						Severe PMS		
Lymph Nodes	___	___	Vomiting of blood								
	___	___									

Other serious illnesses which might affect your ability to perform the essential functions of the position offered (please explain).

Have you ever had Chicken pox, herpes or shingles?

State details of prior injuries or operations which might affect your ability to perform the essential functions of the position offered.

What, if any, accommodations do you feel would be needed in order for you to perform the essential functions of the position offered?

I, THE UNDERSIGNED, CERTIFY THE ABOVE ANSWERS ARE TRUE,

Signed Date

esa
EMPLOYMENT SCREENING ASSOCIATES

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

_____, as a condition of employment, and/or continued employment, that all applicants consent to and authorize a verification of the information submitted on their application or resume. Please read this statement carefully.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that this Company may now, or at any time while I am employed or representing the company, conduct a verification of my education, employment history, credit history, and/or motor vehicle records. In addition this company may contact personal references, require that I provide a urine specimen or hair strands to be tested for the presence of drugs or alcohol, and receive any criminal history record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any state, and/or other information as deemed necessary to fulfill the job requirements. Also, if an offer of employment has been made, I authorize review of my worker's compensation claim history.

I authorize Employment Screening Associates and any of its agents and/or employees to disclose verbally and in writing the results of this verification process to the designated authorized representatives of this Company. The results will be used to determine employment eligibility under this Company's employment policies. Under no circumstances will ESA provide or disclose any information regarding your credit history. We do not share, disclose or sell any information that can be used to authenticate your identity such as your Social Security Number, Date of Birth or Mother's Maiden Name.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide Employment Screening Associates with all information that may be requested, and I hereby release all of the persons and agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge this Company, its agent, Employment Screening Associates, and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if employment was denied based on information obtained by my prospective employer, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report. If I am a resident of Minnesota, California or Oklahoma only and would like a copy of the investigative report, I will check here ☐.

Please provide all requested information and provide addresses for the last seven- (7) years

Applicant's Name: FIRST MIDDLE LAST _____ Maiden Or Other Name(s)

Current Address - Street, City, State, Zip _____ How Long

Previous Address - City, State, Zip _____ How Long

Previous Address - City, State, Zip _____ How Long

Social Security Number _____ Date of Birth (for confirmation of ID only)

Drivers License Number _____ State _____ Name - exactly as it appears on Driver's License

Email Address _____

[ ] Yes [ ] No
Authorization to contact present employer for reference? _____ Signature _____ Date

Criminal History
Have you been convicted or plead guilty to a crime in the last 7 years? [ ] Yes [ ] No

- Brief description of crime: _____ Misdemeanor / Felony (Please Circle)
- Date: _____ Place of conviction: _____ City _____ State _____ County

List additional convictions: _____

Release of Background Check Results Send to:

Nurses Care Inc
571 Congress Park Drive, Suite 200
Dayton, Ohio 45459
513-424-1141

Fingerprint Reason for request: 3701.881

Name:_____ Title:_____

Address:_____

City, State, Zip:_____

Daytome Phone:_____

SSN:_____ Branch:_____

Date of Birth:_____ Place of Birth:_____

Release of Background Check Results

I certify that I have given Nurses Care, Inc. peremission to obtain all criminal history information pertaining to me in the files of the Ohio Bureau of Criminal Identification and Investigation (BC&I) and the Federal Bureau of investigation (FBI) (if requested), and to release that information to Nurses Care, Inc.

By placing my fingerprint images on the WEBCHECK Scanner, I am authorizing BC&I to release criminal history information about me to Nurses Care, Inc.

I hereby release BCI&I and any individuals connected therewith from all liability in connection with the dissemination of such criminal history information.

SIGNATURE:_____ **DATE:**_____