

# Innovation



Healthcare Solutions Enterprise, Inc.

## EMPLOYMENT APPLICATION

**INSTRUCTIONS:** If you need help filling out this application form or for any phase of the employment process, please notify the person who gave you this form and every reasonable effort will be made to meet your needs in a reasonable amount of time.

- Please read "Applicant Note" below.
- Complete all pages of this application.
- Print clearly. Incomplete or illegible applications may not be accepted.
- Application will be valid for 60 days.

**APPLICANT NOTE:** This application form is intended for use in evaluating your qualifications for employment with us, an independently owned and operated Innovation Healthcare Solutions Enterprise Inc. This is not an employment contract. Please answer all appropriate questions completely and accurately. False or misleading statements during the interview and on this form are grounds for terminating the application process or, if discovered after employment begins, terminating employment. All qualified applicants will receive consideration and will be treated throughout their employment without regard to race, color, religion, sex, national origin, age, disability, or any other protected class status under applicable law. Additional testing for the presence of illegal drugs in your body may be required prior to employment.

### PERSONAL INFORMATION

Today's Date: \_\_\_\_\_

Positions(s) Applied For: \_\_\_\_\_

Name: \_\_\_\_\_

Last

First

Middle

Current Address: \_\_\_\_\_

Street

City

State

Zip Code

Previous Address: \_\_\_\_\_

Street

City

State

Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact(s): \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name

Phone

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name

Phone

Valid Driver's License #: \_\_\_\_\_ State Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Make & Model of Vehicle: \_\_\_\_\_ Year of Vehicle: \_\_\_\_\_

Auto Insurance Co: \_\_\_\_\_ Policy # \_\_\_\_\_ Exp Date: \_\_\_\_\_

Have you ever applied here before? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ If yes, when? \_\_\_\_\_

Have you ever been employed here before? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ If yes, when? \_\_\_\_\_

How did you hear about our Innovation Healthcare Solutions Enterprise Inc.?

Have you been given a copy of the job description for the position for which you have applied to review? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Are you able to perform the essential functions of the job for which you are applying with or without a reasonable accommodation? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Why are you interested in employment with us? \_\_\_\_\_  
\_\_\_\_\_

## **AVAILABILITY**

Due to the nature of the business, no guarantee can be made as to the schedule or the number of hours worked.

What date are you available to begin work? \_\_\_\_\_

Please complete all areas of availability:

\_\_\_\_\_ Mornings \_\_\_\_\_ Afternoon \_\_\_\_\_ Evenings \_\_\_\_\_ Overnights \_\_\_\_\_ Weekdays \_\_\_\_\_ Weekends

Please indicate the days of the week as well as the earliest and latest times that you are available for work.

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Shift	From:							
	To:							

## **PREFERENCES**

Please indicate all areas of the counties in which you are willing to work:

\_\_\_\_\_ Forsyth \_\_\_\_\_ Yadkin \_\_\_\_\_ Davidson \_\_\_\_\_ Davie \_\_\_\_\_ Guilford County

Please indicate the types of services which you are willing to provide:

<input type="checkbox"/>	Companions / Respite / Sitter	<input type="checkbox"/>	Mobile Foot Care (RN and LPN Only applicants)	<input type="checkbox"/>	Nursing Services Home Care LPN, RN
<input type="checkbox"/>	In-Home Aide (listed on NC Registry)	<input type="checkbox"/>	Infusion Services (RN only)	<input type="checkbox"/>	
<input type="checkbox"/>	In-Home Aide (Personal Care Assistant) Non Registry	<input type="checkbox"/>	Nursing Pool (Nurse Aide, LPN, RN only applicants)	<input type="checkbox"/>	

*\*In order to be able to provide transportation or run errands, you will be required to have a valid driver's license and current auto insurance. A motor vehicle record check will be conducted, and proof of insurance will be required.*

Are you willing to provide service to a client with a pet? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ If yes, which ones: \_\_\_\_\_ Cats \_\_\_\_\_ Dogs

Are you willing to provide service to a client that smokes? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

## **JOB RELATED SKILLS**

Describe any training or life skills you have that apply to caring for a senior:

\_\_\_\_\_

Describe any work history you have that would apply to caring for a senior: \_\_\_\_\_

\_\_\_\_\_

What do you like (or think you would like) most about caring for patients? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you like (or think you would like) least about working with older adults? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What personal rewards do you get from working in healthcare? \_\_\_\_\_

\_\_\_\_\_

EDUCATION \*

School Type	School Name	City, State	Major/Subject	# Yrs Attended	Graduate
High School					Y / N
Vocational/Technical					Y / N
College/University					Y / N

\*For employment our minimum education requirement is either a GED or High School diploma

WORK HISTORY

Your application will not be considered unless all questions in this section are answered. Since we will make every effort to contact previous employers, the correct telephone numbers of past employers are essential.

MOST RECENT EMPLOYER

Are you currently working for this employer? Yes No If yes, may we contact? Yes No

Company Name

City

State

( ) Phone Number

Dates Employed: From to

Job Title

Supervisor's Name

Duties

\$ per

Salary (Hour, Week, Month)

Reason for Leaving

SECOND MOST RECENT EMPLOYER

Company Name

City

State

( ) Phone Number

Dates Employed: From to

Job Title

Supervisor's Name

Duties

\$ per

Salary (Hour, Week, Month)

Reason for Leaving

MOST RECENT EMPLOYER

Company Name

City

State

( ) Phone Number

Dates Employed: From to

Job Title

Supervisor's Name

Duties

\$ per

Salary (Hour, Week, Month)

Reason for Leaving

## SECURITY

\*\*\*\*\*Please be sure to complete the attached Authorization to do a criminal and motor vehicle background check.

As a condition of employment all employees must be "Bondable" & "Insurable". Are you at least 19 years old? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

List states *and* counties of residence for the past seven years: \_\_\_\_\_

Have you had any moving traffic violations? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Have you been charged/convicted of a felony and/or misdemeanor/or served time? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ If yes, please describe:

Incident

City/State

Charge

1) \_\_\_\_\_

2) \_\_\_\_\_

Have you ever been a charged perpetrator or appeared on any child abuse registry in the last 5 years? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

## REFERENCES (Do not include relatives)

Please complete 3 references. Your application will not be considered unless 3 references are provided. Since we will contact these references, please notify them in advance. If we are unable to reach all 3 references, you will be asked to provide additional references. There must be at least 2 employers within the 3 references.

Full Name	Phone Number	Best Time of Day to Call	Relationship	Number of Years Known
1)	H (    ) W (    )	AM / PM AM / PM		
2)	H (    ) W (    )	AM / PM AM / PM		
3)	H (    ) W (    )	AM / PM AM / PM		
4)	H (    ) W (    )	AM / PM AM / PM		
5)	H (    ) W (    )	AM / PM AM / PM		
6)	H (    ) W (    )	AM / PM AM / PM		

**CERTIFICATION AND RELEASE:** I certify that I have read and understand the applicant note on page one (1) of this form and that the answers given by me to the foregoing questions and the statements made by me are complete and true to the best of my knowledge and belief. I understand that any false information, omissions or misrepresentations of facts in this application may result in rejection of my application or discharge at any time during my employment. I authorize the company and/or its agents, including consumer-reporting bureaus, to verify any of this information including, but not limited to, criminal history and motor vehicle driving records. I authorize all persons, schools, companies and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I release this company from any liability which might result from making such investigations. I also understand that the use of illegal drugs is prohibited during employment. I am willing to submit to drug testing to detect the use of illegal drugs at any time of employment. I understand that this application is not a contract of employment. My employment is contingent upon confirmation of credentials and successful pass of criminal background, registry, and OIG checks. I also understand that if hired, regardless of any oral presentations to the contrary, the employment relationship between Innovation Healthcare Solutions Enterprise Inc. and myself is terminable at-will, so that both the company and I remain free to choose to end out work relationship at any time for any or no reason. Any changes in this employment relationship must be made in writing. My signature below acknowledges that I have read, understand, and agree to the above disclosure. I also understand that due to the nature of the business, no amount of work can be guaranteed.

**APPLICANT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_