AMERICAN EMPIRE HOME HEALTH CARE SERVICES, INC.

American Empire Home Health Care Services, Inc. does not discriminate in hiring or employment on the basis of race, color, religious creed, national origin, ancestry, sex, or on the basis of age or physical or mental handicap unrelated to the ability to perform the work required. No question on this application is intended to obtain information to be used for such discrimination. This application will be given every consideration. However, its acceptance does not imply that the applicant will be employed.

CONFIDENTIAL (PLEASE PRINT CLEARLY)	HIRE DATE	TODAY'S DATE

PERSONAL	LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY NO.

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER

EMAIL ADDRESS	CAN YOU FURNISH PROOF THAT YOU ARE LEGALLY PERMITTED TO WORK IN THE U.S.? ☐ **YES** ☐ **NO**	CELL PHONE NUMBER

NOTIFY IN CASE OF EMERGENCY	PHONE NUMBER

ARE YOU 18 OR OLDER? ☐ **YES** ☐ **NO** IF HIRED, YOU WILL BE REQUIRED TO PROVIDE PROOF OF AGE	HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR? ☐ **YES** ☐ **NO** IF YES, PLEASE EXPLAIN

EDUCATION	NAME OF SCHOOL	LOCATION	DIPLOMA/DEGREE	DATE COMPLETED
HIGH SCHOOL				
COLLEGE				
VOCATION/BUSINESS				
PROFESSIONAL				

OTHER EDUCATION, SPECIAL COURSES OR SPECIAL HONORS _____

_____

U.S. MILITARY EXPERIENCE	BRANCH OF SERVICE	INITIAL RANK	FINAL RANK

SERVICE SCHOOLS ATTENDED _____

_____

PROFESSIONAL LICENSE AND/OR CERTIFICATION			
TYPE	NUMBER	DATE ISSUED	STATE ISSUED

DESIRED EMPLOYMENT	FIRST CHOICE	SECOND CHOICE	DATE AVAILABLE	SALARY DESIRED	☐FULL TIME ☐PART TIME ☐PER DIEM

HAVE YOU WORKED FOR THIS COMPANY BEFORE? ☐ **YES** ☐ **NO** DATE _____ to _____

HAVE YOU EVER RECEIVED WORKER'S COMPENSATION? ☐ **YES** ☐ **NO** DATE _____ to _____

HAVE YOU EVER RECEIVED DISABILITY INSURANCE? ☐ **YES** ☐ **NO** DATE _____ to _____

AMERICAN EMPIRE HOME HEALTH CARE SERVICES, INC.

EMPLOYMENT HISTORY
MOST RECENT EMPLOYERS FIRST

COMPANY NAME	MAY WE CONTACT? ☐ **YES** ☐ **NO**		☐ FULL TIME ☐ PART TIME ☐ PER DIEM	PHONE NUMBER
ADDRESS		JOB TITLE		IMMEDIATE SUPERVISOR
EMPLOYMENT START DATE	EMPLOYMENT END DATE	STARTING SALARY		SALARY AT THE END
REASON FOR LEAVING ____________				

COMPANY NAME	MAY WE CONTACT? ☐ **YES** ☐ **NO**		☐ FULL TIME ☐ PART TIME ☐ PER DIEM	PHONE NUMBER
ADDRESS		JOB TITLE		IMMEDIATE SUPERVISOR
EMPLOYMENT START DATE	EMPLOYMENT END DATE	STARTING SALARY		SALARY AT THE END
REASON FOR LEAVING ____________				

COMPANY NAME	MAY WE CONTACT? ☐ **YES** ☐ **NO**		☐ FULL TIME ☐ PART TIME ☐ PER DIEM	PHONE NUMBER
ADDRESS		JOB TITLE		IMMEDIATE SUPERVISOR
EMPLOYMENT START DATE	EMPLOYMENT END DATE	STARTING SALARY		SALARY AT THE END
REASON FOR LEAVING ____________				

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and I agree to have any of the statements checked by the Agency unless I have indicated to the contrary. I authorized the references listed above to provide the Agency any and all information concerning my previous employment and any pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to the Agency as well as from the use of disclosure of such information by the Agency or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or if I am hired, in my dismissal from employment.

In consideration of my employment, I agree to conform to the rules and standards of the Agency and agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, either at my option or at the option of the Agency. I understand that no employee or representative of the Agency other than the President of American Empire Home Health Care Services, Inc. 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. Further, the President of American Empire Home Health Care Services, Inc. may not alter the at-will nature of the employment relationship unless he does so specifically and in writing. I also understand that all offers of employment are conditioned on the provision of satisfactory proof of an applicant's identity and legal right to work in the U.S.

I understand that any offer of employment with the Agency may be conditioned completing a pre-employment medical examination. Purpose of medical examination is to determine whether I am able to perform the essential functions of the job I am offered with or without reasonable accommodation, to identify any reasonable accommodation if such is warranted, and to ensure that my performance of the essential functions does not present a direct threat to my health and safety of others. I agree to forego such pre-employment medical examination. If hired by the Agency, I further agree to undergo any periodic medical examinations, which are permitted or required by Law.

_______________________________________ APPLICANT SIGNATURE

____________________ DATE

AMERICAN EMPIRE HOME HEALTH CARE SERVICES, INC.

TELEPHONE REFERENCE CHECK

Date _____

Applicant Name _____ SS # _____

Position applied for _____

Date of Telephone Reference Check _____

Employer Contact Person _____ Position _____

Employment Dates: From _____ To _____

Employee Position _____

Reason/s for Leaving _____

Would You Rehire? ☐ Yes ☐ No If NO, please explain _____

_____

Please rate the applicant on the following:

Attendance	☐ Poor	☐ Average	☐ Above Average
Cooperation	☐ Poor	☐ Average	☐ Above Average
Initiative	☐ Poor	☐ Average	☐ Above Average
Job Knowledge	☐ Poor	☐ Average	☐ Above Average
Tolerance with people	☐ Poor	☐ Average	☐ Above Average

Does the applicant have any work habits or personality traits that may negatively affect his or her work? _____

_____

Additional Comments: _____

_____

_____ _____

Person Completing the Telephone Reference Check Title