PH: (478) 746-9988
FX: (478) 308 -7001
EXTENDED HEALTH SERVICES
4340 North Henry Blvd
SUITE 260
Stockbridge, Ga. 30281

APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER

COMPLETE ALL ITEMS. PLEASE PRINT IN INK. ANSWER ACCURATELY. TODAYS DATE _____

NAME_____ S/S # _____
Last First Middle

Email Address:_____

Present Address: _____
Street Address, Apt # City State Zip Code

Most Recent Prior Address _____
Street Address, Apt # City State Zip Code

How long at present address? _____ HOME PHONE: _____ CELL PHONE: _____

ARE YOU A U.S. CITIZEN OR AUTHORIZED TO WORK IN THE U.S. ON AN UNRESTRICTED BASIS? YES ◯ NO ◯

DO YOU HAVE A VALID DRIVER'S LICENSE? YES ◯ NO ◯ CLASS/TYPE: _____ STATE: _____

ARE YOU AT LEAST 18 YEARS OF AGE? _____

HAVE YOU BEEN CONVICTED OF A CRIME OR PLED GUILTY OR NOLO CONTENDRE TO A CRIME?
YES ◯ NO ◯ IF YES, LIST COUNT, STATE, DATE AND DESCRIBE:

_____

_____

(Conviction will not necessarily disqualify an applicant for employment)

IN CASE OF EMERGENCY NOTIFY NAME:
_____

ADDRESS: _____ PHONE:
_____

-- EMPLOYMENT --

I AM APPLYING FOR THE FOLLOWING POSITION: _____

DAYS OF THE WEEK AVAILABLE FOR WORK: SU MO TU WE TH FR SA (Circle all available)

DATE AVAILIBLE TO BEGIN WORK? _____

DESCRIBE YOUR HEALTHCARE EXPERIENCE, IF ANY (Where obtained and length of time):
_____

_____

ARE YOU A CNA ON THE GEORGIA REGISTRY? YES NO (Circle)

ARE YOU A LICENSED RN OR LPN? (Circle which one) WITHIN THE STATE OF GEORGIA? YES NO (Circle)

PLEASE LIST ANY SPECIAL EDUCATION – SKILLS, EXPERIENCE OR EQUIPMENT OPERATION ABILITIES THAT YOU HAVE WHICH MAY BE USEFUL IN THE POSITION FOR WHICH YOU ARE APPLYING.

WERE YOU EVER EMPLOYED BY THIS COMPANY? IF YES, WHEN AND WHERE?

REFERRED BY :

-- EMPLOYMENT HISTORY --

EMPLOYER (Present or Most Recent)	TYPE OF BUSINESS	TELEPHONE NUMBER
ADDRESS (Street, City State Zip)		
STARTING DATE: (Month / Year)	STARTING SALARY	STARTING POSITION
LEAVING DATE: (Month/ Year)	SALARY ON LEAVING	PRESENT POSITION
NAME AND TITLE OF SUPERVISOR		

JOB DESCRIPTION AND RESPONSIBILITIES

REASON FOR LEAVING:

EMPLOYER	TYPE OF BUSINESS	TELEPHONE NUMBER
ADDRESS (Street, City State Zip)		
DATE STARTED: (Month / Year)	STARTING SALARY	STARTING POSITION
RESIGNATION DATE: (Month/ Year)	SALARY WHEN RESIGNED	POSITION WHEN RESIGNED

NAME AND TITLE OF SUPERVISOR

JOB DESCRIPTION AND RESPONSIBILITIES

_____

_____

REASON FOR LEAVING:

_____

EMPLOYER	TYPE OF BUSINESS	TELEPHONE NUMBER
ADDRESS (Street, City State Zip)		
DATE STARTED: (Month / Year)	STARTING SALARY	STARTING POSITION
RESIGNATION DATE: (Month/ Year)	SALARY WHEN RESIGNED	POSITION WHEN RESIGNED
NAME AND TITLE OF SUPERVISOR		

JOB DESCRIPTION AND RESPONSIBILITIES

_____

_____

REASON FOR LEAVING:

_____

EMPLOYMENT (CON'T)

EMPLOYER	TYPE OF BUSINESS	TELEPHONE NUMBER
ADDRESS (Street, City State Zip)		
DATE STARTED: (Month / Year)	STARTING SALARY	STARTING POSITION
RESIGNATION DATE: (Month/ Year)	SALARY WHEN RESIGNED	POSITION WHEN RESIGNED
NAME AND TITLE OF SUPERVISOR		

JOB DESCRIPTION AND RESPONSIBILITIES

_____

_____

REASON FOR LEAVING:

_____

IF PRESENTLY EMPLOYED, MAY WE CONTACT YOUR EMPLOYER FOR REFERENCES?

_____

MAY WE CONTACT YOU AT YOUR PLACE OF EMPLOYMENT? _____

-- EDUCATION --

NAME AND ADDRESS OF SCHOOL	GRADUATED?	MAJOR STUDY
HIGH SCHOOL		
BUSINESS OF TECHNICAL SCHOOL		
COLLEGE OR UNIVERSITY		
OTHER		
OTHER		

SPECIAL SKILLS (con't from 1st page):

_____

_____

REFERENCES

NAME: _____ OCCUPATION: _____

ADDRESS: _____

CITY AND STATE: _____ PHONE: _____

NAME: _____ OCCUPATION: _____

ADDRESS: _____

CITY AND STATE: _____ PHONE: _____

NAME: _____ OCCUPATION: _____

ADDRESS: _____

CITY AND STATE: _____ PHONE: _____

PRE-EMPLOYMENT STATEMENT

I understand that Extended Health Services (EHS)is committed to providing equal opportunity in all employment practices, including but not limited to selection, hiring, promotion, transfer and compensation to all qualified applicants and employees without regard to age, race, color, national origin, sex, religion, disability or any other category protected by law.

In making this application for employment, I understand that EHS may investigate any driving record, and my criminal record as may be required by state and federal regulations. This inquiry includes information as to my character, general reputation, personal characteristics, and mode of living. I understand that I have a right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigative report.

I authorize former and EHS employers, work and personal references listed in the application, and any other individuals I may name to give EHS or its designee any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release such parties from all liability for any damages that may result from furnishing same to EHS.

I understand that EHS reserves the right, to the extend permitted by law, to require a medical examination including but not limited to, any drug screening, blood test, or other procedure, of an applicant or an employee after a conditional job offer or at any time during employment and I hereby give my consent to any such test or examination. The completion of a physical examination that conforms to the requirements and specifications of the Americans With Disabilities Act and/or the successful completion of a drug test that conforms to state and federal laws. I consent to the release of the results of any such test or examination to EHS.

I understand this employment application and any other EHS documents are not promises of employment. Should I be employed, I understand that my employment will be on a trial period of 180 days from the date of my hiring. I further understand that, if I am employed, I can terminate my employment with or without cause, at any time, and that EHS has a similar right to terminate my employment with or without notice. I understand that no manager or representative or EHS 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, except that the vice-president or owner may do so in writing.

The information given by me in this application is true and complete in all respects, and I agree that if the information is found to be false, misleading or unsatisfactory in any respect (in the exclusive judgment of EHS) that I will be disqualified from consideration for employment or subject to immediate dismissal if found to be so after I am hired.
THIS APPLICATION WILL BE CONSIDERED ACTIVE FOR A PERIOD OF SIX (6) MONTHS. IF YOU WISH TO BE CONSIDERED FOR EMPLOYMENT AFTER THAT TIME, YOU MUST REAPPLY. I HAVE READ THE FOREGOING APPLICANTS STATEMENT IN ITS ENIRETY AND UNDERSTAND THIS STATEMENT.

NAME: _____ DATE: _____

EXTENDED HEALTH SERVICES, INC.

"Providing In-Home Assistance"

STATEMENT OF CREDIBILITY

I, _____, HAVE NEVER BEEN SHOWN BY CREDIBLE EVIDENCE TO

HAVE ABUSED, NEGLECTED, SEXUALLY ASSAULTED, EXPLOITED, OR DEPRIVED ANY PERSON

OR TO HAVE SUBJECTED ANY PERSON TO SERIOUS INJURY AS A RESULT OF INTENTIONAL

OR GROSSLY NEGLIGENT MISCONDUCT AS EVIDENCE BY ORAL OR WRITTEN STATEMENT TO

THIS EFFECT OBTAINED AT THE TIME OF APPLICATION.

_____ _____

SIGNATURE DATE

EXTENDED HEALTH SERVICES and TRAINING
REFERENCE FORM

Because we care so much about pleasing our clients, we are asking you to help…

The applicant named below has applied for a position with Extended Health Services & Training and has listed you as a previous employer. We would appreciate you assistance in verifying this applicant's employment and in evaluating his/her job performance so that we can maintain our high standards. All information provided will be held in strict confidence. Thank you.

1. Does the information below correspond with your records?Yes___ No___ If no, please give correct information: _____
_____

2. Would you rehire this employee? Yes____ No____ If no, please explain. _____
_____

3. FOR PARAPROFESSIONAL PERSONNEL - If Applicable

I certify that the applicant has had experience in the following under RN supervision:
____ Home Health Aide Skills, and/or ____ Personal Care Aide Skills

4. EVALUATION:

CRITERIA	EXCELLENT	GOOD	AVERAGE	POOR
Attendance				
Punctuality				
Dependability				
Quality of Work				
Job Knowledge				
Accepts Supervision				
Appropriate Attire				
Caring Demeanor				

5. COMMENTS: _____

_____

_____

Name of Institution/ Company

_____ _____ _____

Signature Title Date

TO BE COMPLETED BY APPLICANT

_____ _____

Applicant Name (Print) Social Security Number

I hereby authorize you to disclose all and any information concerning my employment with your firm to Extended Health Services. I understand this is in accordance with all applicable Federal and State laws.

_____ _____

Signature of Applicant Date

WE ARE AN EQUAL OPPORTUNITY EMPLOYER