ADVANCED™
HOME HEALTHCARE

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

NAME	SOCIAL SECURITY NUMBER
PRESENT ADDRESS _____ _____ CITY STATE ZIP CODE	PHONE: _____ DOB: _____ EMAIL:

EDUCATION HISTORY

LEVEL	LEVEL	YEARS ATTENDED	SUBJECT STUDIED
GRAMMAR SCHOOL	_____		
HIGH SCHOOL	_____		
COLLEGE	_____		
TRADE OTHER SCHOOL	_____		

GENERAL INFORMATION

SUBJECTS OF SPECIAL STUDY, SPECIAL TRAINING, U.S. MILITARY OR NAVAL SERVICE

EMPLOYMENT HISTORY (IF YOU HAVE A RESUME DO NOT COMPLETE)

FROM TO	NAME & LOCATION OF EMPLOYER	POSITION	REASON FOR LEAVING
_____	_____		_____
_____	_____		_____
_____	_____		_____

AUTHORIZATION: I certify that the facts contained in this application are true and complete to the best of my knowledge and I understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the employers listed above. I understand that I must provide a written personal reference and a business reference before my application can be considered.

APPLICANT SIGNATURE: _____ DATE: _____

INTERVIEWED BY: _____ DATE: _____

ADVANCED™
HOME HEALTHCARE

EMPLOYMENT REFERENCE REQUEST

Date: _____

Company Name: _____
Attention: _____
Address: _____
Or Fax No.: _____

I have applied for employment with ADVANCED HOME HEALT CARE OF TAMPA
I authorize you to provide information regarding to my last employment with you. Thank you for your prompt reply.

Applicant's Signature: _____
Applicant's Name: _____

To be completed by Former Employer:

Job Skills	Excellent	Very Good	Good	Poor
Reliability and Attendance				
Ability to work with others				
Organizational Skills				
Honesty				
Ability to accept directions				
Supervisory ability capacity				
Patient Care Skills				

Date of Employment: _____ to _____

_____ _____ _____
Signature of Representative Title Date

In office use only:
Date sent: Via ☐mailed _____ ☐Fax _____ ☐Phone _____ ☐By: _____

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Supervisory ability capacity				
Patient Care Skills				

Date of Employment: _____ to _____

_____ _____ _____
Signature of Representative Title Date

In office use only:
Date sent: Via ☐mailed _____ ☐Fax _____ ☐Phone _____ ☐By: _____

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LICENSE/CERTIFICATE VERIFICATION

EMPLOYEE NAME: _____DATE:_____

Employee Name: _____

Position/Title:_____

Type of License/Certificate: _____

License/Certificate#:_____ Expiration Date: _____

I hereby affirm that the license/certificate that I have presented is a valid license/certificate and pertains to me.

Employee Signature: _____ Date: _____

I verify that I have examined the original license(s)/certificate(s) presented to me by the above mentioned individual.

Signature: _____

Title: _____ Date: _____

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CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION, CRIMINAL BACKGROUND SCREENING DATE FORM.

EMPLOYEE NAME: _____DATE:_____

I have been formally instructed that my Physical Examination Form, and any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency.

I understand that no medical/criminal data are to be removed from the Home Health Agency unless a "Release of Information" form has been completed and signed by me. It is my understanding that such Release of Information (THIS FORM) authorizes the Agency to release my Physical/Background Information data to State/Federal surveyors as their request if needed to conduct a survey or any necessary investigation.

I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.

EMPLOYEE SIGNATURE: _____DATE_____