QUALITY HOME HEALTH CARE, INC.
A full range of services in the comfort and privacy of your own home
(414) 315-3717 | Fax (414) 425-4871

EQUAL OPPORTUNITY EMPLOYER
All qualified applicants will receive equal consideration regardless of race, color, sex, mental status, national origin, disability, age, religion or any other protected basis as prohibited by law

Employment Application

Instructions

a. Please print in INK; no white out.
b. Answer all questions. Mark those questions which do not apply to you as "NA".
c. Carefully read the agreement at the end of the application and affix your signature.

Personal Information

NAME: Last First M.I. DATE

CURRENT ADDRESS PHONE NO. ( )

CITY STATE ZIP CODE OTHER PHONE NO. ( )

EMAIL ADDRESS

Authorized to work in the U.S. ❑ Yes ❑ No **YOU WILL BE REQUIRED TO PROVIDE PROOF OF EMPLOYMENT ELIGIBILITY**

Referral Source

❑ QHHC Staff Member: _____
❑ QHHC Job Posting: _____
❑ QHHC Job Line (phone): _____
❑ Newspaper: _____
❑ School: _____
❑ Professional Publication/Journal: _____
❑ Recruitment Event (Job/Career Fair, Open House): _____
❑ Community Agency: _____
❑ Self Inquiry/Walk-in: _____
❑ Direct Mail: _____
❑ Other: _____

Position Most Qualified for:
(You must select ***one*** position from our current Job Vacancy List)
1) _____
NURSING APPLICANT - Please identify unit of interest:
_____
Available Start Date: _____
Salary Desired: _____

Please indicate what you are willing to work:

Shift	**Status**	**Days**	
❑ Any	❑ Any	❑ Any	❑ Thurs
❑ 1st	❑ Full Time	❑ Mon	❑ Fri
❑ 2nd	❑ Part Time (20-39 hrs/wk)	❑ Tues	❑ Sat
❑ 3rd	❑ Optional Part Time (as needed)	❑ Weds	❑ Sun
❑ Rotating	❑ Temporary	❑ Holidays	

Do you have any shift limitations?
(i.e.: school hours, other job, etc.) ❑ Yes ❑ No If yes, please explain: _____

Have you ever been employed by Quality Home Health Care? ❑ Yes ❑ No
If yes, when? _____ Your name while employed _____
Are you related to anyone currently employed by Quality Home Health Care? ❑ Yes ❑ No
If yes, name of person Last _____ First _____
Relationship _____ Position (if known) _____

Have you ever been notified that you are excluded from participating in a medicare provider program? ❑ Yes ❑ No
If yes, explain: _____
Have you ever been convicted of, or pled guilty or no contest to a felony or misdemeanor or are currently facing a pending felony or misdemeanor charge that has not yet been resolved? (You should understand that answering "yes" will not necessarily preclude your employment with QHHC. However, if you lie or misrepresent the facts of a criminal arrest or conviction, you will be terminated or not hired because of dishonesty.) ❑ Yes ❑ No
If yes, please describe the conviction(s) or pending criminal charge(s) in detail, including dates _____
_____
Describe any specialized training, skills you have been involved in _____
_____

Name: Last First M.I.
Date:
PLEASE PRINT

Employment Record for Last 10 Years - This section must be completed.

Begin with your present or most recent job. List your employers for at least 10 years including all full and part time employment. All time must be accounted for including military service, schooling, self-employment and periods of unemployment. Attach separate sheet of paper if necessary. **Please complete fully in your own handwriting. Incomplete applications will not be accepted.**

1

CURRENT/PREVIOUS EMPLOYER			DATES OF EMPLOYMENT From:
ADDRESS			To:
CITY	STATE	ZIP CODE	PHONE NO. ( )
YOUR NAME WHILE EMPLOYED			START RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
POSITION TITLE			FINAL RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
DESCRIPTION OF JOB DUTIES			SCHEDULE ❑ Full Time ❑ Part Time ❑ Temporary
			SUPERVISOR
REASON FOR LEAVING			PERSON WE MAY CONTACT FOR A REFERENCE

2

CURRENT/PREVIOUS EMPLOYER			DATES OF EMPLOYMENT From:
ADDRESS			To:
CITY	STATE	ZIP CODE	PHONE NO. ( )
YOUR NAME WHILE EMPLOYED			START RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
POSITION TITLE			FINAL RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
DESCRIPTION OF JOB DUTIES			SCHEDULE ❑ Full Time ❑ Part Time ❑ Temporary
			SUPERVISOR
REASON FOR LEAVING			PERSON WE MAY CONTACT FOR A REFERENCE

3

CURRENT/PREVIOUS EMPLOYER			DATES OF EMPLOYMENT From:
ADDRESS			To:
CITY	STATE	ZIP CODE	PHONE NO. ( )
YOUR NAME WHILE EMPLOYED			START RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
POSITION TITLE			FINAL RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
DESCRIPTION OF JOB DUTIES			SCHEDULE ❑ Full Time ❑ Part Time ❑ Temporary
			SUPERVISOR
REASON FOR LEAVING			PERSON WE MAY CONTACT FOR A REFERENCE

4

CURRENT/PREVIOUS EMPLOYER			DATES OF EMPLOYMENT From:
ADDRESS			To:
CITY	STATE	ZIP CODE	PHONE NO. ( )
YOUR NAME WHILE EMPLOYED			START RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
POSITION TITLE			FINAL RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
DESCRIPTION OF JOB DUTIES			SCHEDULE ❑ Full Time ❑ Part Time ❑ Temporary
			SUPERVISOR
REASON FOR LEAVING			PERSON WE MAY CONTACT FOR A REFERENCE

5

CURRENT/PREVIOUS EMPLOYER			DATES OF EMPLOYMENT From:
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CITY	STATE	ZIP CODE	PHONE NO. ( )
YOUR NAME WHILE EMPLOYED			START RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
POSITION TITLE			FINAL RATE OF PAY $ ❑ Hour ❑ Week ❑ Month
DESCRIPTION OF JOB DUTIES			SCHEDULE ❑ Full Time ❑ Part Time ❑ Temporary
			SUPERVISOR
REASON FOR LEAVING			PERSON WE MAY CONTACT FOR A REFERENCE

If necessary, use a separate sheet to complete 10 year history

Education

Type	Name and Location	Graduated?	Circle Last Year Completed	Diploma or Degree
High School		Yes No	9 10 11 12	
Technical School		Yes No	1 2 3	
College		Yes No	1 2 3 4 5 6	
Other		Yes No		

Have you received a GED or High School Equivalency Diploma (HSED)? ❑ Yes ❑ No Date received (Mo./Yr.)_____ From where:_____

YOU WILL BE REQUIRED TO PROVIDE PROOF OF EDUCATION.

Computer and Office Skills Inventory

Please indicate experience or proficiency in the following areas:

❑ Computer Software/Word Processing (Excel, Outlook, etc.) _____
_____
_____

❑ Medical Terminology _____
❑ Insurance Terminology _____
❑ Medical Transcription _____

❑ Data Entry/Retrieval _____
❑ Typing WPM _____
❑ Office machines you can operate (calculator, fax, copy, etc.) _____
_____
_____
_____

Certifications, Registrations, Licenses, and Professional Credentials

Are you currently ❑ Licensed ❑ Eligible for license ❑ Certified ❑ Registered ❑ Registry eligible

IF CERTIFIED, REGISTERED, OR LICENSED	TYPE	STATE ISSUED	NUMBER	DATE	EXPIRATION DATE

Is your certification/registration/license currently under investigation? ❑ No ❑ Yes If yes, please explain: _____
_____

Has your certification/registration/license been suspended or revoked in any state? ❑ No ❑ Yes If yes, please explain: _____
_____

YOU WILL BE REQUIRED TO PROVIDE PROOF OF CERTIFICATION/REGISTRATION/LICENSE ANNUALLY.

Conditions of Application (Please read carefully before submitting this application.)

In applying for work at Quality Home Health Care (QHHC), I understand and agree as follows:

1. **True and Complete Information.** I understand that all the information I furnish in my employment application and related documents and during any employment interview must be true and complete. I certify that all such information is or will be true and complete and that I have included any additional information or explanations that may be appropriate. I further understand that any false statement by me in this application or in any related document or the omission of any requested information will be cause for rejection of my application or for my dismissal if I have already been employed.
2. **Investigation.** I hereby authorize QHHC to investigate all statements made in this application, any related documents, and in any employment interview. I understand that any offer of employment is contingent upon the satisfactory completion of such investigation. Except as otherwise specifically indicated in this application, I further authorize QHHC to obtain all information necessary to evaluate my suitability for employment. All employers, personal references, and academic institutions named in this application are similarly authorized to provide such information, and I agree to sign whatever additional form may be necessary to confirm such authorization. I hereby release QHHC and all credentials, and suitability for employment as authorized in this application. I may be completing this application electronically. If so, I agree that the submission of the application is my approval of all items noted including reference checking and other pre-employment activities. I further understand, upon interviewing for a position, I will provide a physical signature for approval for authorization which may be needed during the course of employment at QHHC,
3. **Employment at Will.** I understand that all employment between QHHC and its employees are terminable at will, meaning that, if I am hired, my employment can be terminated at any time, with or without cause or with or without notice, at my option or at the option of QHHC. I further under stand that no employee or agent of QHHC is authorized to offer me an employment relationship other than the one that is terminable at will.
4. **Terms and Conditions May Be Changed.** I understand that, if I am hired, any terms and conditions of my employment and all personnel policies that may be issued (whether in an employee handbook or other written document) are not intended to give rise to contract rights and are subject to change by QHHC at any time, with or without notice.
5. **Physical Examination & Drug Screen.** If I am hired by QHHC, I understand that any offer of employment is contingent upon successful completion of a physical examination, which will include drug screens.
6. **Acknowledgement.** I understand I may ask questions regarding any of the information requested in this application or in any related document, and I acknowledge that any questions I asked were answered to my satisfaction. I further acknowledge that I have read and understand the preceding Conditions of Application.

Signature of Applicant _____ Date Signed _____

Printed Name of Applicant _____