United Family
Home Health Care LLC
Love – Care - Happiness

3610 Dodge Street, Suite 204, Omaha, NE 68131
Tel: 402.763.8935 Fax: 402.885.8956 Email: unitedfamilyhhc@gmail.com

APPLICATION FOR EMPLOYMENT

_____Full Time _____Part Time _____Temporary

If you need help filling out this application form or during any phase of the employment application process, please notify the person who gave you this form or another member of the Human Resources Department and every effort will be made to accommodate your needs in a reasonable amount of time.

Position Desired: _____ DATE: _____

FIRST NAME: _____ MI _____ LAST NAME: _____

PHONE NUMBER: _____

_____

STREET ADDRESS CITY STATE ZIP CODE

_____

SOCIALSECURITY # DRIVER' LISENCE # ISSUE STATE EXPIRATION DATE

HAVE YOU EVER BEEN EMPLOYED AT THIS US? _____YES, _____NO.

WHO REFERED TO US: FRIEND/EMPLOYEE/NEIGHBOR/ NEWS PAPER OR, OTHERS

_____.

ENTER DATE YOU CAN START WORK: _____.

LIST ANY RELATIVES EMPLOYED AT THIS FACILITY.
_____.

EDUCATION:

	NAME OF THE SCHOOL	DEGREE RECEIVED	GRADUATED YES/ NO	AREAS OF SPECIALIZATION
HIGH SCHOOL				
COLLEGE				

MILITARY STATUS
Veteran of U.S Armed Forces: _____Yes_____No

DATES FROM _____ TO _____

Did you attend professional school? _____YES _____NO

LICENSE AND PROFESSIONAL ACTIVITIES	DID YOU GRADUATE?
NURSING	
PRACTICAL NURSING	
X-RAY	
LABORATORY	
OTHER	

This facility is an equal opportunity employer, federal and state laws prohibits discrimination of employment because of race, color, religion, age, sex, national origin or disability. No question on this application is asked for the purpose of limiting or excluding any applicant consideration for employment because of race color, religion, age, sex, national origin, or disability.

EMPLOYMENT REFERENCES:
List most recent employer first.

If currently employed-may we contact your present employer? _____Yes ____No

1. Place of employment_____ Position held _____

Address: _____Name of supervisor: _____

City: _____ State: _____ Phone number: _____

Employment date from: _____ to: _____

Name used during employment: _____salary/wages: _____
Reason for leaving:
_____

_____

2. Place of employment_____ Position held _____

Address: _____Name of supervisor: _____

City: _____ State: _____ Phone number: _____

Employment date from: _____ to: _____

Name used during employment: _____salary/wages: _____
Reason for leaving:
_____

3. Place of employment_____ Position held _____

Address: _____Name of supervisor: _____

City: _____ State: _____ Phone number: _____

Employment date from: _____ to: _____

Name used during employment: _____salary/wages: _____
Reason for leaving:
_____

_____

Other pertinent data:

Have you ever been convicted of a crime other than a misdemeanor or summary offence; ____Yes ____No

Years of conviction:
_____

Charges:
_____

_____

Medical professionals only:
Have you ever been involved in a medical malpractice, action? Yes no
Explain:
_____

_____

If employment is offered, can you submit a birth certificate, social security card, and certificate of U.S citizenship or verification of your legal right to work in the U.S? _____Yes _____ No.

Employment will be contingent upon successful completion of a medical examination.

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APPLICATION DISCLOSURE

Please read this statement carefully. If you have any questions, please seek assistance before signing the application. This is an equal opportunity employer and selects individual best on matched for the job based upon job-related qualifications regardless of race, color, creed, sex, religion, national origin, age or disability. I understand that any misrepresentation, misinformation or inaccuracy of the statement contained in this application may result in termination of my employment or withdrawal of an offer of employment.

I authorize the company to investigate all information and references and to obtain any transcripts, records, or documents pertaining to my background and business experience as required arriving at an employment decision. I also hereby release the company, its officers, employees, representatives, or agents, from all labiality and/or damage incurred by myself in obtaining such information. I understand and that if I have physical or mental impairment that substantially limits one or more of my major life activities, or a record of such impairment, or if I otherwise believe myself to be covered the Americans with disabilities activities act, I can advise the company at any time during the application, interview or hiring process about the accommodations the company could make to enable to perform the essential functions of the job I am seeking. I understand and that submission of information regarding reasonable accommodation is voluntary and that my refusal to provide it will not subject to adverse treatment in the employment process.

I further understand and that information obtained by the company regarding my disability will be kept confidential, except that, if hired, (1) supervisors and managers may be informed regarding restrictions on my work or' duties, and regarding necessary accommodations, (2) first aid and safety personnel may be informed, when and to the extent appropriate, if the condition might require emergency treatment; and (3) government officials investigating compliance with the Americans with disabilities act may be informed. In this connection, I authorize any physician or hospital to release to the company any information that may be necessary to determine my ability to perform the essential functions of a job for which I am being considered prior to employment or during my employment with the company if offered employment the company may require me to take a physical examination and drug and alcohol screen the result of which I agree can be required to the company.

I hereby understand and acknowledge that unless otherwise defined by the applicable law, any employment relation sum with this organization is of an" at will" nature, which means that the employee may resign at any time and the employer may discharge employment at any time with or without cause. It is further understood that this –at will "call acknowledged in writing by an authorized executive of this organization.

If hired, I agree to conform to the rules and regulations of this company as issued from time to time.

_____ _____

APPLICANT SIGNATURE DATE

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AUTHORIZATION TO RELEASE INFORMATION FORM

Note: Submitting an incomplete or illegible form may delay the background check results.

I hereby AUTHORIZE and request any law enforcement agency to furnish bearer with criminal history and identity check information in their possession regarding me in connection with my employment in a critical position. I am willing that a photocopy of this authorization be accepted with the same authority as the original. I understand this AUTHORIZATION is to be part of the written employment application, which I sign.

I understand that the positions that are designated critical require background checks for the propose of evaluating me for employment, promotion, reassignment, reclassification, transfer, or retention as an employee. I also understand and any misrepresentation, falsification or omission of facts herein may be grounds for disqualification, release or dismissal.

PRINT NAME:

_____

Last Name First Name Middle Name

DATE IF BIRTH: _____ SOCIAL SECURITY # : _____

HOME PHONE #: _____ BUSINESS PHONE #: _____

OTHER NAMES YOU HAVE USED: _____ SEX: ____M ____F

DIVERS'S LICENSE INFORMATION

_____

License number Expiration Date State of Issue.

Current Address:

_____

Street Number & Names City State Zip How Long?

HAVE YOU EVER BEEN CONVICTED OF A CRIME UNDER ANOTHER NAME? _____ YES _____NO

IF YES, STATES NAME:

_____

PRIVACY NOTICE

The principal purpose for requesting the information on this form is to conduct background checks on individuals selected for critical positions. Our policy and federal statute authorize the maintenance of this information.
Furnishing all information requested on this form is mandatory. Failure to provide such information shall result in a determination that the application is ineligible for employment or not appropriate for reassignment.

I hereby certify that all statements on this application are true and correct to the best of my knowledge and belief. I understand United Family Home Health Care LLC. Solicits this information so as to be informed of my previous record and character. I understand that my employment with United Family Home Health Care LLC depends upon successful completion of a criminal background investigation. If employed, I understand any falsification; misrepresentation or omission of facts of this record may be considered cause of release or dismissal.

APPLICANT SIGNATURE _____ DATE: _____