DIVINE HOME HEALTH CARE, LLC
JOB APPLICATION FORM

This agency bases hiring decisions on the ability, skills, education, experience, and background of applicants, and does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, sexual orientation, national origin, age, disability, or any other characteristic protected by law.

Equal Opportunity Employer/Provider

Date of Application: (mm/dd/yy) _______/________/___________

Position(s) Applied for: ☐ RN ☐ LPN ☐ HHA ☐ Therapist ☐ Other________________

Name: ___________________________, ____________________________, _____________________
(Last) (First) (Middle Initial)

Address: ___________________________________ City: ____________ State: _______ Zip: _______

Telephone Number ( ) ___________________ Best time to reach: ☐ A.M. ☐ P.M

Date of Birth (mm/dd/yy) _____/_____/________ SSN #:__________________________________

Are you of legal age to work? ☐Yes ☐ No

Are you a U.S. Citizen? ☐ Yes ☐ No If no are you authorized to work in the U.S. ☐ Yes ☐ No

If yes, provide Alien Number: ____

Are you available to work: ☐ Full-time ☐ Part-time ☐ Casual

Emergency Contact Name: __________________________________ Phone: (_____) _____________

Have you ever been convicted of a Crime other than a routine traffic citation? ☐ Yes ☐ No
(If yes attach a written explanation)

How did you hear about our company? ☐ Direct Mailer ☐ Newspaper Ad ☐ Referral by another employee. If referred by another employee, state name: ___________________________
____

EDUCATION:

High School

Institution Attended: _____________________________ City: _________________ State: ________

Years Attended: (Month/Year) ________/__________________

Did you graduate: ☐ Yes ☐ No

Diploma: ____

College

Institution Attended: _____________________________City: _________________ State: _________

Years Attended: (Month/Year) __________/ _________________

Did you graduate: ☐Yes ☐ No

Degree at Completion: ____

Technical /vocational

Institution Attended: ______________________ City: __________State: _____

Years Attended: (Month/Year) ________/ __________

Did you graduate: □ Yes □ No

Course of Study: ____

Other classes/Training: ____

MILLITARY SERVICE

Branch:______________________________Rank:____________________

Rank at Discharge: _____________________Type of Discharge: ______________

Present Membership in National Guard or Reserves: ________________________

Were you honorably discharged? □ Yes □ No

Describe your duties and any special training: ____________________________

____

CERTIFICATIONS/LICENSURE

Current certificates or licenses:

Type: _____________________________Organization or State Issued __________

Date Issued____/_____/________ Expiration date: ____/____/_______

Type: _____________________________Organization or State Issued __________

Date Issued____/_____/________ Expiration date: ____/____/_______

Type: _____________________________Organization or State Issued __________

Date Issued____/_____/________ Expiration date: ____/____/_______

(**All professional licenses will be verified at the time of employment)**

PREVIOUS EMPLOYMENT

List current employer first:

1. _________________________________Date of employment: _____ to_____

(Employers Name) *(Start)* *(End)*

City: ___________ State: ______ Phone #: (___) ___________ Supervisor: ________

Job Title: ____________________ Starting Salary $: ______ Ending Salary $: _______

Responsibilities: ____

____

May we contact your present employers? □Yes □ No. If no, please explain why: __________

____

References verified by: ____ Date: _____/______/________

2. ____ Date of employment: _____ to_____
(Employers Name) *(Start)* *(End)*
City: ________________ State: ________ Phone #: (___) _______________ Supervisor: ____________
Job Title: ____________________________ Starting Salary $: ________ Ending Salary $: __________
Responsibilities: ____
____
May we contact your present employers? □Yes □ No. If no, please explain why: _____________
____

References verified by: ____ Date: _____/______/________

3. ____ Date of employment: _____ to_____
(Employers Name) *(Start)* *(End)*
City: ________________ State: ________ Phone #: (___) _______________ Supervisor: ____________
Job Title: ____________________________ Starting Salary $: ________ Ending Salary $: __________
Responsibilities: ____
____
May we contact your present employers? □Yes □ No. If no, please explain why: _____________
____

References verified by: ____ Date: _____/______/________

REFERRENCES:

1. Name: ____________________________ Relationship: _________________ Title: ________________
Company: ____ Phone Number: (_____) ______________
2. Name: ____________________________ Relationship: _________________ Title: ________________
Company: ____ Phone Number: (_____) ______________
3. Name: ____________________________ Relationship: _________________ Title: ________________
Company: ____ Phone Number: (_____) ______________

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application lead to employment, I understand that false or misleading information in my application or interview may result in my release.

_________________________________ ______________________________ _____/____/_______
Employee Name *Signature* *Date*

_________________________________ _________________________ ____/____/______

DHHC Name *Signature* *Date*

ADDENDUM TO EMPLOYMENT APPLICATION

The Ohio Administrative Code (5123:2-.05) requires that home health care companies ascertain from applicants for employment that have not been convicted, plead guilty of the offenses listed below. Your signature below indicates that you have not committed nor plead guilty to:

Aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, failing to provide for a functionally impaired person, aggravated menacing, patient abuse and neglect, kidnapping, abduction, criminal child enticement, rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, importuning, voyeurism, public indecency, compelling prostitution, promoting prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually oriented materials involving a minor, illegal use of a minor in nudity-oriented material or performance, aggravated robbery, robbery, aggravated burglary, burglary, unlawful abortion, endangering children, contributing to unruliness or delinquency of a child, domestic violence, carrying a concealed weapon, having weapons while under disability, improperly discharging a firearm at or into a habitation or school, corrupting others with drugs, drug trafficking, illegal administration or distribution of anabolic steroids, placing harmful objects in food or confection, child stealing, possession of drugs, felonious sexual penetration.

I, ____ have read the contents of this addendum to my application for employment with Divine Home Health Care, LLC. I also understand that I am required by law to notify Divine Home Health Care, LLC within 14 (fourteen) days if I receive formal charges, convictions or make a guilty plea to any one of the disqualifying offenses listed above.

_________________________________ _________________________ ____/____/______

Employee Name *Signature* *Date*

_________________________________ _________________________ ____/____/______

DHHC Name *Signature* *Date*

CONFIDENTIALITY AGREEMENT

In compliance with government (federal, state, local) rules, regulations and guidelines, as well as professional standards of the health care industry, the nature of services Divine Home Health Care, LLC provides requires that all client information be handled in a private and confidential manner by all staff and employees.

In compliance with HIPPA regulations, information about our agency, employees or clients will only be released to authorized individuals with prior written client consent. Exceptions to this policy will be explained during our New Employee Orientation. All staff, managers and employees are hereby advised that all agency reports, memoranda, notes, invoices and any other documents will remain a part of the agency's confidential records.

As a condition of employment, the undersigned agrees to abide by the terms of this confidentiality agreement.

_______________________________________ ______________________________ ____/____/______
Employee Name *Signature* *Date*

_______________________________________ ______________________________ ____/____/______
DHHC Name *Signature* *Date*