



Application for Employment

Sunshine Home Health

Personal Information

Name:	Social Security Number:	Anticipated Position:
Home Address:	City:	State/Zip:
Primary Phone:	Are you legally eligible for employment in the U.S? Yes _____ No _____ <small>(If offered employment you will be required to provide documentation to verify eligibility.)</small>	

Education Background

High School

Number of years completed (circle one) 1 2 3 4	Diploma: Yes ___ No ___ G.E.D.: Yes ___ No ___
School Name:	City/State:

College and/or Vocational School

School Name:	City/State:
Number of years completed (circle one) 1 2 3 4	Major:
Degree Earned:	Degree Earned:

Other Training or Degrees

School:	City/State:
Course:	Degree/Certificate Earned:
Address:	City, State, Zip:

Professional Licenses or Memberships

Type of License(s) Held:	State in which licenses are current:
License Number:	License Expiration Date:
Other Professional Memberships:	

You need not disclose membership in professional organizations that may reveal information regarding race, color, creed, sex, religion, national origin, ancestry, age, disability, marital status, veteran status, or any other protected status.



During the last ten years, have you ever been convicted of a crime other than minor traffic offense? Yes ___ No ___

If yes, please explain: _____

(Driving under the influence of drugs or alcohol is not considered a minor traffic offense.)

Have you ever been named as a perpetrator of abuse/neglect or exploitation of a child, elderly person or as an adult by a state agency in a case where in the state agency determined that the allegation against you was valid or substantiated? Yes ___ No ___

Employment	
(List your most current or last employer first)	
If any employment was under a different name, indicate name _____	
Company Name:	Phone:
Address:	Contact Name:
Position:	Reason for Leaving:
Employment Dates:	May we contact your present employer? Yes ___ No ___

Company Name:	Phone:
Address:	Contact Name:
Position:	Reason for Leaving:
Employment Dates:	

Company Name:	Phone:
Address:	Contact Name:
Position:	Reason for Leaving:
Employment Dates:	

Company Name:	Phone:
Address:	Contact Name:
Position:	Reason for Leaving:
Employment Dates:	May we contact your present employer? Yes ___ No ___



Have you ever been employed with Sunshine Home Health before? Yes _____ No _____

If yes, please provide the dates of employment: _____

Professional References

Name:

Address:

Relationship:

Email:

Phone:

Name:

Address:

Relationship:

Email:

Phone:

Personal References

Name:

Address:

Relationship:

Email:

Phone:

Name:

Address:

Relationship:

Email:

Phone:

I certify that all of the information submitted by me on this application is true and complete. I understand that if any false information, omissions, or misrepresentations are discovered, my application may be rejected and if I am employed, my employment may be terminated at any time.

In consideration of my employment, I agree to the company's rules and regulations and I agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at either my or the company's option. I also understand and agree that the terms and conditions of my employment may be changed, with or without cause and with or without notice, at any time by the company. I understand that no company representative, other than its Administrator, and then only when in writing and signed by the Administrator, has any authority to enter into any agreement for employment or any specific period of time, or to any agreement contrary to the foregoing. I also acknowledge that I am consenting to a criminal background check with my signature.

Date Signed

Employee's Signature