



APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE
EQUAL OPPORTUNITY EMPLOYER

NAME (LAST NAME FIRST)		SOCIAL SECURITY NUMBER	
PRESENT ADDRESS			
CITY		STATE	ZIP CODE
PHONE NO.	EMAIL ADDRESS.		
REFERRED BY			

Employment Desired _____

POSITION	DATE YOU CAN START	SALARY DESIRED
ARE YOU EMPLOYED NOW? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>	ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>
EVER APPLIED TO THIS COMPANY BEFORE? YES <input type="checkbox"/> NO <input type="checkbox"/>	WHERE	WHEN

Education History _____

	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE	SUBJECTS STUDIED
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS, OR CORRESPONDENCE SCHOOL				

General Information _____

SUBJECTS OF SPECIAL STUDY/RESEARCH WORK	
SPECIAL TRAINING	
SPECIAL SKILLS	
U.S MILITARY OR NAVAL SERVICE	RANK

Former Employers (LIST BELOW LAST EMPLOYERS, STARTING WITH LAST ONE FIRST) _____

DATE MONTH AND YEAR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM TO				
FROM TO				
FROM TO				

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REFERENCES GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	PHONE NUMBER	YEARS KNOW

AUTHORIZATION

*"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.
 I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.
 I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.
 This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws."*

DATE

SIGNATURE

-----DO NOT WRITE BELOW THIS LINE-----

DATE
 REMARKS

hs...

INTERVIEWED BY

NEATNESS			CHARACTER	
PERSONALITY			ABILITY	
HIRED	FOR DEPT.	POSITION	WILL REPORT	SALARY WAGES

APPROVED:

EMPLOYMENT MANAGER

DEPARTMENT HEAD

This application for employment is sold only for general use throughout the United States. Adams assumes no responsibility and hereby disclaims any liability for the inclusion in this form of any questions or requests for information upon which a violation of local, state, and/or federal law may be based. It is the user's responsibility to ensure that this form's use complies with applicable laws, which change from time to time



CONTRACTOR EMERGENCY NOTIFICATION

AS PER AGENCY POLICY, EVERY CONTRATOR MUST COMPLETE AT LEAST TWO EMERGENCY NOTIFICATIONS AS WELL AS UPDATE THE FORM AS NECESSARY.

Contractor Name: _____ Date: _____

IN CASE OF EMERGENCY NOTIFY NEXT OF KIN

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

SECONDARY EMERGENCY CONTACT (FRIEND OR RELATIVE NOT LEAVING WITH YOU)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____



SCHEDULE A

COMPENSATION/HEALTH SCREENING REQUIREMENTS & FEES

COMPENSATION:

Description	Rates

Overtime payment begins after forty (40) hours have been worked. Payment for overtime is one and one-half of the hourly rates. Overtime can only be performed with the prior written approval of the client. Any unauthorized overtime worked without prior written approval by client is grounds for immediate termination of the Independent Contractor Agreement.



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Doral, FL 33172
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Reference request form

TO BE COMPLETED BY APPLICANT

REFERENCE NAME: _____

FACILITY NAME: _____

TELEPHONE: _____ FAX: _____

I HAVE APPLIED TO HOME CARE PLUS NURSE REGISTRY LLC, FOR A POSITION AS A _____.
I AUTHORIZE YOU TO RESPOND TO THE QUESTIONS BELOW SO THAT THE AGENCY MAY ACT ON MY APPLICATION. I RELEASE YOU TO FROM ALL LIABILITY IN SUPPLYING THIS INFORMATION REGARDING MY EMPLOYMENT WITH YOU.

APPLICANT NAME

APPLICANT SIGNATURE

I WORKED FOR YOU FROM _____ TO _____ AS A _____.

TO BE COMPLETED BY FORMER EMPLOYER

WOULD YOU RE-EMPLOY APPLICANT? ___ YES ___ NO

IS THE ABOVE INFORMATION CORRECT? ___ YES ___ NO

IF NO, PLEASE EXPLAIN: _____

	EXCELLENT	VERY GOOD	GOOD	POOR
JOB SKILL				
JOB KNOWLEDGE				
INITIATIVE				
ATTENDANCE				
ABILITY TO WORK WITH OTHERS				
JUDGMENT				
HONESTY				
ABILITY TO ACCEPT DIRECTIONS				
GROOMING AND APPEARANCE				
TIME MANAGEMENT				

Signature

Date

Over the phone

To be completed by Home Care Plus Nurse Registry LLC

Person contacted: _____ Title: _____ Date: _____

Administrator/Designee signature: _____