EMPLOYMENT APPLICATION – SUNRISE HOME HEALTH

PERSONAL INFORMATION

Name: _____ Date: _____
Last Name First Name Middle Initial

Address: _____ Phone #:_____
Street City, State Zip

Social Security #: _____ Other names you have worked under: _____

Are you a U.S citizen or authorized to work in the U.S. on an unrestricted basis? Yes ☐ No ☐

Can you, after empolyment, submit:

Proof of your legal right to work in the U.S.? Yes ☐ No ☐ A State I.D.or other proof of age? Yes ☐ No ☐

Have you ever been convicted of a crime except minor traffic violations ? Yes ☐ No ☐

If yes provide details: _____

Person to be notified in an emergency: _____ Phone #: _____

Address:_____ Relation: _____

POSITION DESIRED

Position(s) applied for: _____ Salary Requested: _____

Specify: ☐ Full-time ☐ Part-time ☐ Temporary ☐ Weekends

Hours and days available: _____

Were you previously employed by Sunrise? Yes ☐ No ☐

If yes, when and where? _____

Names of relatives employed: _____

If an offer is extended, when would you be available for work? _____

Do you have any physical or mental conditions that may require special accommodations for the position for which you are applying?

Yes ☐ No ☐

If yes what accommodations are necessary? _____

How did you become aware of the position for which you are applying? Provide name of individual or source: _____

_____

Do you have a reliable method of transportation to use if you're hired to work for this Agency? Yes ☐ No ☐

EDUCATION AND TRAINING

Name of School and Location (City and State)	Year Graduated	Diploma / Degree

Professional and technical applicants only:

Professional License No. (State & Number)	Date License Issued	Renewal Number	Expiration Date

List membership in any professional organizations: ____

____

Check the boxes below to indicate experience in the following:

CLERICAL

☐ Accounting
☐ Admissions
☐ Unit Clerk
☐ Cashier
☐ Medical Records
☐ Transcriber

☐ Secretary
☐ Collections/Credit
☐ Personnel
☐ Insurance
☐ Customer Service
☐ Scheduling

NURSING

☐ Emergency Room
☐ Oncology
☐ Home Health
☐ Hospice
☐ Hospital
☐ Care Coordination

☐ Outpatient Clinics
☐ ICU / CCU
☐ Case Management
☐ Community Care

OTHER

☐ Pharmacist ☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy

COMPUTER LITERACY

☐ Microsoft Word ☐Microsoft Excel ☐Other Software: ______________________________

____

Do you speak, read, or write in any language other then English? ☐ Yes ☐ No If yes, please describe: ____________

____

Please use this space below for any additional information necessary to describe your full qualifications:

____

____

EMPLOYMENT HISTORY *(All blanks must be completed. Do not write "see resume.")*

Are you currently employed? Yes ☐ No ☐ May we contact your present employer? Yes ☐ No ☐

List below your work experience beginning with the most recent job.

Job Title:		**Employer Information**		**Job Duties**
Hire Date:		Name:		
End Date:		Street		
Starting Salary:		City/State/Zip		
Final Salary:		Phone:		
Reason for Leaving:		Supervisor:		

Job Title:		**Employer Information**		**Job Duties**
Hire Date:		Name:		
End Date:		Street		
Starting Salary:		City/State/Zip		
Final Salary:		Phone:		
Reason for Leaving:		Supervisor:		

Job Title:		**Employer Information**		**Job Duties**
Hire Date:		Name:		
End Date:		Street		
Starting Salary:		City/State/Zip		
Final Salary:		Phone:		
Reason for Leaving:		Supervisor:		

REFERENCES *(Please do NOT list relatives.)*

Name	Occupation	Phone Number

PLEASE READ CAREFULLY:

I hereby certify that the answers to the foregoing questions are true to the best of my knowledge and agree to have any of the statements checked unless I have indicated to the contrary.

I am aware that a more detailed investigation concerning background and credit may also be conducted, if applicable to the job for which I am applying, and I hereby authorize such an investigation.

I understand that employment is contingent upon satisfactory completion of reference checks and that, upon my written request, information on the nature and scope of an inquiry, if one is made, will be provided to me.

I further understand that should I be hired by Sunrise Home Health Services, I can be removed, with or without cause, at the option of the facility and that my employment and continued employment is at the will of Sunrise Home Health Services.

I agree to wear all protective clothing or devices required by the Agency to comply with all safety policies and procedures.

I understand that nothing contained in this employment application is intended to lead to or create an employment contract between Sunrise Home Health Services. I further understand and agree that the employment relationship that may result from my application will be employment-at-will, and either Sunrise Home Health Services or I may terminate the relationship at any time.

I understand that any misrepresentation or falsification can be grounds for refusal of employment. I further understand that, if employed, any false statements or misrepresentations made herein may be cause for dismissal.

_____ _____

Applicant Signature Date

Authorization for Verifications

As an applicant for a position with Sunrise Home Health Services, I have been asked to furnish information for use in reviewing my background information and qualifications. In connection, I hereby authorize past employers and educational institutions to release information about my past work and educational history. I also authorize Sunrise Home Health Services to verify my background information and my work/personal history to determine my qualification for the job.

Please release or verify the following ***checked* items only:**

PLACES OF EMPLOYMENT:

- ☐ Any information requested
- ☐ Dates of employment
- ☐ Positions held

EDUCATIONAL INSTITUTIONS:

- ☐ Degree/Certification obtained

VERIFICATIONS

- ☐ Criminal History
- ☐ Office of the Inspector General
- ☐ EMR/Nurse Aid

Please check both boxes below to confirm authorization.

☐ I do hereby release all persons, firms, agencies, or companies, whomsoever, from any damages resulting from furnishing such information.

☐ This authorization shall be valid for three months from the date of this application. You may retain this copy of my release for your files.

THANK YOU FOR YOUR INTEREST IN JOINING THE SUNRISE TEAM!