MEMORANDUM

FROM: Ageless Healthcare, LLC

SUBJECT: Application Required Documents

APPLICANT'S NAME: _____

DATE: _____

It is a requirement that all pre-applicants provide the necessary documentation before completing an application for employment:

1. Nursing License for Maryland _____
2. CPR Certificate _____
3. Social Security Card _____
4. Current 2PT TB Clearance (PPD or Chest X-Ray) _____
5. Criminal Background C heck _____
6. Driver's License or ID Card _____
7. One on One interview Date _____
8. How were You referred _____
9. Date of Hire _____
10. First Aid _____
11. Start Date _____

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

NAME(LASTNAME FIRST)			SOCIAL SECURITY NO.	
PRESENT ADDRESS		APT. NO.	CITY	ZIP
PERMANENT ADDRESS		APT. NO.	CITY	ZIP
ARE YOU 18 YEARS OR OLDER? ☐ YES ☐ NO	PHONE NO.			

DESIRED EMPLOYMENT

POSITION	START DATE	DESIRED SALARY
ARE YOU CURRENTLY EMPLOYED ☐ YES ☐ NO	MAY WE INQUIRE OF YOU CURRENT EMPLOYER? ☐ YES ☐ NO	
CURRENT EMPLOYER		TELEPHONE:
REASON FOR LEAVING		
NAME OF YOUR LAST SUPERVISOR		
EVER WORKED FOR THIS COMPANY BEFORE ☐ YES ☐ NO	WHO REFERRED YOU TO HOME HEALTHCARE SOLUTIONS ☐ FRIEND ☐ EMPLOYEE ☐ ADVERTISMENT ☐ GOVERNMENT PLACEMENT AGENDY ☐ INTERNET ☐ OTHER, SPECIFY: _____	

EDUCATION

LEVEL	NAME AND LOCATION OF SCHOOL	NO. OF YEARS ATTENDED	DID YOU GRADUATE	MAJOR
ELEMENTARY SCHOOL				
HIGH SCHOOL				
COLLEGE/UNIVERSITY				
PROFESSIONAL TRAINING				

EMPLOYMENT HISTOFY

List your last two (2) employers, assignments of volunteer activities, including experience. Explain any gap in employment in the comments section below.

NAME OF EMPLOYER			JOB TITLE		
ADDRESS			CITY	STATE	ZIP
FROM	TO	What was the nature of you work?			HOURLY RATE IN $
NAME OF SUPERVISOR		PHONE:	COMMENTS		

NAME OF EMPLOYER			JOB TITLE		
ADDRESS			CITY	STATE	ZIP
FROM	TO	What was the nature of you work?			HOURLY RATE IN $
NAME OF SUPERVISOR		PHONE:	COMMENTS		
ARE YOU ELIGIBLE FOR EMPLOYMENT IN THE UNITED STATES? *(Proof of eligibility will be required before employment)* ☐ YES ☐ NO					

Person to be contacted in case of an emergency: Relationship: _____

Name: _____ Telephone #: _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____
Number Street

PERSONAL REFERENCES

NAME	ADDRESS	BUSINESS	FROM	TO
HAVE YOU EVER BEEN CONVICTED OR A FELONY WITHIN THE LAST 5 YEARS?				
IF YES, PLEASE EXPLAIN (Will not necessarily exclude you from consideration)				

I certify that the facts contained in this application are true and complete. Any misrepresentation or falsification of information or significant omissions will be cause for rejection of my application or for a subsequent discipline up to and including dismissal from employment if discovered at the later date.

I understand that if employed, my employment is not guaranteed for any term, and my employment may be terminated by the employer or myself at any time and for any reason with or without prior notice. No representative of Action Healthcare Services, Inc. other than the owners is authorized to make any assurance or promise of continued employment and any such assurance must be in writing signed by the owners.

If I am employed, I agree to comply with and be bound by the safety and health rules and regulations, and rules of conduct of Ageless Healthcare ,LLC
This application will remain on active file for 60 days. If I am hired within this period, this form will be transferred to my individual personal file. If I am not hired or have not heard from this agency within 60 days, this application is no longer active and I will need to reapply for employment if I wish to be considered for a job with Ageless Healthcare, LLC

I do hereby give the employer and/or its agents, including consumer reporting bureaus, the right to investigate any and all statements made in this application for the purpose of employment and retention of employment. This investigation may include, but not limited to, credit reports, criminal conviction records, motor vehicle driving records and previous employment history. Further, I hereby release from liability and hold harmless Ageless Healthcare, LLC representative, all persons and organizations/companies for furnishing such information.

If required, I agree to a drug-testing prior and during employment or for post-accident occurrences. The employer, Ageless Healthcare, LLC. is an Equal Opportunity Employer. The employer does not discriminate in employment and no questions on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state or federal law.

NOTICE: This is to inform you that as part of processing your employment application, we may obtain a consumer report, which includes information as to your character, general reputation, personal characteristics and mode of living. If an investigative report is requested, you have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. By signing below, you acknowledge receipt of a copy of this notice and a copy of the "Summary of Your Rights under the Fair Credit Reporting Act."

Signature of Applicant: _____ Date: _____

SKILLS AND PREFERENCES INVENTORY

CERTIFICATION (Check one)

☐ RN ☐ LPN ☐ GNA/CNA NAME:_____ PHONE:_____

☐ OTHERS LICENSE #: _____ STATE:_____

The following information will help us place you where your skills, knowledge of nursing and preferences will be best suited.

SKILLS	CIRCLE ONE	SKILLS	CIRCLE ONE
Can you do vital signs?	Yes No	Can you do neurological assessments?	Yes No
Can you chart nurses' notes?	Yes No	Can you give intramuscular medications?	Yes No
Can you do catheter care?	Yes No	Can you give IV medications?	Yes No
Can you insert catheters?	Yes No	Can you assess patients for admission?	Yes No
Can you start IVs?	Yes No	Can you discharge patients?	Yes No
Can you section patients?	Yes No	Have you had CPR?	Yes No
Can you set up oxygen for patients?	Yes No	Do you have intensive care experience?	Yes No

In which of the following areas have you had experience? (Check one)

☐ Med-Surg. ☐ OB/GYN ☐ Oncology ☐ Geriatric ☐ Emergency Room

Have you had any special training in nursing? If so, what?

PREFERENCES	CIRCLE ONE	PREFERENCES	CIRCLE ONE
Are you a licensed driver?	Yes No	Will you work shifts at a hospital?	Yes No
Will you travel 30 minutes one way?	Yes No	Will you work shifts at a nursing home?	Yes No
Will you work every other weekend?	Yes No	Will you work private duty cases?	Yes No

Please rate your physical condition. (Check one)

☐ Excellent ☐ Good ☐ Fair

Circle the times you are available:

☐ Day ☐ Evening ☐ Night S M T W TR F S

Do you have any handicaps? If so, please describe:
How many hours a week do you wish to work?
Please attach photocopies of Driver's License, Professional License, CPR Certifications and any other relevant certifications.

VERIFICATION OF PREVIOUS EMPLOYMENT

TO: _____

Company Name: _____
Address: _____
Phone No: _____
Applicant's Name: _____
Position Applying For: _____
Employed From: _____ to: _____

I hereby authorize Ageless Healthcare LLC to contact all past employers and other individuals, agencies or entities concerning the information I have supplied and waive, release and hold harmless such individuals; agencies or entities from any claims arising from the information they may supply A + Believers Choice .

Applicant's Signature Date

_____ _____

The above applicant has applied for employment with us. Your evaluation will be greatly appreciated.

Staff Recruiter Date

_____ ----- ----------

TO BE COMPLETED BY EMPLOYER

Job Title:_____
Reason for Leaving: _____
Are applicant's personal qualifications, skills and personal habits such as to render him/her a desirable employee? Yes ____ No _____Would you rehire? Yes _____ No _____

EVALUATION

	Excellent	Good	Fair	Poor
Quality of Work	□	□	□	□
Attendance/Punctuality	□	□	□	□
Cooperation	□	□	□	□
Performance Under Pressure	□	□	□	□
Ability to Work Independently	□	□	□	□
Personal Appearance	□	□	□	□

CHARACTER REFERENCE VERIFICATION

NAME: .....
First Middle Last

Permanent Address: .....

City: ..... State: ..... Zip Code: .....

Daytime Phone: ..... Evening Phone: ..... Cell: .....

CHARACTER REFERENCES

NAME: .....
First Middle Last

Permanent Address: .....

City: ..... State: ..... Zip Code: .....

Daytime Phone: ..... Evening Phone: ..... Cell: .....

Comments: .....

NAME: .....
First Middle Last

Permanent Address: .....

City: ..... State: ..... Zip Code: .....

Daytime Phone: ..... Evening Phone: ..... Cell: .....

Comments: .....

NAME: .....
First Middle Last

Permanent Address: .....

City: ..... State: ..... Zip Code: .....

Daytime Phone: ..... Evening Phone: ..... Cell: .....

Comments: .....

.....
Employee Signature

.....
Date

.....
Agency Staff Signature

.....
Date