Care Health Services, Inc. **WE ARE AN EQUAL OPPORTUNITY EMPLOYER**

APPLICATION FOR EMPLOYMENT

Please note that in order for an application to be considered for employment, this application must be filled out completely. Any questions should be directed to a representative of the Personnel Department.

Name (Last, First, Middle | Social Security Number | Phone # to reached

Address (Number, Street, City, State, Zip | How did you hear of us?

Are you over the age of 18? □ Yes □ No

Are you a U.S. Citizen? □ Yes □ No

If not a U.S. Citizen, give visa number.

If you are applying for a position which requires access to an automobile to perform duties, complete the following section:

Car available
□ Yes □ No

Driver's License Number | State | Auto Tag Number | State

Auto Insurance
□ Yes □ No

Carrier | Policy Number

EMPLOYMENT DESIRED

Position Applying | When can you report for work? | Hourly wage expected

Check Desired Work Classification: □ Full Time □ Part Time □ Temporary (how long):

Days you can work | Hours you can work

EDUCATION

Name of School	Location	Year Completed	Graruate
High School		□ **9** □ **10** □ **11** □ **12**	□ Yes □ No Year:

□ **1** □ **2** □ **3** □ **4** □ Yes □ No

Year:

College or University

□ Yes □ No

Year:

Business, Technical or Other Training

Are you currently studying? □ Yes □ No If yes what and where:

Do you plan to return to school? □ Yes □ No

If applying for a professional licensed position:

Name or Professional License State and License Number

Professional Liability Insurance? □ Yes □ No

Carrier Name Amount or Coverage

FORMER EMPLOYERS

GIVE INFORMATION REGARDING ALL PREVIOUSEMPLOYMENT – INCLUDING MILITARY SERVICE (Starting with Present Employment)

	Name and address of CO.	Dates From To	Job Duties	Name, Number of Supervisor	Hourly Wage	Reason Leaving
1.						
2.						
3.						

CARE HEALTH SERVICES, INC.

TO: ALL APPLICANTS AND EMPLOYEES OF CARE HEALTH SERVICES, INC.

Effective July 1, 2008, the Agency for Health Care Administration (AHCA) has amended the Home Health Agency State Law.

Home Health Agencies may not employ:

1. a case manager, discharge planner, facility-based staff member, or 3rd party vendor who is involved in the discharge-planning process of a facility [hospital, ambulatory-surgical center, nursing home, home health agency, nurse registry or hospice] from whom the home health agency receives referrals.

2. a member of a physician's office staff or a member of the physician's immediate family, *if* the home health agency has received a patient referral in the preceding 12 months from the physician or his office.

   Immediate family means: husband or wife; birth or adoptive parent, child or sibling; a step-parent, step-child, step-brother, or step-sister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; or a spouse of a grandparent or grandchild.

Please read and sign the following:

I have read and understand the foregoing and I have no physician family members nor do I work in any capacity as outlined above. I will inform Care Health services, Inc. if I become a member of a physician's office staff or immediate family or if I become a case manager, discharge planner, facility-based staff member or 3rd party vendor who is involved in the discharge planning process of a facility form whom Care Health Services, inc. receives referrals.

_____ _____

Please print Date

_____

Signature

APPLICANT NOTICE

This is a notice to all potential employees of CARE HEALTH SERVICES.

Unless you are hired for a full time position we do not provide full time employment and do not guarantee 40 hours of employment to any of our roster staff. All roster staff are considered part time employees. If you have accepted an assignment, we expect you to fulfill your obligation or contact the office at least 4 hours before you cancel. A NO SHOW or FAILURE TO NOTIFY TIMELY of your absence is a reason for immediate termination without further notice from this agency and may include a financial responsibility for you.

We are pleased to advise you that CARE HEALTH SERVICES is a DRUG-FREE WORKPLACE. As a condition of employment with our Agency we require a pre-employment drug screen and intermittent drug screening at the discretion of the Agency. Should any pre-employment applicant have a positive drug test, that applicant will not be eligible for employment with CARE HEALTH SERVICES.

CARE HEALTH SERVICES will investigate any and all complaints from our clients regarding theft of personal property that may involve employees of this Agency. Upon receipt of a complaint of theft, the client will contact the local law enforcement agency and file a report for investigation. Should the investigation reveal that an employee of the Agency was involved in the theft, immediate termination from the company will occur and the State authorities relevant to licensure and certification notified and may result in loss of employment status in health care.

I have read and fully understand and agree to the above statements.

_____ _____

DATE APPLICANT SIGNATURE

_____

INTERVIEWER SIGNATURE

CARE HEALTH SERVICES, INC.
NOTICE TO PRE-EMPLOYMENT APPLICANT
CONSUMER CREDIT REPORT DISCLOSURE

Please be advised that as a part of the screening for employment with CARE HEALTH SERVICES the Agency will request a consumer credit report from a national consumer reporting agency.

Such a report is authorized by the Federal Fair Credit Reporting Act (FRCA) and may be used by an employer as a tool for screening applicants.

Before taking any adverse actions based in whole or in part on the consumer report CARE HEALTH SERVICES will provide you with a copy of the report as well as a copy of a written summary of the consumer's rights as prescribed by the FRCA.

AUTHORIZATION BY APPLICANT TO PULL CREDIT

As a consideration for employment with CARE HEALTH SERVICES, I understand that a consumer credit report will be furnished to CARE HEALTH SERVICES and I hereby agree and authorize it as a part of the required screening by the Agency.

_____ _____

DATE APPLICANT'S SIGNATURE

_____ _____

DATE PERSONNEL ASSISTANT

Care Health Services, Inc.

Provide one work OR one Personal Reference
(USE NO FAMILYMEMBERS)

REDI-NURSE
A VISITING REDI-NURSE
155 SW Port St. Lucie Blvd.
Port St. Lucie FL 34984
772-335-1229

REDI-NURSE
A VISITING REDI-NURSE
1800 Forest Hill Blvd. Ste. B-1
West Palm Beach Fl 33406
561-433-8800

Name: _____

Phone: _____

REFERENCE REQUEST

I have applied for employment with Care Health Services, Inc. I authorize them to collect any information concerning my qualifications and past performance. I also authorize and request that you reply to the questions below. I hereby release you from any and all liability in supplying any information regarding my employment with you.

Thank you for your assistance.

_____
Applicant signature Date

Applicant Name: _____ Social Security Number: _____

Maiden Name: (if used for prior employment): _____ Position applied for: _____

To Be Completed By Previous Employer: **[ ] Mail** **[ ] Phone** **[ ] Fax**

Position held: _____ Dates from: _____ to _____

Reason for leaving: _____

Would you rehire: [ ] Yes [ ] No If no, why not? _____
_____

Please Circle Appropriate Rating

	Above Average	Satisfactory			Below Average	Comments
Punctuality & Attendance	5	4	3	2	1	
Appearance (Grooming)	5	4	3	2	1	
Honesty	5	4	3	2	1	
Judgement	5	4	3	2	1	
Job Knowledge	5	4	3	2	1	
Performance of Duties	5	4	3	2	1	
Organization of Time	5	4	3	2	1	
Ability to Accept Direction	5	4	3	2	1	
Compatibility with Coworkers	5	4	3	2	1	

Additional Comments:

_____

_____

_____

Information Supplied by: _____ Title: _____

Information Obtained by: _____ Title: _____

Date: _____

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Care Health Services, Inc.

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(USE NO FAMILYMEMBERS)

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Additional Comments:

_____

_____

_____

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Information Obtained by: _____ Title: _____

Date: _____

CHS Form #151 Revised 9/2008