



APPLICATION for EMPLOYMENT

Date _____

PERSONAL INFORMATION

Please print clearly

Name _____
Last First Middle

Address _____
Street City State Zip

Phone # _____ Other Phone # _____ SS# _____

Are you 18 years of age or older..... Yes No
 Have you ever been convicted of a crime..... Yes No
 Are you prevented from lawfully becoming employed in this country because of Visa or immigration status..... Yes No
 Do you have any sensory or speech impairment..... Yes No
If yes, please explain: _____
 Are communication aides needed..... Yes No
If yes, explain: _____
 Do you have a non-English language preference..... Yes No
 Please specify your preferred language: _____

EMPLOYMENT DESIRED

Position _____ Date you Can start _____ Salary Desired _____

Are you employed now..... Yes No
 If so, may we inquire of your present employer..... Yes No
 Have you ever applied for employment with us before..... Yes No
If yes, please indicate when: _____
 Please specify any accommodation that you might need to accomplish this position: _____

If you are applying for an office position, do you have experience in or can you:

Type.....	Yes	No	<i>If yes, what speed?</i> _____	words per minute	
Take dictation.....	Yes	No	<i>If yes, what speed?</i> _____	words per minute	
Computer experience.....	Yes	No	Microsoft Word	Microsoft Excel	Power Point
			Other software?	<i>Please specify:</i> _____	

AVAILABILITY

Please write in the hours you can work below:

	Part Time	Full Time	Contract
Monday _____	Friday _____		
Tuesday _____	Saturday _____		
Wednesday _____	Sunday _____		
Thursday _____		Days only	Evenings

This form has been revised to comply with the provisions of the Americans with Disabilities Act And the final regulations and interpretive guidance promulgated by the EEOC .

EDUCATION / TRAINING

School	Name & Address of School	Courses Taken	Did you graduate? Yes No If yes, when:	Diploma, degree or certificate received
High School			Yes No If yes, when:	
College			Yes No If yes, when:	
Vocational or Business			Yes No If yes, when:	
Professional Education			Yes No If yes, when:	
Other			Yes No If yes, when:	

PROFESSIONAL LICENSES and/or CERTIFICATES

Type	Organization or State Issued	Date Issued	Number

EMPLOYMENT HISTORY

List current employer first and others in reverse chronological order:

Date Month and Year	Name and Address of Employer	Salary	Position	Reason for Leaving
From				
To				
From				
To				
From				
To				
From				
To				

Which of these jobs did you like best? _____

What did you like most about this job? _____

REFERENCES

Please provide the names of 3 persons not related to you, whom you have known at least one year:

Name and Relationship	Title	Company Name / Address	Phone #
1			
2			
3			

EMERGENCY CONTACT

Whom may we contact in case of an emergency?

Name _____ Relationship _____

Address _____ Phone # _____

NONDISCRIMINATION

LEGACY HOME HEALTH complies with Title VI of Federal Rights Act 1964, Section 504 of Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. All employment policies and practices are administered without regard to race, color, religion, sex, age, marital status, national origin, or non-job related disability. **LEGACY HOME HEALTH** shall not discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment. The management of **LEGACY HOME HEALTH** reserves the right to terminate the employment of any employee for any reason, with or without cause and with or without notice at any time and recognizes the employee's right to the same. It is our policy to provide patient care services to all qualified persons without regard to race, color, religion, sex, age, marital status, national origin, or non-job related disability.

AGREEMENT

I UNDERSTAND THAT **LEGACY HOME HEALTH** is a drug-free employer and reserves the right to test for illegal drug use.

I UNDERSTAND THAT if hired I will be required to follow the personnel policies and rules of **LEGACY HOME HEALTH**. I understand that not following the rules may lead to dismissal. I also understand that my employment may be ended for giving incorrect information on this application.

I FURTHER UNDERSTAND this application does not mean I will be hired by **LEGACY HOME HEALTH**. I understand that if I am employed, it will be on a probationary or trial basis according to personnel policies.

Applicant Signature

Date



Reference Check Form

Applicant Name: _____ SSN: _____

Reference: _____

Company Name: _____

Telephone #: _____

Dates of employment: From: _____ To: _____

I hereby give my permission for the organization or person listed above to release information requested.

APPLICANT SIGNATURE

DATE

TO BE COMPLETED BY AGENCY ONLY

Job Title: _____

Hourly rate or Salary: _____

Work performance: Satisfactory Unsatisfactory

Attendance: Satisfactory Unsatisfactory

Is this person eligible for rehire? Yes No

Comments:

Name of Supervisor / Date

Company



Legacy
Home Healthcare

Reference Check Form

Applicant Name: _____ SSN: _____

Reference: _____

Company Name: _____

Telephone #: _____

Dates of employment: From: _____ To: _____

I hereby give my permission for the organization or person listed above to release information requested.

APPLICANT SIGNATURE

DATE

TO BE COMPLETED BY AGENCY ONLY

Job Title: _____

Hourly rate or Salary: _____

Work performance: Satisfactory Unsatisfactory

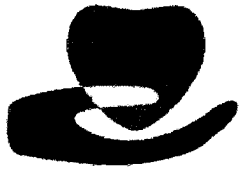
Attendance: Satisfactory Unsatisfactory

Is this person eligible for rehire? Yes No

Comments:

Name of Supervisor / Date

Company



Legacy
Home Healthcare

DMV RESTRICTIONS POLICY

As a condition of employment with Legacy Home Healthcare you will be required to complete the attached form REQUEST FOR DRIVING RECORDS. Your driving records will only be requested prior to an offer of employment.

Grounds for denial of employment for an MVR are any record of the following type A violations in the last five years, any of the following type B violations in the last three years and three or more type C violations in the last two years:

Type A

DUI or DWI for alcohol or drugs, Refusal to take a substance test, Hit and run, Fleeing or evading police or roadblock, Vehicular Assault, Homicide or manslaughter with a vehicle, Using vehicle in connection with a felony,

Type B

Driving with license suspended or revoked, Resisting arrest, Driving with an open container, Reckless driving,, Racing/speed contest, Careless Driving

Type C

Accidents or moving violations that include: Speeding, Improper lane change, Failure to yield, Failure to obey traffic signal or sign

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**REQUEST FOR DRIVING RECORDS
Disclosure & Authorization – General**

Last Name	First Name	Middle Initial	Suffix
Social Security Number			
Date of Birth			
Drivers License Number/State			

I hereby declare that the information provided by me in my application for employment is true, complete and correct to the best of my knowledge. I understand that any misstatements or omission of fact may result in denial of employment or, if employed, shall be considered cause for dismissal.

Disclosure & Authorization

I authorize Moco Incorporated (Moco), whose address is PO Box 2826, Seattle, WA 98111, to prepare an investigative report containing information as to my character, general reputation, personal characteristics, mode of living and/or driving record and to release all information obtained during the investigation to the employer and employer's agents.

I understand that I have specific rights under the Fair Credit Reporting Act 15 USC §1681 et seq (FCRA). Those rights include: 1) The right to make a written request within a reasonable period to receive additional detailed information about the nature and scope of the investigation as required section 606 (b) of the FCRA; and, 2) The right to request a written Summary of Rights pursuant to section 609 (c) of the FCRA.

You may have additional rights under Consumer Reporting and other laws in your state.

Print Name	Signature	Date
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EMPLOYER USE ONLY			
Client Name/Number: _____	Submitted by: _____		
Phone Number: _____	Fax Number: _____		
Special Instructions: _____			