



EMPLOYMENT APPLICATION

Hospice of Redmond disregards race, color, sex, national origin, marital status, age or any other protected classification unrelated to job performance in employment decisions. Hospice of Redmond extends equal employment opportunity to all qualified disabled persons, if the Hospice can make reasonable accommodations for the disabled.

PERSONAL DATA

Full Name _____ SS# _____ Date _____

Address _____

_____ Are you more than 18 yrs. of age? _____

Phone _____

Hospice of Redmond complies with Immigration Reform and control Act of 1986 and hires only authorized workers; if Hospice of Redmond hires you, you must provide the appropriate verification of your work eligibility. If you cannot provide the requested verification, Hospice of Redmond will discontinue your employment.

WORK DESIRED & AVAILABILITY

Hospice of Redmond considers your application only for the specific job and may not retain the application. Future openings may require new applications.

Job applied for _____ Full-time _____ Part-time _____ On-Call _____

The nature of hospice business requires that employees maintain regular attendance and workday, evening and night shifts. If for any reason you would not be present regularly during any of these shifts, please indicate which shifts you cannot work regularly.

Please describe all training, qualifications, or skills that are relevant to the position you are applying for:

EDUCATION

Schools or colleges (including any education in military service or special training courses and certificates received.)

Name, Type and Location of School	Academic Major Skills or Trade	Degree, Diploma or Certificate and Year Received

WORK EXPERIENCE

Employer name, address, phone # and Supervisor Name	Dates employed (mm/yy—mm/yy) Did you work under a different name?	Position	Job Duties Reason for leaving:
Employer name, address, phone # and Supervisor Name	Dates employed (mm/yy—mm/yy) Did you work under a different name?	Position	Job Duties Reason for leaving:
Employer name, address, phone # and Supervisor Name	Dates employed (mm/yy—mm/yy) Did you work under a different name?	Position	Job Duties Reason for leaving:
Employer name, address, phone # and Supervisor Name	Dates employed (mm/yy—mm/yy) Did you work under a different name?	Position	Job Duties Reason for leaving:
Employer name, address, phone # and Supervisor Name	Dates employed (mm/yy—mm/yy) Did you work under a different name?	Position	Job Duties Reason for leaving:

PROFESSIONAL REGISTRATION / LICENSURE

Type of registration or license	State Number	Expiration Date	Verified

Have you ever had your license revoked or suspended in any state? _____ If so, for what reason?

Do you have any mental or physical condition which would hinder you or prevent the performance of the duties of this position? If yes, please explain in detail and indicate what accommodations, if any would permit you to perform the duties in question.

Have you ever pleaded guilty to, or been convicted of a criminal offense; any arrest, indictment or charge for sexual offense or property crime; OR any disciplinary action taken by a health professional regulatory board or agency?

YES NO If yes, please lists dates and circumstances _____

I understand that appointment cannot be finalized until a criminal background check has been performed, and I agree to furnish the required information. I understand that any information received by Hospice of Redmond as a result of this inquiry will be used only for its consideration and will be kept in confidence.

I understand that I have the right to be told if the information in my file has been used to deny my application for hiring.

I understand I will not be automatically excluded from consideration if I have been convicted of a crime. My suitability for the position will be evaluated based upon the totality of circumstances, such as: the nature of the crime, the date of the conviction, the type of work involved, etc.

Please list **all** previous names and years used: _____

Please list **all** states you have resided in: _____

Driver's license number: _____ State of issue: _____ Date of birth: _____

Place of birth: _____

In submitting this application for employment, I authorize investigation of all statements contained in it, and I understand and agree that any misrepresentation by me in this application may result in cancellation of the application and/or separation from the hospice's service if I have been employed.

In consideration of any employment, I agree to conform to the rules, regulations, policies and procedures of Hospice of Redmond. I also understand that Hospice of Redmond reserves the right to employ at will. This means that employment can be terminated, with or without cause, and with or without notice, at any time, at the option of the company or at the option of the employee. I understand that no representative of Hospice of Redmond except the Executive Director has the authority to enter into any agreement for any specified time to make any agreement contrary to the foregoing.

Upon signing this form, I authorize the Hospice of Redmond to conduct a criminal background check, and I certify I have read all of this application and that the information I have provide above is true and correct.

Signature of applicant

Date

REFERENCE CHECK

I am applying for a job at Hospice of Redmond which provides health care to the public. I understand the hospice must therefore be careful in selecting in employees. I understand that for the hospice and its personnel to make a knowledgeable decision as to my eligibility for the position, they must check with prior employers and personal references. I consent to and authorize Hospice of Redmond and its personnel to ask any or all of the references listed in my application for information concerning me whether good or bad, and I know that a complete answer is important to their selection criteria. I therefore release all parties and person connected with any request for information from all claims, liability and damages for whatever reason arising out of furnishing the information.

Signature of applicant

Date

PLEASE DO NOT WRITE BELOW THIS LINE—FOR HOSPICE USE ONLY

Results of reference check:

1. _____

2. _____

3. _____

4. _____