



Arkansas Hospice

Applying For _____

Preferred Location _____

Date _____

NAME:

Employment Application

PLEASE...

...complete all items, even though the information is included on your resume or other documents.

...be sure you have signed your application.

...specify the exact position title in which you are interested.

...be sure you have given current telephone numbers for reference checking.

**ALL PERSONS HIRED MUST PRESENT DOCUMENTATION
DEMONSTRATING EMPLOYMENT ELIGIBILITY
VERIFICATION**

An Equal Opportunity Employer

Arkansas Hospice

Employment Application

IN ACCORDANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS, ARKANSAS HOSPICE IS AN EQUAL OPPORTUNITY EMPLOYER AND DOES NOT DISCRIMINATE AGAINST ANY PERSON ON THE BASIS OF RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, AGE, OR DISABILITY.

TYPE OR PRINT CLEARLY

PERSONAL DATA

Social Security Number			
Name (last)	(First)	(Middle)	
Home Address (Street)	(City)	(State)	(Zip)
Previous Address (Street)	(City)	(State)	(Zip)
Home Telephone	Office telephone or other telephone where you can be reached		

EMPLOYMENT DATA

MILITARY STATUS

Position desired	Have you ever been in the U.S. Military Service? If Yes, give dates Yes <input type="checkbox"/> No <input type="checkbox"/> From: To:
Part-Time <input type="checkbox"/> PRN <input type="checkbox"/> Date available for work Full-Time <input type="checkbox"/> Temporary <input type="checkbox"/> Not applicable <input type="checkbox"/>	What branch? . Present reserve status
Minimum salary desired	EDUCATION/OFFICE SKILLS
Will you work shifts? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes: Nights? <input type="checkbox"/> Evenings? <input type="checkbox"/> Weekends: Yes <input type="checkbox"/> No <input type="checkbox"/>	Estimated typing speed Transcription? What type?
How did you learn of this vacancy?	Word processing equipment, software or other office machines you can operate
Do any of your relatives or in-laws work at Arkansas Hospice? Yes <input type="checkbox"/> No <input type="checkbox"/> Who? Relationship	Name of high school Did you graduate? Yes <input type="checkbox"/> No <input type="checkbox"/> If you did not graduate do you have your GED? Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever worked at Arkansas Hospice before? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when? Have you applied for employment here before? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when?	Name of college & years attended: Degree:
Have you ever been discharged or asked to resign from a job? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain.	Please list professional licenses/certifications with the license # and date license 1st Issued
Have you ever been convicted of a crime? Yes <input type="checkbox"/> No <input type="checkbox"/> Please list any past convictions including any that have been expunged. (Will not necessarily exclude you from consideration) If yes, when? What for?	Special research, training or business school & year obtained List languages in which you are fluent

OTHER DATA

To what professional organizations do you belong?	Please list any other skills that may be job-related or that you feel would be of value to this job or Arkansas Hospice
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WORK EXPERIENCE

STARTING WITH YOUR PRESENT OR LAST JOB, PLEASE LIST THE LAST THREE JOBS YOU HAVE HELD, IN REVERSE ORDER. SINCE WE MAKE EVERY EFFORT TO CONTACT PREVIOUS EMPLOYERS, THE *CORRECT TELEPHONE NUMBERS OF PAST EMPLOYERS ARE CRITICAL*. ASK FOR A PHONE BOOK OR CALL INFORMATION IF NECESSARY.

1. Present or Last Employer:		Business Address:	
Supervisor's Name	Phone Number	Your Job Title	Dates of Employment From: To:
		May We Contact?	
Your Duties:			
Reason For Leaving:		Name Used if Different From Current	Salary/Wages Paid
2. Second Last Employer:		Business Address:	
Supervisor's Name	Phone Number	Your Job Title	Dates of Employment From: To:
		May We Contact?	
Your Duties:			
Reason For Leaving:		Name Used if Different From Current	Salary/Wages Paid
3. Third Last Employer:		Business Address:	
Supervisor's Name	Phone Number	Your Job Title	Dates of Employment From: To:
		May We Contact?	
Your Duties:			
Reason For Leaving:		Name Used if Different From Current	Salary/Wages Paid

REFERENCES

List three work related references.

NAME	ADDRESS/ <i>PHONE</i>	YRS KNOWN

Arkansas Hospice

REFERENCE RELEASE

HUMAN RESOURCE SERVICES
ARKANSAS HOSPICE
5600 WEST 12th ST.
LITTLE ROCK, AR 72204

I acknowledge filing an application for employment with Arkansas Hospice. I authorize all former employers, references, education institutions, and law enforcement authorities to furnish any information concerning my background that is pertinent to my qualifications for employment, and I hereby release them from all liability in connection with their doing so.

Signature

Date

Arkansas Hospice

APPLICANT STATEMENTS

The information that I have provided on this application is true and complete to the best of my knowledge. I understand that misrepresentation, omission, or falsification of any fact in my application, resume, or any other materials, or during any interviews, will be sufficient cause in and of itself for disqualification from employment or termination from employment whenever discovered.

I authorize Arkansas Hospice and/or its agents, including consumer-reporting bureaus to investigate and verify any of the information I provide.

I understand that nothing contained in this employment application or in the granting of an interview is intended to create an employment contract between the Arkansas Hospice and myself for either employment or the providing of any benefit. If an employment relationship is established, I understand that I have the right to terminate my employment at any time and that Arkansas Hospice retains a similar right. I understand that no manager or representative of the company, other than the Executive Director, has any authority to enter into any agreement with me for employment for any specified period of time, and that any such agreement, if made, will not be enforceable unless it is in writing and signed by me and the Executive Director.

I UNDERSTAND THAT ARKANSAS HOSPICE IS A SMOKE-FREE WORKPLACE AND WILL ABIDE BY THIS POLICY.

I AUTHORIZE ALL FORMER EMPLOYERS, REFERENCES, SCHOOLS, AND LAW ENFORCEMENT AUTHORITIES TO RELEASE INFORMATION THEY HAVE CONCERNING MY BACKGROUND. I HEREBY RELEASE THEM FROM ANY AND ALL LIABILITY FOR DAMAGES ARISING FROM THE FURNISHING OF THIS INFORMATION.

This application will remain active for a period of ninety (90) days from the date on which it is signed. After that period, the applicant must complete a new application in order to be considered for future employment opportunities.

Applicant's Signature: _____

Date: _____

Arkansas Hospice

CONSENT FOR ARKANSAS HOSPICE TO PROVIDE INFORMATION TO REGULATORY AGENCIES

I give Arkansas Hospice permission to provide information on my application and, if I am hired, information in connection with my employment, to the state licensing board that issued my license or other regulatory entity that regulates my practice area. Information about my employment may include the date and duration of my employment, all my performance evaluations, results of drug or alcohol tests administered to me during my employment and any other information about me that is documented in my personnel file. If I am no longer employed by Arkansas Hospice, the circumstances of my separation and whether I am eligible for rehire may also be provided to the board or entity. I release Arkansas Hospice from all liability in connection with the furnishing of this information.

Signature

Date

PRE-EMPLOYMENT DRUG TESTING CONSENT AND RELEASE FORM

I hereby consent to submit to urinalysis and/or other tests as shall be determined by *Arkansas Hospice* in the selection process of applicants for employment, for the purpose of determining the drug content thereof.

I agree that CONCENTRA may collect these specimens for these tests and may test them or forward them to a testing laboratory designated by the company for analysis.

I further agree to and hereby authorize the release of the results of said tests to *Arkansas Hospice*. I understand that it is the current illegal use of drugs that would prohibit me from being employed at Arkansas Hospice.

I further agree to hold harmless *Arkansas Hospice* and its agents (including the above named physician or clinic) from any liability arising in whole or part out of the collection of specimens, testing, and use of the information from said testing in connection with *Arkansas Hospice's* consideration of my employment application.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant Print Name: _____

Applicant Signature: _____

Date: _____

IF YOU HAVE MORE CLINICAL WORK EXPERIENCE THAN YOU HAVE ROOM FOR ON YOUR APPLICATION PLEASE LIST ON THIS SHEET. YOU ONLY NEED TO LEAVE THE COMPANY NAME, DATES OF EMPLOYMENT AND A PHONE OR CONTACT

CO: _____

DATE OF EMPLOYMENT: _____

PHONE AND/OR CONTACT: _____

CO: _____

DATE OF EMPLOYMENT: _____

PHONE AND/OR CONTACT: _____

CO: _____

DATE OF EMPLOYMENT: _____

PHONE AND/OR CONTACT: _____

CO: _____

DATE OF EMPLOYMENT: _____

PHONE AND/OR CONTACT: _____

CO: _____

DATE OF EMPLOYMENT: _____

PHONE AND/OR CONTACT: _____

CO: _____

DATE OF EMPLOYMENT: _____

PHONE AND/OR CONTACT: _____

AR920130Z

HEALTH FACILITY SERVICES

FACILITY ID NUMBER 7 9 9 _ _ _

FACILITY NAME _____ ADDRESS _____
FACILITY PHONE # () _____

___ STATE CHECK ONLY STATE AND NATIONAL CHECK ___

- ITEMS NEEDED: 1. THIS FORM COMPLETED (TYPED OR PRINTED CLEARLY)
2. ONE \$20.00 CHECK/MONEY ORDER MADE PAYABLE TO "ARKANSAS STATE POLICE".
3. IF A NATIONAL CHECK IS ALSO REQUIRED:
A. ONE COMPLETED FINGERPRINT CARD
B. AN ADDITIONAL \$24.00 CHECK/MONEY ORDER MADE PAYABLE TO "ARKANSAS STATE POLICE".

LAST NAME FIRST MIDDLE MAIDEN

DATE OF BIRTH RACE SEX SOCIAL SECURITY NUMBER

DRIVER'S LICENSE # STATE OF ISSUE

MAILING ADDRESS STATE ZIP CODE

THE NAME, ADDRESS, AND DATE OF BIRTH APPEAR ON THE FOLLOWING GOVERNMENT ISSUED IDENTIFICATION DOCUMENT __ DRIVERS LICENSE __ STATE ID CARD __ OTHER (LIST) _____

THE APPLICANT MUST LIST ALL FELONY & MISDEMEANOR CHARGE(S) FOR WHICH HE/SHE WAS FOUND GUILTY OF OR PLED GUILTY OR NOLO CONTERNDERE TO:

DATE OF CHARGE LOCATION DISCRPTION OF CHARGE SENTENCE/DISPOSITION

___ 82001 CIVIL RECORD CHECK \$20.00

___ 80001 FBI RECORD CHECK \$24.00

