

Application for Employment

Hospice of Stanly Co.
960 N. First Street
Albemarle, NC 28001

PLEASE PRINT

Equal access to programs, services and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of Hospice of Stanly County, Inc.

Position(s) applied for _____ Expected Salary _____ Date of application ____/____/____

Name _____

Address _____

Telephone # () _____ Mobile/Beeper/Other Phone # () _____ SS # _____

Are you legally eligible for employment in this country? Yes No

Date available for work _____/_____/_____

Type of employment desired Full-Time Part-Time Temporary Volunteer Educational Co-Op

Are you able to meet the attendance requirements of the position? Yes No

Are you able to meet the qualifications required for this position? Yes No

Have you ever been convicted of a crime or felony? Yes No

If yes, please explain _____

CONVICTION WILL NOT NECESSARILY BE A BAR TO EMPLOYMENT. EACH INSTANCE AND EXPLANATION WILL BE CONSIDERED IN RELATION TO THE POSITION FOR WHICH YOU ARE APPLYING.

Employment History

Provide the following information for you past four (4) employers, assignments or volunteer activities, starting with the most recent.

FROM	TO	EMPLOYER	TELEPHONE ()
JOB TITLE		ADDRESS	
IMMEDIATE SUPERVISOR		SUMMARIZE JOB RESPONSIBILITIES	
SUPERVISOR'S TITLE			
REASON FOR LEAVING		HOURLY RATE/SALARY START \$ _____ PER _____ START \$ _____ PER _____	
FROM	TO	EMPLOYER	TELEPHONE ()
JOB TITLE		ADDRESS	
IMMEDIATE SUPERVISOR		SUMMARIZE JOB RESPONSIBILITIES	
SUPERVISOR'S TITLE			
REASON FOR LEAVING		HOURLY RATE/SALARY START \$ _____ PER _____ START \$ _____ PER _____	
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SUPERVISOR'S TITLE			
REASON FOR LEAVING		HOURLY RATE/SALARY START \$ _____ PER _____ START \$ _____ PER _____	

Skills and Qualifications

Summarize any training, skills, licenses, and/or certificates that may qualify you as being able to perform job-related functions in the position for which you are applying.

LICENSURE (Registered Professionals & Certified Technical Applicants Only)

Medical Specialty _____ State _____ Expiration Date _____ Cert./List. Number _____

Educational Background

NAME AND LOCATION	YEARS COMPLETED	DID YOU GRADUATE	DEGREE OR COURSE OF STUDY

References

NAME	TELEPHONE NUMBER	YEARS KNOWN

I UNDERSTAND THAT IF I AM EMPLOYED, ANY MISREPRESENTATION OR MATERIAL OMISSION MADE BY ME ON THIS APPLICATION WILL BE SUFFICIENT CAUSE FOR CANCELLATION OF THIS APPLICATION OR IMMEDIATE DISCHARGE FROM THE EMPLOYER'S SERVICE, WHENEVER IT IS DISCOVERED.

I GIVE THE EMPLOYER THE RIGHT TO CONTACT AND OBTAIN INFORMATION FROM ALL REFERENCES, EMPLOYERS, EDUCATIONAL INSTITUTIONS AND TO OTHERWISE VERIFY THE ACCURACY OF THE INFORMATION CONTAINED IN THIS APPLICATION. I HEREBY RELEASE FROM LIABILITY THE EMPLOYER AND ITS REPRESENTATIVES FOR SEEKING, GATHERING AND USING SUCH INFORMATION AND ALL OTHER PERSONS, CORPORATIONS OR ORGANIZATIONS FOR FURNISHING SUCH INFORMATION.

THE EMPLOYER DOES NOT UNLAWFULLY DISCRIMINATE IN EMPLOYMENT AND NO QUESTION ON THIS APPLICATION IS USED FOR THE PURPOSE OF LIMITING OR EXCUSING ANY APPLICANT FROM CONSIDERATION FOR EMPLOYMENT ON A BASIS PROHIBITED BY LOCAL, STATE OR FEDERAL LAW.

THIS APPLICATION IS CURRENT FOR ONLY 60 DAYS. AT THE CONCLUSION OF THIS TIME, IF I HAVE NOT HEARD FROM THE EMPLOYER AND STILL WISH TO BE CONSIDERED FOR EMPLOYMENT, IT WILL BE NECESSARY TO FILL OUT A NEW APPLICATION.

IF I AM HIRED, I UNDERSTAND THAT I AM FREE TO RESIGN AT ANY TIME, WITH OR WITHOUT CAUSE AND WITHOUT PRIOR NOTICE, AND THE EMPLOYER RESERVES THE SAME RIGHT TO TERMINATE MY EMPLOYMENT AT ANY TIME, WITH OR WITHOUT CAUSE AND WITHOUT PRIOR NOTICE, EXCEPT AS MAY BE REQUIRED BY LAW. THIS APPLICATION DOES NOT CONSTITUTE AN AGREEMENT OR CONTRACT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OR DEFINITE DURATION. I UNDERSTAND THAT NO REPRESENTATIVE OF THE EMPLOYER, OTHER THAN AN AUTHORIZED OFFICER, HAS THE AUTHORITY TO MAKE ANY ASSURANCES TO THE CONTRARY. I FURTHER UNDERSTAND THAT ANY SUCH ASSURANCES MUST BE IN WRITING AND SIGNED BY AN AUTHORIZED OFFICER.

I UNDERSTAND IT IS THIS COMPANY'S POLICY NOT TO REFUSE TO HIRE A QUALIFIED INDIVIDUAL WITH A DISABILITY BECAUSE OF THAT PERSON'S NEED FOR A REASONABLE ACCOMMODATION AS REQUIRED BY THE ADA.

I ALSO UNDERSTAND THAT IF I AM HIRED, I WILL BE REQUIRED TO PROVIDE PROOF OF IDENTITY AND LEGAL WORK AUTHORIZATION.

I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

Signature of Applicant _____ Date ____/____/____

Hospice of Stanly County, Inc.
PERMISSION FOR REFERENCE RELEASE

TO WHOM IT MAY CONCERN:

Having made application for employment with Hospice of Stanly County, Inc., I hereby authorize Hospice of Stanly County, Inc. to investigate and verify my history and character as necessary to arrive at an employment decision. I hereby release from liability or damage those individuals, schools, companies, bureaus, and/or agencies which provide such information. I have read and understand the statements.

DATE

SIGNATURE

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DATE

SIGNATURE

Interview Notes

**INTERVIEWED
BY**

DATE

COMMENTS

Telephone References

ORGANIZATION

EMPLOYMENT DATES

COMMENTS

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