

APPLICATION FOR EMPLOYEE

Federal and State laws prohibit discrimination in employment because of sex, race, creed, religion, national origin, age, handicap, marital status, status with regard to public assistance or veterans employment. We are an equal opportunity employer.

PERSONAL INFORMATION

Date _____

Name _____ Social Security # _____
Last First Middle

Other surnames that I have used: _____

Present Address _____
Street City State Zip

Permanent Address _____
Street City State Zip

Home Phone #: _____ Alternate Phone #: _____

How did you hear about this position? _____ Referred By: _____

Are you legally entitled to work in the United States? ☐ YES ☐ NO Are you at least 18 years of age? ☐ YES ☐ NO

U.S. Military or Naval Service _____ Rank _____ Present Membership in National Guard or Reserves? ☐ YES ☐ NO

EMPLOYMENT DESIRED

Position: ☐ RN ☐ DSP/Caregiver ☐ Homemaker ☐ Home Health Aide ☐ Staffing ☐ Clerical
☐ Personal Care Attendant ☐ Other _____

Have you passed Competency Testing? ☐ YES ☐ NO Do you have a Certificate? ☐ YES ☐ NO

Do you have a current Driver's License? ☐ YES ☐ NO Do you currently have a car? ☐ YES ☐ NO

Have you ever applied to this Company before? ☐ YES ☐ NO Where? _____ When? _____

PROFESSIONAL LICENSES, CERTIFICATION, AND REGISTRATIONS

Do you have any professional licenses, certifications and/or registrations? ☐ YES ☐ NO

License/Certificate/ Registration #:	Type	State Issued	Date Expires	Status (List Active, Inactive, Restricted, Conditional or Pending)

REFERENCES

Give below the names of three work related references.

NAME	ADDRESS	COMPANY/POSITION	PHONE

EDUCATION

	NAME AND LOCATION OF SCHOOL	YEARS ATTENDED	GRADUATED	DEGREE/CERTIFICATION
HIGH SCHOOL			<input type="checkbox"/> Yes	
			<input type="checkbox"/> No	
COLLEGE			<input type="checkbox"/> Yes	
			<input type="checkbox"/> No	
COLLEGE			<input type="checkbox"/> Yes	
			<input type="checkbox"/> No	
ADDITIONAL TRAINING				

FORMER EMPLOYERS

List below your complete employment history for the last five years, starting with the most recent position first.
Attach additional pages if necessary.

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER SUPERVISOR'S NAME	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
	May we contact? <input type="checkbox"/> YES <input type="checkbox"/> NO			
FROM				
TO				
FROM				
TO				
FROM				
TO				

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice.

I hereby agree that, as a condition of employment by the Agency, I will promptly inform the Agency in writing of any criminal convictions, in any jurisdiction (including all pleas of guilty), other than minor traffic offenses, of which I am convicted after today.

VOLUNTARY SELF-IDENTIFICATION INFORMATION

Absolute Caring Inc is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to sex, race, color, national origin or ancestry, age, handicap, marital status, source of income, class, physical characteristics, sexual orientation or political beliefs.

As an employer, we comply with government regulations and affirmative action responsibilities. Solely to help us comply with government record keeping, reporting and other legal requirements, please complete this Voluntary Self-Identification Information form. This data is for analysis and affirmative action only and submission of this information is voluntary. This data will be kept in a confidential file separate from your Application for Employment.

Date _____

Position Applied For _____

Gender:

- ☐ Male
- ☐ Female
- ☐ Choose not to respond

Race/Ethnic Background:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black / African or African American
- ☐ Hispanic / Latino
- ☐ White / Caucasian
- ☐ Two or More Races
- ☐ Choose not to respond

Veteran Status:

- ☐ Vietnam era veteran
- ☐ Disabled veteran
- ☐ Other veteran
- ☐ Non-veteran
- ☐ Choose not to respond

Disability Status*:

- ☐ Disabled
- ☐ Not disabled
- ☐ Choose not to respond

Date _____ Signature _____

* According to the American with Disabilities Act, the term "disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of that individual, a record of such an impairment, or being regarded as having such an impairment.

Background Information and Release Form

Minnesota Law requires that we secure the following information from any prospective employee who may be involved in duties requiring contact with clients in their homes. It is very important that you provide complete and accurate information. Failure to do so may bring adverse consequences, including the loss of any employment with **Absolute Caring Inc**. I authorize Absolute Caring Inc the Department of Human Services, the Office of Inspector General and the MN Bureau of Criminal Apprehension to conduct a background investigation as part of the employment screening and selection process.

Please complete all the information in this application in order to process the background check

Background information					
Last Name		First		M.I.	
Street Address				Apartment/Unit #	
City		State		ZIP	
Phone					
Date of Birth (MM/DD/YY)		Social Security No.			
Gender		Race			
DRIVER'S LICENSE #/STATE ID			STATE ISSUED		
Other Names Used by Applicant					

I hereby authorize all individuals, institutions, and entities with which I have been associated, who have knowledge concerning information requested in this form to consult with and release relevant information to Absolute Caring Inc, and designees

I hereby release Absolute Caring Inc., its agents and designees, and all other individuals, institutions and entities providing information in accordance with the authorization contained herein from liability for the acts performed in good faith and without malice in connection with the investigation of this form and the release and exchange of information authorized above. This release shall be in addition to any other applicable immunity provided by law for investigatory activities.

I hereby agree that, as a condition of employment by Absolute Caring Inc, I will promptly inform the agency in writing of any criminal conviction, in any jurisdiction (including all pleas of guilty), Other than minor traffic offenses, of which I am convicted after today. I am informed of the content of the Background Study Privacy Notice. I understand that Minnesota Absolute Caring Inc will run a background check through the Department of Human Services, the Office of Inspector General and the MN Bureau of Criminal Apprehension.

Signature:	Date:
PRINT FULL NAME:	

office use only			
THE FOREGOING INFORMATION COLLECTED BY		INFORMATION COLLECTED ON	/ /

CONFIDENTIALITY OF CLIENT INFORMATION

AGENCY POLICY:

By accepting employment with **Absolute Caring Inc**, you have obligated yourself to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. Do not pass on medical information to clients and visitors unless you have been instructed to do so by your supervisor. In addition, all information seen or heard regarding clients, directly or indirectly, is completely confidential and not to be discussed even with your family.

Your job as **Absolute Caring Inc**, employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of agency this, but can also involve an employee in legal proceedings. Information about clients or the agency is not to be given to media. This is essential for protection of both the client and the agency. Very strict laws regarding the release of information concerning clients bind agencies.

I have read and agree to abide by the above policy on confidentiality. I realize that violating this policy may result in termination of my employment

Employee Name (print)

Signature of Employee

Date

