

**EMPLOYMENT APPLICATION**

This form will become part of your permanent record. Resumes are not accepted in lieu of the completion of this application. Some questions may not be completely applicable to the job position you are seeking; however, we ask that you please answer all questions. Please answer accurately and neatly in your own hand printing (unless you are requested to fill out this application on-line). **A BACKGROUND CHECK, MOTOR VEHICLE REPORT, AND DRUG TEST IS PERFORMED ON ALL EMPLOYEES.**

Last		First		Middle		<input type="checkbox"/> Part-Time <input type="checkbox"/> Full Time	
Position(s) Applied For				Referred by		Date	
Present Home Address (Number, Street, Apt.)							
City			State	Zip Code	How long have you resided at current address?		
Home Phone		Cell Phone		Alternative Phone		Email	
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No What type of visa? _____		Are you at least 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No		If applying for a position that requires driving, please provide the following information: I have a valid GA driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No GA DL# _____ Car Insurance Co.: _____ Policy #: _____ Exp: _____			
Have you previously applied for a position with AGAPE HOSPICE CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____				Have you ever been convicted of a felony? A conviction will not necessarily disqualify an applicant from employment. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give location, date, charge, and disposition of case(s) on a separate page.			
Have you been employed by AGAPE HOSPICE CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, give dates of employment? _____				Are you: <input type="checkbox"/> Currently employed <input type="checkbox"/> Currently on layoff <input type="checkbox"/> Subject to recall			
Do you have any ongoing obligation or commitment to, or interest with, another employer, business or activity which might affect your duties of employment with Agape Hospice Care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____							
In order to permit a check of your work and educational records, have you ever had a name or used a name other than the name used on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify name(s) and relevant dates: _____							
Do you have any friends or relatives who work with AGAPE HOSPICE CARE hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete below: Name _____ Relationship _____ Name _____ Relationship _____							

**AVAILABILITY RECORD**

Available for work: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> On-Call		Will you work overtime if asked? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you willing to work evening shifts? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you willing to work on an alternating schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hours, shifts, or days you will not work? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, explain: _____			

**EMPLOYMENT HISTORY** – Please list ALL former jobs (list most current first). Account for all time periods including unemployment, self-employment and military service. Attach separate page(s) as necessary.

Employer		Type of Business	Job Title
Address			Telephone
Dates Employed	Immediate Supervisor	Hourly Rate/Salary (starting and final)	May we contact this employer [ ] Yes [ ] No
Duties			
Reason for Leaving			
Employer		Type of Business	Job Title
Address			Telephone
Dates Employed	Immediate Supervisor	Hourly Rate/Salary (starting and final)	May we contact this employer [ ] Yes [ ] No
Duties			
Reason for Leaving			
Employer		Type of Business	Job Title
Address			Telephone
Dates Employed	Immediate Supervisor	Hourly Rate/Salary (starting and final)	May we contact this employer [ ] Yes [ ] No
Duties			
Reason for Leaving			
Employer		Type of Business	Job Title
Address			Telephone
Dates Employed	Immediate Supervisor	Hourly Rate/Salary (starting and final)	May we contact this employer [ ] Yes [ ] No
Duties			
Reason for Leaving			
Employer		Type of Business	Job Title
Address			Telephone
Dates Employed	Immediate Supervisor	Hourly Rate/Salary (starting and final)	May we contact this employer [ ] Yes [ ] No
Duties			
Reason for Leaving			

**CONT'D – EMPLOYMENT HISTORY** – Please list ALL former jobs (list most current first). Account for all time periods including unemployment, self-employment and military service. Attach separate page(s) as necessary.

Employer		Type of Business	Job Title
Address			Telephone
Dates Employed	Immediate Supervisor	Hourly Rate/Salary (starting and final)	May we contact this employer [ ] Yes [ ] No
Duties			
Reason for Leaving			
Employer		Type of Business	Job Title
Address			Telephone
Dates Employed	Immediate Supervisor	Hourly Rate/Salary (starting and final)	May we contact this employer [ ] Yes [ ] No
Duties			
Reason for Leaving			

Have you ever been dismissed or forced to resign from any employment? [ ] Yes [ ] No If yes, explain:

\_\_\_\_\_

May we contact your present employer? [ ] Yes [ ] No

May we contact your previous employer(s)? [ ] Yes [ ] No

Please identify any previous employers who you DO NOT want us to contact and state the reason(s) for not contacting them below:

\_\_\_\_\_

Do you have reliable transportation to and from work? [ ] Yes [ ] No

(PLEASE SUPPLY A COPY OF CURRENT AUTO INSURANCE CARD and Motor Vehicle Report [MVR])

Please provide a brief summary of your skills and qualifications that make you qualified for the position(s) you are applying for below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>EDUCATIONAL DATA</b>			
<b>Education</b>	<b>Name &amp; Location of School</b>	<b>Major Course(s)</b>	<b>Diploma/Degree</b>
High School			
Technical or Trade School			
Technical or Trade School			
Junior College, College or University			
Junior College, College or University			
Other Training/ Education			
High School & College Activities			

<b>LICENSES/CERTIFICATIONS</b> – Currently held and job related (PLEASE SUPPLY A COPY UPON EMPLOYMENT)				
<b>Licenses/Certifications</b>	<b>Registration Number</b>	<b>Issuing State</b>	<b>Date Issued</b>	<b>Date Expires</b>

Have any of the above ever lapsed?  Yes  No If yes, state the reason for the lapse, revocation or suspension:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date of Reinstatement: \_\_\_\_\_

<b>U.S. MILITARY SERVICE</b>	
Are you a veteran of the U.S. Military Service? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what branch of service?
If yes, beginning of active duty:	End date of active duty?
Date of discharge from military service:	

<b>REFERENCES</b> (List three persons not related to you whom you have known at least one year.)				
<b>Name</b>	<b>Address</b>	<b>Telephone</b>	<b>Occupation</b>	<b>Years Known</b>

List below any other information or remarks that you wish to have considered as part of your application for employment:

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**NOTICE TO APPLICANTS: AGAPE HOSPICE CARE** complies with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability to perform job-related functions. If you are given a conditional offer of employment, you will be required to undergo a medical examination, which includes a test for illicit drugs. All medical information will be kept confidential and in a separate file.

**AGAPE HOSPICE CARE** is an Equal Opportunity Employer. We adhere to a policy of making employment decisions without regard to the race, color, age sex, religion, national origin, disability, marital status, citizenship, veteran status or other protected group status of any qualified individual.

**APPLICANTS ACKNOWLEDGEMENT** Please read carefully before signing.

I certify that the answers given herein are true and to the best of my knowledge. I authorize the investigation of all matters contained in this application and hereby give **AGAPE HOSPICE CARE** and it’s agents and representatives permission to contact schools, previous employers, references, governmental agencies and others, and hereby release **AGAPE HOSPICE CARE** and it’s employees and agents, as well as those persons providing information, from any liability as a result of such contact or information provided. I understand that misrepresentations or omissions of material facts called for in this application may be cause for dismissal at any time without previous notice.

I understand that, if I am employed, my employment with **AGAPE HOSPICE CARE** (“the employer”) is “at-will”, which means that my employment is for no specific term and that either the Employer or the Employee is free to terminate the employment relationship at any time for any reason, or no reason at all. I further understand that no oral promise or representation, Employer policy, custom, business practice or another procedure (including the Employee Handbook or Personal Manual) constitutes an employment contract or modification of the at-will employment relationship between me and the Employer.

The contents of any Employee Handbook or Personal Manual, as well as other Employer policies and practices, are subject to change or modification by the Employer solely at its discretion, without notice. I also understand that no supervisor or other official of the Employer (except its Chief Executive Officer, in writing) has authority to enter into any agreement with me or to make any agreement contrary to the foregoing.

I understand that I will be required to undergo a screening for use of illicit drugs or alcohol abuse as part of a pre-employment physical examination and that, in addition, all employees are subject to screening for use of illicit drugs or alcohol abuse

This application will remain active for six (6) months. Any applicant wishing to be considered for employment beyond three (3) months should reapply.

Signature	Print Name	Date
<b>Agape Hospice Care</b> Doc: AHC-EMPAPP-06-2020 Date Approved: 09/2009 (rev 06/2011)		<b>Employment Application – EMPAPP</b> Page 5 of 8 Revision #: 003.0620

**REQUEST AND AUTHORIZATION RELEASE INFORMATION**

**APPLICANT COMPLETES THIS SECTION:**

I authorize investigation of all matters contained in my employment application and hereby give the prospective Employer permission to contact schools, previous employers, references and others. By signing this statement, I hereby agree to release and hold harmless the prospective Employer, its employees, officers, directors, agents and representatives and also all persons providing information and their employers, from any and all liability whatsoever for contacts made by, or information provided to, the prospective Employer.

_____	_____
Name	Social Security Number
_____	_____
Signature	Date

**AGAPE HOSPICE CARE – (AS THE PROSPECTIVE EMPLOYER) COMPLETES THIS SECTION:**

TO: \_\_\_\_\_  
(Company Name)

ATTN: \_\_\_\_\_  
(Name/Title of Authorized Individual)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The above-named individual has applied for employment with **AGAPE HOSPICE CARE**. We would appreciate your company sharing previous employment information with us. The individual's signed authorization is provided above to allow release of this information.

_____	_____	_____
Signature	Title	Date
_____		
Print Name		

**EMERGENCY CONTACT INFORMATION**

\_\_\_\_\_  
Employee Name Date

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Other information/Special Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rep: \_\_\_\_\_

**AGAPE HOSPICE CARE  
BACKGROUND CHECK  
AUTHORIZATION AND RELEASE FORM**

**\*\*THIS FORM CANNOT BE PROCESSED IF INCOMPLETE, ILLEGIBLE OR INACCURTE\*\***

I, \_\_\_\_\_, having applied for employment, do hereby authorize AGAPE HOSPICE CARE to obtain any information regarding my background, Motor Vehicle Report (MVR) which includes Driver's history, violations and Driver's License status, education history and employment history including evaluations. Said information is to be released to AGAPE HOSPICE CARE.

I further release and hold harmless AGAPE HOSPICE CARE, and any business or individual who supplies said information, from any liability resulting from dissemination of said information.

Driver's License # or ID#: \_\_\_\_\_ State \_\_\_\_\_

Name as it appears on Driver's License # or ID#: \_\_\_\_\_

SSN#: \_\_\_\_\_ Place of Birth \_\_\_\_\_

Other Legal Names used

Since 1997 (maiden/aliases) 1) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

2) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

How many consecutive years have you lived in Georgia?: \_\_\_\_\_

Please print addresses (including City/State/Zip Code/Dates) for the **PAST 7 YEARS**  
(if additional space is needed, please use a separate sheet.)

1) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

2) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

3) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

4) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

5) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

Date of active military service (if applicable or write N/A): \_\_\_\_\_

The following is required for criminal record identification purposes only:

Date of Birth \_\_\_\_\_

Race \_\_\_\_\_

Sex [ ] Male [ ] Female

**CONSENT FORM**

I hereby authorize **AGAPE HOSPICE CARE** to receive any criminal history record information pertaining to me which may be in files of any State or local criminal agency in Georgia or any other State.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Agape Hospice Care**

Doc: AHC-EMPAPP-06-2020

Date Approved: 09/2009 (rev 06/2011)

**Employment Application – EMPAPP**

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