Employment Application

Full Name:				Date:	
	Last	*First*	*M.I.*		

Address:		
	Street Address	*Apartment/Unit #*

	City	*State*	*ZIP Code*

Phone:		Email	

Date Available:		Social Security No.:		Desired Salary:	**$**

Position Applied for:	

Are you a citizen of the United States?	YES	NO	If no, are you authorized to work in the U.S.?	YES	NO

Have you ever worked for this company?	YES	NO	If yes, when?	

Have you ever been convicted of a felony?	YES	NO	

If yes, explain:	

High School:		Address:	

From:		To:		Did you graduate?	YES	NO	Diploma:	

College:		Address:	

From:		To:		Did you graduate?	YES	NO	Degree:	

Other:		Address:	

From:		To:		Did you graduate?	YES	NO	Degree:	

Please list three professional references.

Full Name:		Relationship:	
Company:		Phone:	
Address:			

Full Name:		Relationship:	
Company:		Phone:	
Address:			

Full Name:		Relationship:	
Company:		Phone:	
Address:			

Company:		Phone:	
Address:		Supervisor:	

Job Title:		Starting Salary:	**$**	Ending Salary:	**$**

Responsibilities:	

From:		To:		Reason for Leaving:	

May we contact your previous supervisor for a reference?	YES	NO	

Company:		Phone:	
Address:		Supervisor:	

Job Title:		Starting Salary:	**$**	Ending Salary:	**$**

Responsibilities:	

From:		To:		Reason for Leaving:	

May we contact your previous supervisor for a reference?	YES	NO	

Company:				Phone:	
Address:				Supervisor:	

Job Title:		Starting Salary:	**$**	Ending Salary:	**$**

Responsibilities:	

From:		To:		Reason for Leaving:	

May we contact your previous supervisor for a reference?	YES	NO	

Branch:		From:		To:	

Rank at Discharge:		Type of Discharge:	

If other than honorable, explain:	

If your former employment references, education or military service are under a name other than indicated on application, please indicate below:

Last: _____First:_____MI:___

A record of criminal or guilty/no contest pleas may disqualify an applicant from employment. Relevant factors for consideration may include the following: State laws barring employment in a healthcare facility, date of offense, and nature of the position sought. Declining or failing to fully disclose all convictions and guilty /no contest pleas on this application will result in rejection of the application or termination of employment.

Have you ever been convicted of or pled guilty/no contest to any criminal offense (minor traffic violations excluded)? _____Yes____No

If yes, identify the level of the offense: Misdemeanor, felony, other:_____
City and state of the offense(s)_____

Date of offense(s)_____

Offense
description(s)_____

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature:		Date:	

The Office of the Inspector General (OIG) may impose financial penalties against health care providers that employ or enter contracts with excluded individuals or entities to provide items or services to federal program beneficiaries (section 1128A(a)(6) of the ACT; 42 CFR 1003.102(a)(2)). Providers such as hospitals, nursing homes and hospices may face exposure if they submit claims to a federal health care program for health care items or services provided, directly or indirectly, by excluded individuals or entities.

Individuals may be excluded from participation in federal health care programs for a number of reasons including a Medicare/Medicaid fraud or abuse conviction, license revocation, or failure to repay a federal student loan.

If a health care provider arranges or contracts (by employment or otherwise) with an individual or entity who is excluded by the OIG from program participation for the provision of items or services reimbursable under such a federal program, the provider may be subject to fines of up to $10,000 for each item or service furnished by the excluded individual or entity, as well as an assessment of up to three times the amount claimed and program exclusion may be imposed.

Furthermore, if an excluded individual seeks employment with the Medicare/Medicaid participating provider, it could affect their opportunity for reinstatement at the conclusion of the exclusion period.

I certify that I am not subject to exclusion or debarment under federal law or designated in a nurse aid registry as having a finding concerning abuse, neglect, or mistreatment of a patient or misappropriation of a patient's property.

_____	_____	___/___/___
Signature	Print Name	Date

It is the policy of the company and all of its subsidiaries to provide equal employment opportunities to all employees and applicants for employment without regard to race, color, religion, sex, national origin, age, disability, or veteran status.

I understand that any offer of employment, or continued employment, is contingent upon the company's decision that the results of my background investigation and/or drug test and other references (work related, personal, license verification (including Nurses) are satisfactory.

If employed, I will be required to complete and Employment Verification Form (I9), and within three days show satisfactory evidence of identity and eligibility for employment.

I understand that emergency conditions may require me to temporarily work shifts other than the one for which I am applying and agree to such scheduling changes as directed by my department head or administrator of this institution.

I understand that my employment is at-will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of facts appearing on this application form.

_____ ___/___/___

Applicant's Signature Date

Drug- Free Workplace Acknowledgment and Consent

I understand that the company and all of its subsidiaries maintain a drug-free workplace. I understand that I may be subject to drug and/or alcohol screening during the course of my employment under specified terms and conditions and the result of such screening may be grounds for disqualifying me or terminating my employment. I hereby consent to such testing.
I authorize the testing laboratory to release my test results to the Medical Review Officer (MRO) and/or to designated supervisors and managers on a need-to-know basis.

If there is a positive test result, I understand that the MRO may ask me to provide, and I agree to provide, information about any legal non-prescription drugs and other drugs for which I have a prescription that I take routinely or have taken within the last thirty days. I understand that any communication I may have the collection site personnel,

testing laboratories or MRO does not create or imply any form of doctor/ patient relationship.

I understand that if I refuse to submit to a drug test or alter a drug test in anyway, that these will be grounds for separation from employment. I also understand that coming to work under the influence of drugs or alcohol is a violation of the company policy and will be subject to disciplinary action up to and including separation from employment and that the appropriate licensing board will be contacted if applicable.

I acknowledge that a telephonic or photographic copy of this document shall be as valid as the original.

I understand that any offer of employment, or continued employment, is conditioned upon the company's decision that the results of my background investigation and /or drug testing are satisfactory.

_____ ___/___/___
Applicants Printed Name Date

_____
Signature of Applicant

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Verification of Previous Employment/Reference Check

Company:_____

Address:_____

Date employed
from:_____To:_____

The person named below has applied for a position with our company.
Please fax completed form to: ____-____-_____
or contact Human Resources with questions at _____-_____-_____.

Applicant Name: _____SS#_____-_____-_____

Applicant
Signature:_____

Position Applied
for:_____

Please answer the questions below:

Position held:_____

Are the above dates of employment correct? Yes___ No___
If NO, please give actual work dates: From:_____ To_____

Reason for separation:_____
_____
_____
_____
_____

Is this person eligible for re-hire: Yes_____ No_____
Overall quality of life performance:_____
_____
_____
_____

Additional comments:_____
_____
_____
_____

Completed by:_____**Title**_____**Date**_____

Equal Employment Opportunity Survey

Date:_____

It is the policy of this employer and all of its subsidiaries to provide equal employment opportunities to all employees and applicants for employment without regard to race, color, religion, sex, national origin, age, disability or veteran status.

This employer is required by federal law to track the sex and race of applicants for employment. The information requested below is solely for the purpose of complying with these recordkeeping requirements. Submission of this form is voluntary. This information will be kept confidential and will be maintained separately from your employment application. Your responses below will have no effect on our company's decision concerning your application for employment.

Name (Last, First, Middle)
_____

Sex:

Female

Male

Race:

____ Caucasian

____African-American

____Hispanic

____Asian or Pacific Islander

____American Indian or Alaskan Native

EMPLOYMENT ACKNOWLEDGMENT

I, _____the undersigned, hereby accept employment at this agency in the position of _____ in the _____department.

I agree to the following terms and conditions of employment:

1. I understand and agree to the condition that the first 90 days of my employment are an introductory period, so that my work may be evaluated. I also agree to attend New Employee Orientation on my first day of employment, if I do not attend, my position will be terminated.

2. My work performance, personal appearance, and behavior must meet the standards outlined in the Employee Handbook and any other facility policy and procedure manual.

4. If I have a complaint or grievance, I will discuss it first with my supervisor and follow procedures set forth in the Employee Handbook.

5.I understand that this is a Full-Time____ Part-Time ____ PRN____

I further understand that this schedule and specific assignment may be changed depending upon the needs of the organization. I do not have the authority to change my schedule or assignment location without permission from my supervisor or manager.

6. My beginning hourly rate will be $_____per hour.

If I plan to terminate my employment, I will give two weeks written notice.

My date of hire is _____.

_____ _____

Supervisor/Witness **Employee / Date**

TEXAS DEPARTMENT OF PUBLIC SAFETY/ TEXAS DEPARTMENT OF HUMAN SERVICES AND EMPLOYEE MISCONDUCT REGISTRY

In connection with my application for employment (including contract for services) with Valor Hospice. I hereby fully release and discharge you and Texas Department of Public Safety (TDPS), their respective affiliates, subsidiaries, directors, officers, employees, agents and attorneys thereof, and each of them, and any individual, organization, entity, agency or other source providing information to above named employer and/or TDPS from all claims and damages arising out of or relating to any investigation of my background for employment purposes.

I hereby authorize and give my consent to Valor Hospice. to seek information regarding my criminal history background. If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for you to procure criminal reports at any time during my employment (or contract) period.

I understand that when an offer of employment is made to an applicant, this facility must search the Texas Health & Safety Code misconduct registry and the Texas Department of Aging and Disability Services nurse aide registry to determine whether the individual is designated in either registry as having abused, neglected, or exploited a resident or a consumer of a facility. This facility must also search the OFFICE OF INSPECTOR GENERAL (OIG): List of Excluded Individuals/Entities (LEIE) - Reports individuals and businesses excluded from participating in Medicare, Medicaid, or other federally funded health care programs

I also understand that Valor Hospice. will also check the Texas Health & safety Code

Misconduct Registry and the Texas Department of Aging and Disability Services Nurse aide Registry and the OFFICE OF INSPECTOR GENERAL (OIG): List of Excluded Individuals/Entities annually on all employees at their anniversary date.

Valor Hospice. will not employ any person who is listed negatively in either registry or on the OFFICE OF INSPECTOR GENERAL (OIG): List of Excluded Individuals/Entities per Chapter 93 of the Texas Administrative Code and Chapter 253 of the Texas Health and Safety Code, Employee Misconduct Registry.

For purposes of gathering this information, I agree to supply the following information:

_____
_____
PRINT FULL NAME: **SOCIAL SECURITY #**

_____ _____
_____
Other names used – Maiden Name **DATE OF BIRTH** **SEX**

_____
_____

SIGNATURE_____
DATE:_____

FOR HUMAN RESOURCES ONLY

VERIFIED BY: _____ **LIC. #:** _____ **LIC. EXP:**_____

MISCONDUCT:_____ **TX Dept. of Public Safety** _____ **CIA** _____

Direct Deposit Authorization Agreement

I hereby authorize Valor Hospice to deposit 100% of my paycheck or make reversals into the account listed below. The authority remains in effect until Valor Hospice has received written notification from me of termination in time to allow reasonable opportunity to act on it or until I have received written notice of

termination of this agreement.

Contact Information

Name:_____
Social Security Number:_____
Phone Number:_____
Home Address:_____
City:_____ State:_____ Zip code:_____
Phone number:_____

Signature:_____ Date:_____
(Please note that the signing of this agreement does not guarantee funds availability)

Required financial institution information

Attach a void check (For Checking Account)- Required