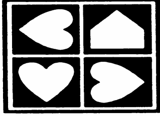

FRANKLIN COUNTY
Home Health Agency, Inc.

3 Home Health Circle
St. Albans, VT 05478
Telephone: 802-527-7531
Facsimile: 802-527-8015
Web Site: www.fchha.org

APPLICATION FOR EMPLOYMENT

Equal Opportunity Employer

(Please print using a pen.)

Last Name	First Name		Middle Initial
Mailing Address	City	State	Zip
Email Address (if you want to be contacted via e-mail):	Telephone No. (Home)		Telephone No. (Cell / Other)

➢ Position Seeking

❑ Care Attendant ❑ LNA ❑ Nurse (RN or LPN) ❑ Rehab (PT, OT, SLP)

❑ Office/Administrative ❑ Social Work ❑ Leadership ❑ Other: ________________________

❑ Full-time ❑ Part-time ❑ Per-diem ❑ Shift Work ❑ Temporary

Please indicate scheduling preference(s): ❑ Day ❑ Evening ❑ Night ❑ Weekend

➢ How did you hear about this position?

❑ Employment Ad: ☑ Indicate which paper:

❑ Buyer's Digest ❑ St. Albans Messenger ❑ County Courier ❑ Burlington Free Press ❑ Seven Days

❑ Other: ____

❑ Employee Referral -- Provide employee's name: ____

❑ FCHHA Website ❑ Career Builder Website ❑ VAHHA Website ❑ Other Website: ___________________

❑ Other: ____

➢ Other names used for education or employment purposes? ____

➢ Have you ever applied for a position with us?

❑ No ❑ Yes: Date(s): ____/____/____

➢ Have you ever been employed by us?

❑ No ❑ Yes: Date(s): ____/____/____

Position held: ___________________________________ Reason for leaving: ______________________________

➢ Are you authorized to work in the United States?

❑ No ❑ Yes *Proof of citizenship or immigration status will be required upon employment.*

➢ Have you ever had a professional or any other health care license restricted, denied, suspended or revoked?

❑ No ❑ Yes: Date: ____/____/____

Nurse / Professional License / Certification Reg. No.: ____________________________ State: ___________

➢ Have you ever been convicted of a misdemeanor or felony crime including motor vehicle violations? If YES, give dates, details and penalties below for each occurrence. If you need more space, please attach a sheet of paper with the required information.

❑ No ❑ Yes: date(s) and explanation(s): ____/___/____ ____

____

____

____

EDUCATION

School	Name and Address of School	Course of Study	Years Completed	Please Check:
High School				❑ Degree ❑ GED
Undergraduate College				❑ Degree
Graduate / Professional				❑ Degree
Other (Specify)				❑ Degree ❑ Certificate

SKILLS / TRAINING

Describe any specialized training, apprenticeship, skills and extra-curricular activities including job-related training received in the United States military.

List any professional, trade, business or civic activities and offices held.

You may exclude membership that would reveal gender, race, religion, national origin, age, ancestry, disability or protected status.

Specialized Skills (Skills/Equipment Operated)

State any additional information you feel may be helpful to us in considering your application..

Other Qualifications

Summarize special job-related skills and qualifications acquired from employment or other experience.

EMPLOYMENT/WORK HISTORY: Please list your current, or most recent, employer and then your two (2) previous employers, assignments, volunteer activities and/or military experience. All the information requested below must be complete to be considered for employment. Please provide names, mailing addresses and phone numbers.

Current Employer (or most recent employer, if not presently employed)			Work Performed
Mailing Address (Street, City, State, Zip)	Start Date		
	____/____/____		
Telephone Number	Hourly Rate/Salary		
Facsimile Number			
Starting/Present Job Title	Starting	Present	
Supervisor			
Reason for Leaving ❑ I am not leaving.			**May we contact? ❑ Yes ❑ No**

Previous Employer	Dates Employed		Work Performed
Mailing Address (Street, City, State, Zip)	From	To	
Telephone Number	Hourly Rate/Salary		
Facsimile Number			
Starting/Present Job Title	Starting	Ending	
Supervisor			
Reason for Leaving			**May we contact? ❑ Yes ❑ No**

Previous Employer	Dates Employed		Work Performed
Mailing Address (Street, City, State, Zip)	From	To	
Telephone Number	Hourly Rate/Salary		
Facsimile Number			
Starting/Present Job Title	Starting	Ending	
Supervisor			
Reason for Leaving:			**May we contact? ❑ Yes ❑ No**

PERSONAL REFERENCES: All the information requested below must be complete to be considered for employment. Please provide names, mailing addresses and phone numbers of two persons who can be contacted as references**;** **DO NOT LIST** family members.

Name: ____________________ Mailing Address: ____________________ City, State, ZIP: ____________________	Relationship: ____________________ Telephone No. (Day): ____________________ Telephone No. (Evening): ____________________
Name: ____________________ Mailing Address: ____________________ City, State, ZIP: ____________________	Relationship: ____________________ Telephone No. (Day): ____________________ Telephone No. (Evening): ____________________

An Equal Opportunity Employer

- In compliance with Federal and State equal employment opportunity laws, all qualified candidates will be considered for employment without regard to their race, creed, color, national origin, ancestry, gender, age, marital status, veteran status or the presence of non-job related medical conditions or disabilities.

To assure the health and safety of our employees and clients, Franklin County Home Health Agency conducts thorough background and reference checks on all prospective employees who are offered employment.

Applicant's Certifications and Agreements

- I understand that the purpose of this application is solely to provide a standardized form on which to submit employment qualifications. I understand that this application will be considered valid for no longer than one year, at which time re-application for employment consideration will be required.
- I certify I am able to perform the essential functions of the position as defined in the job description.
- I authorize all persons, schools, employers and organizations mentioned in this application to provide Franklin County Home Health Agency with any and all information requested. I voluntarily release such persons, schools, employers and organizations from all liability for providing such information.
- I understand that if I am offered employment, I must prove my identity and my eligibility to work in the United States, have a satisfactory response from the Department of Disabilities, Aging & Independent Living, Department for Children & Families, Criminal Record check, Office of Inspector General, and references.
- In the event I am employed by Franklin County Home Health Agency, I agree to comply with all its rules, regulations and directives. I understand that I have a six month introductory period and acknowledge that any employment relationship with this Agency is of an "at will" nature. I understand that "at will" means the Employee may resign at any time and the Employer may terminate employment at any time, with or without cause.
- All of the foregoing information I have supplied in this application is a full and complete statement of the facts and it is understood that any falsification will constitute grounds for dismissal upon discovery thereof. I understand that all information requested on this application is required and must be included to be considered for employment.

______________________________ ____/____/____

Signature of Applicant Date

Office Use Only:

Interviewed on: _____/_____/_____ Interviewed by: ____________________