

F R A N K L I N C O U N T Y
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				<input type="checkbox"/> Degree <input type="checkbox"/> GED
Undergraduate College				<input type="checkbox"/> Degree
Graduate / Professional				<input type="checkbox"/> Degree
Other (Specify)				<input type="checkbox"/> Degree <input type="checkbox"/> 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 <input type="checkbox"/> I am not leaving.		May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	Relationship: _____
Mailing Address: _____	Telephone No. (Day): _____
City, State, ZIP: _____	Telephone No. (Evening): _____
Name: _____	Relationship: _____
Mailing Address: _____	Telephone No. (Day): _____
City, State, ZIP: _____	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.

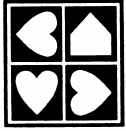
Applicant’s Certifications and Agreements

- 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: _____



F R A N K L I N C O U N T Y

Home Health Agency, Inc.

Applicant Questionnaire

General Information:

Applicant Name: _____ Date: ____/____/____

Position Applied for (please circle): Care Attendant Licensed Nursing Assistant

How did you hear about us? _____

What do you know about Home Health? _____

Are you willing to travel throughout Franklin County to meet the needs of our clients? _____

How will you get back and forth between clients? _____

Allergies: Dog Cat Tobacco Smoke? Are you able and willing to work in homes in which you may encounter these allergens?

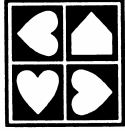
What schedule are you able to commit to? Please document below:

DAYS	HOURS?	HOURS?	HOURS?
Sunday	Days:	Eves:	Nights:
Monday	Days:	Eves:	Nights:
Tuesday	Days:	Eves:	Nights:
Wednesday	Days:	Eves:	Nights:
Thursday	Days:	Eves:	Nights:
Friday	Days:	Eves:	Nights:
Saturday	Days:	Eves:	Nights:

Job History

- 1) Why did you leave your last or current job?
- 2) If you could design the perfect job, what elements might it contain?

OVER →



F R A N K L I N C O U N T Y

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Applicant Questionnaire

- 3) If you could change anything at your current (or a past) job(s), what might it be?

- 4) What kind of boss do you like to work for?

- 5) If you could improve anything about yourself, what might it be?
 - nothing
 - something specific?

- 6) What are the qualities you possess that make you most suited for this work?

- 7) If you went into a home and heard a family member yelling at your patient, what might you do?

- 8) If you went into a home and it was a mess, and your patient was on the floor, what might you do?

- 9) As you reflect on the last three years, what are your most proud accomplishments?

Thank you for taking the time to fill out this Questionnaire