

**PREMIER HEALTH CARE, LLC
EMPLOYMENT APPLICATION**

Date: ___/___/___

Name: _____ DOB: ___/___/___ SSN: ___-___-___

Address: _____ City: _____

Phone: _____ Alternate Phone: _____

Transportation: ___ Own ___ Rely on others

Days Available To Work: M () T () W () TH () F () Sat. () Sun. ()

Note: All CNA's and Health Aides must be available to work some weekends.

All employees are expected to work PRN shifts as needed.

Times Available: AM () PM () ANY () Overnight: Yes () No ()

Emergency Contact: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Personal References:

Name: _____ Phone: _____ Date Checked ___/___/___ By: _____

Name: _____ Phone: _____ Date Checked ___/___/___ By: _____

Name: _____ Phone: _____ Date Checked ___/___/___ By: _____

Training and Credentials: Mark All That Apply

RN () LPN () CNA () Date of Completion ___/___/___

Experienced Health Aide () Years of Experience _____

Mark All That Apply

CPR () First Aid () Date Completed CPR ___/___/___ Date Completed First Aid ___/___/___

Vaccinations:

Current TB Skin Test () Yes () No If yes, Date Taken: ___/___/___

Current Flu Shot: () Yes () No If yes, Date Taken ___/___/___

FOR OFFICE USE ONLY

Hire Date ___/___/___ Separation Date: ___/___/___ Date Mailed To Employee ___/___/___

Reason for Separation: _____

EMPLOYMENT HISTORY

Most Recent

Employer: _____
Address _____ Phone: _____
Position: _____ Supervisor _____
Date Employed From: _____ To: _____
Reason for Leaving: _____
Date Checked ___ / ___ / ___ By: _____

Employer: _____
Address _____ Phone: _____
Position: _____ Supervisor _____
Date Employed From: _____ To: _____
Reason for Leaving: _____
Date Checked ___ / ___ / ___ By: _____

Employer: _____
Address _____ Phone: _____
Position: _____ Supervisor _____
Date Employed From: _____ To: _____
Reason for Leaving: _____
Date Checked ___ / ___ / ___ By: _____

Employer: _____
Address _____ Phone: _____
Position: _____ Supervisor _____
Date Employed From: _____ To: _____
Reason for Leaving: _____
Date Checked ___ / ___ / ___ By: _____

Applicant's Statement:

I certify that all information provided is true and accurate to the best of my knowledge. I hereby give permission to Premier Health Care to check all references both personal and job related. I give permission for previous employers to release any information necessary for the determination to hire.

Signature _____ Date: _____

PREMIER HEALTH CARE
2843 STAGE CENTER DR, BARTLETT, TN. 38134

EMPLOYMENT APPLICATION

Have you ever been convicted of a felony? Yes No

If yes, what was the nature of the conviction? _____

What year? _____

Premier Health Care does not hire persons convicted of a felony or listed on the abuse registry or sex offender registry. No in home worker convicted of a felony or listed on the abuse registry or sex offender registry may serve consumers.