

South Carolina Home Health Care Employment Application

Personal Data:

Email Address: _____

Date: _____

Last Name	First Name	Middle	SSN
Home Address	City	State	Zip
Home Phone	Cell Phone	DOB	

Emergency Contact Information

Emergency Contact: Name:	Relation:	Emergency Telephone Number:
--------------------------	-----------	-----------------------------

Education and Training

School	Name	City, State	Years Completed
High School			
College			
Vocational/Technical			
Other Training			

Job Information

Position Applying for: _____

RN
 LP/VN
 CNA
 PCA
 Clerical
 Other _____
 Date Available: _____

Previous Facility Types Worked: Check All That Apply

Hospital
 Hospice
 Nursing Home
 Rehab
 Private Duty
 Assisted Living / Residential Treatment

Language Skills: **Other than English, please check any other languages you speak –**

Spanish
 French
 German
 Other: _____

Check the type of assignment you are available for:

Full-time
 Part-time
 Contract
 Travel

Check the days of the week you are available to work:

Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Saturday
 Sunday

Holidays available to work: _____

License Type	License/Certification #	State	Expiration Date
License Type	License/Certification #	State	Expiration Date
License Type	License/Certification #	State	Expiration Date

South Carolina Home Health Care Employment Application

Has your professional license ever been suspended, revoked or under investigation? Yes No
If Yes, Please explain: _____

Certifications: Check all applicable certifications and enter expiration date:

- | | | | |
|-------------------------------|------------------------|--------------------------------|------------------------|
| <input type="checkbox"/> ACLS | Expiration Date: _____ | <input type="checkbox"/> Other | Expiration Date: _____ |
| <input type="checkbox"/> BCLS | Expiration Date: _____ | <input type="checkbox"/> IV | Expiration Date: _____ |
| <input type="checkbox"/> CPR | Expiration Date: _____ | <input type="checkbox"/> NALS | Expiration Date: _____ |
| <input type="checkbox"/> PALS | Expiration Date: _____ | | |

Work Experience: List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.

Facility/Employer Name	Date Employed From: _____ To: _____
Address	Title
City/State/Zip Country	Unit
Number of Beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor
Describe duties and specialty areas:	Telephone #:
Pay Rate/Salary: Hourly _____ Yearly _____	May We Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what name?	Supervisory Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No – How often?
Facility/Employer Name	Date Employed From: _____ To: _____
Address	Title
City/State/Zip Country	Unit
Number of Beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor
Describe duties and specialty areas:	Telephone #:
Pay Rate/Salary: Hourly _____ Yearly _____	May We Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, what name?	Supervisory Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No – How often?

South Carolina Home Health Care Employment Application

PROFESSIONAL/WORK RELATED REFERENCES:		
Name	Relationship	Phone

I understand that I **must** report **ALL** accidents in writing to my immediate supervisor **AND** to SCHHC.
 Yes

I also understand that I must wear all required personal protection equipment (PPE). Yes
 The penalty for not wearing PPE is disciplinary action, up to and including termination.

 Signature

ACKNOWLEDGMENT (Please read carefully and sign)

In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I give South Carolina Home Health Care permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by South Carolina Home Health Care with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, South Carolina Home Health Care may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release South Carolina Home Health Care, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

In consideration of my employment and of my being considered for employment by South Carolina Home Health Care, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either South Carolina Home Health Care or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of South Carolina Home Health Care, at any time, can constitute a contract of employment. No representative or agent of South Carolina Home Health Care has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I understand that South Carolina Home Health Care is not involved in the day-to-day supervision or decision concerning client care. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies South Carolina Home Health Care against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature _____ Date _____