Best Home Health Providers, Inc.
26236 Industrial Blvd, Hayward, CA 94545
Tel: (510) 783-1274, Fax: (510) 783-1252

Employment Application

Best Home Health Providers, Inc., also referred as "BHHP" is an equal opportunity employer. Applicants will be considered for employment without regard to race, religion, color, sex, marital status, sexual orientation, age, national origin, ancestry, mental or physical disability, medical condition, veteran status, citizenship, or any other characteristic protected by state or federal law or local ordinance.

PERSONAL INFORMATION

Full Name:_____ Date:_____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____ Alternate Phone_____

Driver License #:_____ State:_____ Expiration Date:_____

Email:_____Social Security #: _____

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:_____

EMPLOYMENT INFORMATION

Position Desired _____

Salary Desired _____ Date You Can Start _____

What days and hours are you available to work?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From							
To							

EDUCATION, TRAINING AND SKILLS

Type of School	Name of School	Location	# Years Attended	Degree Obtained
High School				
College				
Graduate				
Vocational				
Other				

SKILLS, TRAINING AND QUALIFICATIONS (*please check all that applies*)

☐ Comprehensive Assessment ☐ IV Infusion ☐ TPN ☐ PICC Line Care ☐ Wound Care
☐ Wound Vacuum ☐ Foley/Catheter Care ☐ Colostomy Care ☐ Tracheostomy Care
☐ Blood Draw ☐ Injections (IM, ID, SC) ☐ OASIS Assessment ☐ Staples/suture removal
☐ Infection Control ☐ O2 Therapy & CPAP ☐ Glucometer Use ☐ PT/INR Machine
☐ Patient Confidentiality, HIPAA ☐ Electronic documentation
☐ Others _____ _____

EMPLOYMENT HISTORY (*start with the most recent*)

Company Name	Position
Address and Telephone Number	Employment Dates
Name of Supervisor	Salary
Job Duties	Reason for Leaving

Company Name	Position
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Job Duties	Reason for Leaving

REFERENCES

List below two persons not related to you, from either a business or academic setting who have knowledge of your performance abilities within the last three years.

1. Reference Name_____Relationship_____Years Known _____

Company/ Institution_____Telephone (_____) _____

2. Reference Name_____Relationship _____Years Known _____

Company/ Institution_____Telephone (_____) _____

LICENSING INFORMATION

License/ Certificate Name_____ Expiration Date_____ State Issued _____

License/ Certificate Name_____ Expiration Date_____ State Issued _____

License/ Certificate Name_____ Expiration Date_____ State Issued _____

THE FOLLOWING SECTION IS FOR EMPLOYMENT WITHIN THE HEALTH CARE INDUSTRY IN CALIFORNIA

Please answer the following only if:

1. The position for which you are applying will provide you access to patients.
   Have you ever been arrested for a sex related crime? ☐ Yes ☐ No If yes, please explain.
   _____
   _____
   _____

2. The position for which you are applying will provide you with access to drugs or medications.
   Have you ever been arrested for a drug related crime? ☐ Yes ☐ No If yes, please explain
   _____
   _____
   _____

NOTICE TO APPLICANTS

In completing this application for employment, I understand and agree that:

1. Acceptance of this application does not mean that I will be offered a position with BHHP.
2. I hereby certify that the information contained in this application is true and accurate. I acknowledge that my providing of false or misleading information in this application or in any employment interview will result in my failure to receive an offer or, if I am hired, my immediate dismissal from employment.
3. I hereby authorize BHHP to conduct reference check, investigation into my background, finances, prior employment, criminal history, or any other aspect of my background deemed important to company. I hereby release BHHP and all persons contacted by BHHP from any and all liabilities for any damages that may result from obtaining or furnishing such information to BHHP or any of its agents, employees, or representatives.
4. I understand that I will have to provide certain identifying information to company, including my date of birth and social security number; and will have to provide documentary evidence to establish my identity, age and my right to work in the United States.

AGREEMENT FOR AT-WILL EMPLOYMENT

If I am hired by BHHP, I understand that my employment will be **"at- will**" meaning that I can leave my employment at any time and for any reason, and that my employment may be terminated at any time and for any reason. I maybe asked to sign an employment agreement as a condition of my employment. I will be required to read an Employee Handbook and safety program, acknowledging receipt of both, and agreed to comply with all policies and procedures of the company.

Signature_____ Date _____

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EQUAL EMPLOYMENT OPPORTUNITY DATA

Completion of this form is **entirely voluntary** and all information will remain confidential and will not affect your application for employment. We are required by law to collect this information for equal employment opportunity purposes and it will not become a part of your personal record if you are hired by Best Home Health Providers, Inc.

NAME: _____ SEX: ☐ Female ☐ Male

Position Applied For : _____

Race/Ethnicity:

☐ Asian/Pacific Islander
☐ Caucasian/White
☐ Middle Eastern
☐ American Indian
☐ Hispanic
☐ Black
☐ Filipino
☐ Alaskan Native

Government contractors must take affirmative action, employ and advance qualified individuals subject to the Rehabilitation Act of 1973 and the Viet ERA Veterans Readjustment Act of 1974. Completing the following information is voluntary and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodations, please check where applicable:

☐ Vietnam Veteran ☐ Disabled Veteran ☐ Individual with Disability

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To be completed by employer:
EEO – Category

_____ 1. Managers
_____ 2. Licensed Vocational Nurse
_____ 3. Therapist
_____ 4. Medical Social Worker
_____5. Registered Nurse
_____6. Home Health Aide
_____7. Dietician
_____8. Office and Clerical

Applicant Identification Record

To The Applicant:
The information requested on this form is required by the regulations of the Department of Fair Employment and Housing. Employers in California are required to keep records on file for a period of 2 years. For you protection, the employers are ordered to store the records in a different location away from your application. The information is for data purpose only and is voluntary on your part,

Please mark the space that pertains to you:

☐ Native American ☐ Black ☐ Filipino ☐ Caucasian
☐ Middle Eastern ☐ Hispanic ☐ Asian/Pacific ☐ White Non-Hispanic

National Origin/Ancestry:

☐ Hispanic ☐ Mexican American ☐ Asian ☐ Polynesian ☐ Other

It is understood by Best Home Health Providers, Inc. that the information given above in no way affects your eligibility for employment or other benefits that Best Home Health Providers, Inc. offers.

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EMPLOYMENT VERIFICATION

Applicant Name: _____

Company Name:_____

Dates of Claimed Employment:_____

Position Last Held:_____

Final Rate of pay: _____

Dear_____ ,

The person identified above is being considered for employment and has signed a statement authorizing this verification. We appreciate your opinion and input with the above mentioned person .The information you will be providing shall be kept confidential.

Is the above information correct? Yes ☐ No☐
If not please make the necessary corrections

Using a rating system from 0-10, with ten being excellent and 0-1 extremely poor, what is your opinion to the person's:

Ability_____ Effort_____ Conduct _____ Attendance_____

Knowledge_____ Team Work: _____ Is he/she re-hirable by your Co?: _____

Your further comments on personal or professional strength and weaknesses will be appreciated:

_____

_____

_____

By: _____ Date: _____
Previous Employer Name and Signature

By: _____ Date: _____
Best Home Health Providers, Inc.

**Check if done by ( ) Phone ( ) Mail*

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INTERVIEW SUMMARY

Applicant:_____Position: _____
Date Interviewed: _____ Date Available for Employment: _____

EVALUATION

Qualities	Good	Fair	Poor
Positive attitude			
Adaptability to environment			
Education			
Knowledge level of discipline			
Credentials Required			
Past work experience(s)			
Critical thinking skills			
Willingness to learn			
Length of home care experience(s)			
Other _____			

What is the average number of client's you have managed at any given point? _____

What are your expectations of your supervisor? _____
_____
_____

What types of qualities do you value in a co-worker? _____
_____

What is the most difficult part of your job? _____
_____
_____

Comments: _____
_____
_____

Recommendations: _____
_____

Interviewer's Signature:_____Date: _____

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(IMPORTANT – PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION)

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Best Home Health Providers, Inc. ("the Company") may obtain information about you from a criminal background firm for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which is restricted to information regarding your criminal history, social security verification, motor vehicle records, driving records and verification of your education or employment history. You have the right upon written request made with a reasonable time after receipt of this notice to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by a criminal background firm or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organizational manner of consumer reports and investigative consumer reports (restricted to criminal history, social security verification, motor vehicle records, driving records and verification of your education or employment history) now and throughout the course of your employment to the extent permitted by law. As a result you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge receipt of the DSICLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGTS UNDER THE FAIR CREDIT REPORTYING ACT, provided by Best Home Health Providers, Inc. ("the Company"), and certify that I have read and understand both documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports (restricted to criminal history, social security verification, motor vehicle records, driving records and verification of education or employment history) any at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer or insurance company to furnish background information (restricted to criminal history, social security verification, motor vehicle records, driving records and verification of education or employment history) requested by a criminal background firm or another outside organization acting on behalf of the Company and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report, if one is obtained by the Company. ☐

California applicants or employees only: By signing below,you also acknowldege receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge, If one is obtained by the Company whenver you have a right to receive such a copy under California law. ☐

First:	Middle:	Last:
Other Names/Maiden/AKA:		
SS#:	Non-US ID# (if any) & Country:	
Phone #:	Date of Birth:	DL# & State:
Current Address:		City:
State:	Zip:	Date:
Applicant/Employee Signature:	Client ID: Best Home Health Providers, Inc.	

*This information will be used for background screening purposes only and will not be used as hiring criteria.