Fax to 225-214-1232

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

NAME (LAST, FIRST, MI)			SOCIAL SECURITY #
PRESENT ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE #	CELL PHONE #:	EMAIL:	REFERRED BY:

EMERGENCY CONTACT

NAME	RELATIONSHIP	ADDRESS	TELEPHONE #
DOCTOR	TELEPHONE #	ADDRESS	ALLERGIES

EMPLOYMENT DESIRED

POSITION	DATE YOU CAN START	SALARY DESIRED
ARE YOU EMPLOYED? ☐ YES ☐ NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? ☐ YES ☐ NO	
EVER APPLIED AT THIS COMPANY BEFORE? ☐ YES ☐ NO	WHERE?	WHEN?

EDUCATIONAL BACKGROUND

NAME AND LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL			
HIGH SCHOOL			
COLLEGE			
TRADE, BUSINESS, OR CORRESPONDENCE			

The employment relationship between The Company and its employees is one of mutual consent, which may be terminated at any time – with or without cause – by either the employee or The Company. This relationship is referred to as "employee at will". Nothing contained in any document provided to employees is meant to create an employment contract or imply a guarantee of employment or benefits. The only exception to this policy is for certain employees who may, from time to time, be employed by The Company on a temporary basis for a period of time that is defined in writing.

GENERAL

SPECIAL SKILLS/TRAINING
U.S. MILITARY OR NAVAL SERVICE & RANK

FORMER EMPLOYERS

(LIST BELOW LAST THREE EMPLOYERS, STARTING WITH MOST RECENT)

DATE MONTH & YEAR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM: TO:				
FROM: TO:				
FROM: TO:				

PERSONAL REFERENCES

GIVE THE NAMES BELOW OF THREE PERSONS (NON-RELATED) WHO HAVE KNOWN YOU FOR AT LEAST A YEAR

NAME	ADDRESS	PHONE #	YEARS KNOWN

I certify that the facts contained in this application are true and complete to the best of my knowledge and understanding and that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all my statements contained herein and references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release The Company from all liability that may result from utilization of such information.

I also understand and agree that no representative of The Company has any authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized representative.

DATE:____________________ SIGNATURE:____

INTERVIEWED BY:____ DATE:______________________

REFERENCE REQUEST

Applicant:
Please fill out the information below so that we can contact ***former employer(s)***. No personal references, please.

TO: Company:____
Address:____
____
Phone #:________________________

Dates of Employment: ________________________ **to:** ______________________________

I hereby authorize Pinnacle Home Health to contact the former employer listed above to verify my job history.

____ ______________________________
Signature of Applicant Date

[Office Use Only]

Former Employer:

__________________________ has applied for employment with Pinnacle Home Health and has given your company as a reference as indicated above. We would appreciate it if you would complete the information below and fax it back to us. Thank you!

Dates of employment as stated by applicant are accurate: ❑ YES ❑ NO. If NO, correct dates:___________

Eligible for rehire: ❑ YES ❑ NO.

Scoring (please circle)	1 (Poor)	2	3	4	5 (Excellent)
Dependability					
Commitment					
Dedication					
Knowledge					
Timeliness					
Absenteeism					
Honesty					
Caring					
Willingness					
Manageability					

Signature of Employer:__________________________________ Date:_________________________

Title:____

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Caring					
Willingness					
Manageability					

Signature of Employer:_________________________________ Date:________________________

Title:____

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Dependability					
Commitment					
Dedication					
Knowledge					
Timeliness					
Absenteeism					
Honesty					
Caring					
Willingness					
Manageability					

Signature of Employer:_________________________________ Date:_________________________

Title:____

Louisiana State Board of Nursing

REQUEST FOR PUBLIC RECORD DISCIPLINARY INFORMATION

Full Name: ____

Social Security Number: ______________________________________

Professional License Number: __________________________________

Do you have any restrictions against your license? __ Yes ___ No

If yes, please explain:

____

____

____

____

Do you or have you had any disciplinary action from the LSBN? ___ Yes ___ No

If yes, please explain:

____

____

____

____

I ________________________ agree that my professional license is current and valid and that it is not restricted in any way. I have disclosed any and all information pertaining to previous disciplinary action I have received from the LSBN. I understand that Pinnacle Home Health has the right to review all public records pertaining to any disciplinary action received from the LSBN.

______________________________ ______________________________

Employee Signature **Date**