Friends of Hospice Employment Application

Date:

Last Name	**First**	**Middle**	**Social Security Number**

Permanent Address:	**For how long? Years: _____ Months: _____**	**Contact Information**
Street Address. Apt#		**Home:**
City, State, Zip		**Cellular:** **Email**

Previous Address:	**For how long? Years: _____ Months: _____**	**Emergency Contact**
Street Address: Apt#:		**Name:**
City, State, Zip		**Home/Cell:** **Work:**

Have you worked here previously? ☐ YES ☐ NO If YES, when?

List any friends or relatives working here now or previously, with current phone numbers:

Position you are seeking:	Expected wage:	Available to begin work when?

Work Hours preferred (write in shift/other times): _____ to _____

☐Full Time: ☐ Day shift ☐ Eve. shift ☐ Night shift ☐12-hr shift ☐24-hr shift

☐Part Time (note specific days): ☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat ☐Sun

Will you work overtime if asked? ☐YES ☐NO

Are you interested in double shifts as part of a 40-hour week? ☐YES ☐NO

Are you a U.S. citizen or otherwise eligible for employment under the Department of Justice Immigration and Naturalization Service Requirements? ☐ YES ☐NO

Have you been convicted of a felony crime in the past 7 years? ☐ YES ☐ NO
If YES, give date and explanation:

All employees of Adult Family Homes in the State of Washington must pass a criminal background inquiry. Is there anything that will negatively impact the result of this inquiry? ☐ YES ☐ NO If YES, explain:

Are you prevented from doing certain types of work due to serious injury / illness / physical challenges? ☐ YES ☐ NO
If YES, explain any conditions which prevent you from performing essential job functions:

Certification and Training (check all that apply)

☐ NAC expiration date: _____
☐ HCA expiration date: _____
☐ CPR expiration date: _____
☐ 1st Aid expiration date: _____
☐ RN expiration date: _____
☐ LPN expiration date: _____
☐ Food Handler Card expiration date: _____
☐ Latest TB Test date 1): _____ date 2): _____
☐ Nurse Delegation
☐ Basic "Core" Caregiver Training
☐ Dementia Specialty Training
☐ Developmentally Disabled Specialty Training
☐ Mental Health Specialty Training
☐ Other
☐ Other

Other Training/Certifications/Skills Pertinent to End-of-Life Care

Description	Name/location of school	Date completed

EDUCATION					
	NAME and LOCATION	**COURSE of STUDY**	Years completed	Did you graduate?	Degree or Diploma
High School				☐ YES ☐ NO	
College				☐ YES ☐ NO	
Business/ Trade/ Technical				☐ YES ☐ NO	

EMPLOYMENT HISTORY (List most recent employer first)	
Company Name (most recent):	Telephone:
Address:	Employed From: (month/year) _____ to: (month/year) _____
Name and Title of Supervisor:	Starting Wage: _____ Ending Wage: _____
Job Title and Description of duties:	Reason for leaving: May we contact this employer? ☐ YES ☐ NO If NO, why?
Company Name:	Telephone:
Address:	Employed From: (month/year) _____ to: (month/year) _____
Name and Title of Supervisor:	Starting Wage: _____ Ending Wage: _____
Job Title and Description of duties:	Reason for leaving: May we contact this employer? ☐ YES ☐ NO If NO, why?
Company Name:	Telephone:
Address:	Employed From: (month/year) _____ to: (month/year) _____
Name and Title of Supervisor:	Starting Wage: _____ Ending Wage: _____
Job Title and Description of duties:	Reason for leaving: May we contact this employer? ☐ YES ☐ NO If NO, why?
Please note: Incomplete applications will not be considered.	

Applicant's Certification and Agreement

I certify that the facts set forth in this application for employment are true and complete to the best of my knowledge. I authorize Friends of Hospice (FOH) to confirm any of the facts set forth in this application. I understand that if I am employed, false statements in this application may result in my dismissal. I understand that employment at FOH is "at will" which means that either I or FOH can terminate the employment relationship at any time without cause, and with or without prior notice, and for any reason not prohibited by statute, with status of employment remaining as such.

Signature of Applicant Date