

# Trinity Home Health Care Employment Application

Trinity Home Health Care is an equal opportunity employer, dedicated to a policy of non-discrimination in employment on any basis including age, sex, color, race, creed, national origin, religion, marital status, sexual orientation, political belief or disability.

Federal law prohibits the employment of unauthorized aliens. All persons hired must submit satisfactory proof of employment authorization and identity within three (3) days of being hired. Failure to submit such proof within the required time shall result in immediate employment termination.

## Personal Data

_____	_____	_____	_____
First Name	Middle	Last	
_____	_____	_____	_____
Street Address	City	State	Zip Code
_____	_____	_____	_____
Home Telephone Number	Social Security Number	Today's Date	
_____	_____	_____	_____
Daytime Telephone Number at which we may contact you		Email Address	

Are you 18 years of age or older? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been convicted of a crime? Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes", please explain:

\_\_\_\_\_

How were you referred to Trinity Home Health Care? Please circle the number of the most appropriate response.

1	2	3	4	5	6
College	Recruiter	Employee	Adver-	No	Other: _____
or	or		tisement	Referral;	
University	Agency			Walk-In	

## Position Preferences

For what position are you applying? \_\_\_\_\_

Client Company Name: \_\_\_\_\_

Salary desired: \$ \_\_\_\_\_ per \_\_\_\_\_ (specify hour, week or year)

Schedule desired: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ # of Hours Per Week \_\_\_\_\_

Could you work overtime? Yes \_\_\_\_\_ No \_\_\_\_\_

What date could you start work? \_\_\_\_\_

Could you travel if required by this position? Yes \_\_\_\_\_ % of Time \_\_\_\_\_ No \_\_\_\_\_

## **Education**

### **High School**

School Name: \_\_\_\_\_

City and State: \_\_\_\_\_

Degree or # of Years Completed: \_\_\_\_\_

Major or Subject: \_\_\_\_\_

Grade Point Average: \_\_\_\_\_

### **College**

School Name: \_\_\_\_\_

City and State: \_\_\_\_\_

Degree or # of Years Completed: \_\_\_\_\_

Major or Subject: \_\_\_\_\_

Grade Point Average: \_\_\_\_\_

### **College**

School Name: \_\_\_\_\_

City and State: \_\_\_\_\_

Degree or # of Years Completed: \_\_\_\_\_

Major or Subject: \_\_\_\_\_

Grade Point Average: \_\_\_\_\_

**Graduate School**

School Name: \_\_\_\_\_

City and State: \_\_\_\_\_

Degree or # of Years Completed: \_\_\_\_\_

Major or Subject: \_\_\_\_\_

Grade Point Average: \_\_\_\_\_

List any certificates earned or in progress, and/or any additional training programs not included in your formal education.

\_\_\_\_\_  
\_\_\_\_\_

List any Professional Affiliations to which you belong (please do not list activities which would indicate age, sex, color, race, creed, national origin, religion, marital status, sexual orientation, political belief, or disability):

\_\_\_\_\_  
\_\_\_\_\_

**Previous Employment**

List your current or most recent employment first. Include work related internships, military and volunteer work.

Current Employer: \_\_\_\_\_

City and State: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Supervisor's Name and Title: \_\_\_\_\_

Position Title: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Salary: \_\_\_\_\_ per Hour Week Month Year (circle one)

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

May We Contact Your Employer: Yes \_\_\_ No \_\_\_

Previous Employer: \_\_\_\_\_

City and State: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Supervisor's Name and Title: \_\_\_\_\_

Position Title: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Salary: \_\_\_\_\_ per Hour Week Month Year (circle one)

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

May We Contact Your Employer: Yes \_\_\_ No \_\_\_

Previous Employer: \_\_\_\_\_

City and State: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Supervisor's Name and Title: \_\_\_\_\_

Position Title: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Salary: \_\_\_\_\_ per Hour Week Month Year (circle one)

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

May We Contact Your Employer: Yes \_\_\_ No \_\_\_

**Professional References**

Name	Title	Company	Phone	Professional Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Releases and Applicant's Signature**

In connection with my application for employment, Delaware Law Regulations 19 Del. C. §708, 11 Del. C. §8563 and 11 Del. C. §8564 and as a condition of continuing employment, I understand that investigative background inquiries may be made on me including previous employers, schools, consumer credit, criminal convictions, motor vehicle, and other reports. These reports will include information as to my character, work habits, performance, education, compensation, and experience along with reasons for termination of employment from previous employers. Furthermore, I understand that the company may be requesting information from various federal, state, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil, and other experiences as well as claims involving me in the files of insurance companies. I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from liability and responsibility for doing so. I hereby consent to obtaining the above information from Trinity Home Health Care and/or any of their agents. This authorization and consent shall be valid in original, fax, or copy form.

\_\_\_\_\_  
Initials

**All hiring and employment at Trinity Home Health Care is at will.** I understand this application is not an employment contract, nor can it be used to create one. Employment by Trinity Home Health Care has no specific term and may be terminated by the employee or Trinity Home Health Care with or without notice. I acknowledge that Trinity Home Health Care has not made any promises or representations that differ from those contained in this paragraph.

I understand I must provide satisfactory documents to establish my identity and right to work in the United States, if I am offered a position with Trinity Home Health Care, and that failure to provide full and complete disclosure is a violation of the law will result in the termination of my employment.

I release and agree to hold harmless any individual, company, business institution or government agency from all liability with regard to furnishing information to Trinity Home Health Care. I agree to release and hold harmless Trinity Home Health Care from all liability with respect to the receipt of such information.

I certify that the information I have furnished on this application form is true and complete. I understand that if any misrepresentation has been made by me verbally or in writing, any offer of employment made to me may be withdrawn or my subsequent employment with Trinity Home Health Care may be terminated.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

# Applicant Release

[ ] [Keep this applicant release in secure files separate from personnel records.](#)

Please submit a resume with this Employment Application.

Trinity Home Health Care

In connection with my application for employment (including contract for services) and as a condition of continuing employment, I understand that investigative background inquiries are to be made on me including consumer credit, criminal convictions, motor vehicle, and other reports. These reports will include information as to my character, work habits, performance, education, and experience along with reasons for termination of employment from previous employers. Further I understand that the company will be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil, and other experiences as well as claims involving me in the files of insurance companies.

I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from liability and responsibility for doing so. I hereby consent to obtaining the above information from Trinity Home Health Care and/or any of their agents. This authorization and consent shall be valid in original, fax, or copy form.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*The following information is required by law enforcement agencies and other entities for identification purposes when checking records. It is confidential and will not be used for any other purpose:*

**Please Print Clearly:**

Print Full Name: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_

Print other names you have used: \_\_\_\_\_ Dates used: \_\_\_\_\_

Date of Birth (mm/dd/yy): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Current Drivers License #: \_\_\_\_\_ Issuing State: \_\_\_\_\_

Other Drivers License #s: \_\_\_\_\_ Issuing State: \_\_\_\_\_  
(list last 7 years only)

**Home Addresses (for the last 7 years, list most current first -- use back for more space):**

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

From - To Dates: \_\_\_\_\_ - \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

From - To Dates: \_\_\_\_\_ - \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

From - To Dates: \_\_\_\_\_ - \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

From - To Dates: \_\_\_\_\_ - \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

From - To Dates: \_\_\_\_\_ - \_\_\_\_\_

Check here if there are addresses listed on back \_\_\_\_\_

Trinity Home Health Care \_\_\_\_\_

Last Revised 12/11/06