Please send to Harmony House Health Care, 2950 West Shaulis, Waterloo, IA 50701 or by E-mail to Chris Ames at cames@harmonyhousehealthcare.com

EMPLOYMENT APPLICATION

ABCM Corporation does not discriminate against any person on the basis of race, color, religion, sex, national origin, ancestry, disability, or age in admission, treatment, or participation in its programs or activities or in privileges of employment.

WERE YOU REFERRED HERE BY ANYONE? ___________YES _______NO

NAME:
DID YOU HEAR ABOUT HARMONY HOUSE BY:

NEWSPAPER AD _______INTERNET _______TELEVISION _______RADIO
_______PERSON IN COMMUNITY _______CURRENT EMPLOYER _______FAMILY MEMBER

PLEASE PRINT CLEARLY WHEN FILLING OUT THIS APPLICATION

NAME: ____ DATE:___________
Last First Middle

ADDRESS: ____
Street City State Zip

TELEPHONE: ______________________ SOC. SEC. NUMBER: ______________________

POSITION(S) APPLIED FOR: ____

ARE YOU LEGALLY ALLOWED TO WORK IN THIS COUNTRY? _________________________
(Proof of citizenship in the United States or immigration status will be required if employed by this facility.)

ARE YOU EIGHTEEN (18) YEARS OF AGE OR OLDER? ❒ YES ❒ NO
IF NO, PLEASE GIVE YOUR DATE OF BIRTH: _________________

IF YOU ARE UNDER SIXTEEN (16) YEARS OF AGE, CAN YOU FURNISH A WORK PERMIT? ❒ YES ❒ NO
(Hours worked are restricted and Work Permits are required for fourteen and fifteen year olds)

DATE AVAILABLE TO START WORK: ____________

INDICATE WHETHER YOU CAN WORK THE FOLLOWING:

	YES	NO		YES	NO
FULL-TIME	❑	❑	1ST SHIFT	❑	❑
PART-TIME	❑	❑	2ND SHIFT	❑	❑
ON-CALL	❑	❑	3RD SHIFT	❑	❑
ALTERNATING WEEKENDS	❑	❑	OVERTIME, IF ASKED	❑	❑

ARE YOU RESPONDING TO AN AD, OR WERE YOU REFERRED HERE BY SOMEONE? ❒ YES ❒ NO
IF YES, PLEASE EXPLAIN: ____

IF YOU WANT PART-TIME WORK ONLY, HOW MANY DAYS PER WEEK CAN YOU WORK? ____

DO YOU HAVE OUTSIDE RESPONSIBILITIES THAT LIMIT YOUR AVAILABILITY TO WORK? ❒ YES ❒ NO
IF SO, PLEASE DESCRIBE: ______________________________________

____

IF YOU HAVE GONE TO SCHOOL OR BEEN EMPLOYED UNDER A DIFFERENT NAME, WHAT WAS THAT NAME? ______________________________

DO YOU HAVE A RECORD OF FOUNDED CHILD OR DEPENDENT ADULT ABUSE OR HAVE YOU EVER BEEN CONVICTED OF A CRIME, IN THIS STATE OR ANY OTHER STATE? ❒ YES ❒ NO

HAVE YOU EVER BEEN EXCLUDED FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS, INCLUDED ON THE OIG LIST OF EXCLUDED INDIVIDUALS / ENTITIES (LEIE) OR THE LISTS OF PARTIES EXLUDED FROM THE FEDERAL PROCUREMENT AND NON-PROCUREMENT PROGRAMS (EPLS)? ❒ YES ❒ NO
Causes for exclusion include but are not limited to: convictions related to the distribution or possession of controlled substances; conviction or judgment or indictment for fraud, embezzlement, theft, forgery, or false statements; violation of labor standards; or violation of professional licensing standards.

DO YOU NEED TO LIMIT YOUR ANNUAL EARNINGS FOR ANY REASON?

❒ YES ❒ NO MAXIMUM AMOUNT IS:_________________________

HAVE YOU EVER APPLIED HERE BEFORE? ❒ YES ❒ NO IF SO WHEN?__________

HAVE YOU EVER WORKED HERE BEFORE? ❒ YES ❒ NO

IF SO WHEN? _________ WHO WAS YOUR SUPERVISOR? _______________

ARE YOU LAID-OFF OR SUBJECT TO RECALL? ______________________

MAY WE CALL YOU AT WORK? ❒ YES ❒ NO ; WORK # : _______________

BEST TIME TO CALL YOU AT HOME:_____________ AT WORK: ___________

REFERENCES

PROVIDE THE NAME AND PHONE NUMBER OR OTHER CONTACT INFORMATION FOR 3 REFERENCES WHO ARE NOT RELATED TO YOU:

1.____
Name Contact Information

2.____
Name Contact Information

3.____
Name Contact Information

EDUCATIONAL RECORD

Information Requested	High School	College/University	Graduate or Professional
Name and Location of School			
Years Completed			
Describe Areas of Study			
Did You Graduate			
Degree Received			
Honors Received			

IF YOU ARE A LICENSED PROFESSIONAL, PLEASE COMPLETE THE FOLLOWING:

Type of License:__________________________State:______________________

Expiration Date:___________________________License No:________________

DESCRIBE ANY OTHER SPECIAL SKILLS, TRAINING OR CERTIFICATIONS:

____

____

____

____

EMPLOYMENT HISTORY

PLEASE LIST ANY PRESENT AND PAST EMPLOYERS, STARTING WITH THE MOST RECENT

EMPLOYER: ____ PHONE: _____________
ADDRESS: ____

POSITION: ________________ STARTING DATE: _______ STARTING WAGE: _______
SUPERVISOR: ______________ ENDING DATE: __________ ENDING WAGE: ________

DUTIES: ____
____
REASON FOR LEAVING: ____

****

EMPLOYER: ____ PHONE: _____________
ADDRESS: ____

POSITION: ________________ STARTING DATE: _______ STARTING WAGE: _______
SUPERVISOR: ______________ ENDING DATE: __________ ENDING WAGE: ________

DUTIES: ____
____
REASON FOR LEAVING: ____

****

EMPLOYER: ____ PHONE: _____________
ADDRESS: ____

POSITION: ________________ STARTING DATE: _______ STARTING WAGE: _______
SUPERVISOR: ______________ ENDING DATE: __________ ENDING WAGE: ________

DUTIES: ____
____
REASON FOR LEAVING: ____

****

EMPLOYER: ____ PHONE: _____________
ADDRESS: ____

POSITION: ________________ STARTING DATE: _______ STARTING WAGE: _______
SUPERVISOR: ______________ ENDING DATE: __________ ENDING WAGE: ________

DUTIES: ____
____
REASON FOR LEAVING: ____

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APPLICANT'S STATEMENT

PLEASE READ THE FOLLOWING AGREEMENT CAREFULLY

1. I certify that the information given on this application for employment is true and correct to the best of my knowledge. I also understand that if this application is found to contain false or misleading information or an omission of important facts about me, then this application will be cancelled or, if ever hired, my employment may be terminated.

2. I hereby authorize the investigation of all information provided on this application as may be necessary in arriving at a hiring decision.

3. I have been informed and understand that the Care Center for whom I now seek employment, may conduct an abuse and criminal record check.

4. I understand that this employment application and any other Care Center documents, including employee handbooks, are not intended to create and do not create, an employment contract between the Care Center and me. The Care Center and its employees have an employment relationship which is known as employment at will. This means an employee is not required to work for the Care Center for any set period of time. An employee may voluntarily leave under proper notice. The Care Center is also not required to employ an employee for any set time period. An employee may be terminated by the Care Center at any time.

5. I understand and agree that, if I am employed, the following stipulations will apply:
   a. My initial employment will be on a ninety (90) day trial basis.
   b. Emergency conditions or staffing needs may require me to temporarily work on shifts other than the one for which I am applying. I hereby agree to such scheduling changes as directed by the department head or Administrator.
   c. I will be required to abide by all rules and regulations of the Parent Corporation and /or facility. I also understand that disregard for or any noncompliance with such rules and regulations may be grounds for dismissal from employment.

6. Please check each of the following statements as appropriate:
   a. You ☐ may ☐ may not contact my present employer.
   b. You ☐ may ☐ may not check any & all references, including any previous employers, that I have provided on this application.

7. I do hereby directly request any current and / or former employer to release any information held in my employment file, even if this information may be detrimental to me. I hereby waive any and all claims of any kind against any former employer and / or individual listed as a personal reference for the release of any information about myself, regardless of what the nature of such information may be.

8. I hereby verify that I have read this statement, understand its meaning, and agree to its stipulations.

SIGNED: ____ DATE: __________