



APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER

Fax toll free to 1-866-642-5260

IDENTIFICATION

LAST NAME	FIRST	MIDDLE.	BUSINESS PHONE	SOCIAL SECURITY NUMBER
PRESENT STREET ADDRESS & NUMBER		CITY	STATE	ZIP
TELEPHONE #		TYPE VISA		VISA NUMBER
U.S. CITIZEN YES <input type="checkbox"/> NO <input type="checkbox"/>				
IN CASE OF EMERGENCY PLEASE NOTIFY				TELEPHONE
DO YOU HAVE ANY RELATIVES WORKING FOR AMERICAN SENIOR CARE? YES <input type="checkbox"/> NO <input type="checkbox"/>			NAME	RELATIONSHIP

POSITION OR TYPE OF WORK APPLYING FOR

1.		2.	
SEEKING <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary	SHIFT WILLING TO WORK <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Evening <input type="checkbox"/> Rotating	AVAILABLE TO WORK WEEKENDS <input type="checkbox"/> Yes <input type="checkbox"/> No	SALARY REQUIRED
PRESENTLY EMPLOYEED? <input type="checkbox"/> YES <input type="checkbox"/> NO	MAY WE CONTACT YOUR PRESENT EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	PREVIOUSLY EMPLOYED BY THIS AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE AVAILABLE FOR WORK

TRAINING

Please indicate any education, vocational, on-the-job or any

HIGH SCHOOL:	NAME	LOCATION	DEGREE AND/OR TRAINING RECEIVED	MAJOR / MINOR
COLLEGE TRAINING				
GRADUATE SCHOOL				
OTHER SCHOOL OR SPECIAL TRAINING INCLUDING LANGUAGES OR OTHER SKILLS				
TYPING SPEED WPM	SHORTHAND SPEED WPM	OFFICE MACHINES OR OTHER SPECIAL EQUIPMENT USED:		
PROFESSIONAL LICENSES/CERTIFICATES Type:	STATE ISSUED	NO.	DATE RECEIVED	EXPIRATION DATE

GENERAL

HAVE YOU EVER BEEN CONVICTED OF A FELONY YES NO
 EXPLAIN (CONVICTION WILL NOT NECESSARILY BAR EMPLOYMENT)

Previous Last Employment

NAME OF EMPLOYER		TYPE OF BUSINESS:	ADDRESS		
STARTED MONTH YEAR	LEFT MONTH YEAR	STARTING PAY	FINAL PAY	NAME & TITLE OF SUPERVISOR	TELEPHONE
JOB TITLE AND DESCRIPTION OF DUTIES AND RESPONSIBILITIES:				REASON FOR LEAVING	

Previous

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STARTED MONTH YEAR	LEFT MONTH YEAR	STARTING PAY	FINAL PAY	NAME & TITLE OF SUPERVISOR	TELEPHONE
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AFFIDAVIT

I certify that the information given by me in this application and all other personal and/or professional references are correct and without consequential omissions and understand that any misstatement or omission will void this application and is grounds for dismissal.

I authorize any company, school, or other institutions or persons to release any information regarding my employment, charter, qualifications or health and release parties from all liability for any damage that may result from furnishing same to you.

American Senior Care Management may require at any time a blood test, urinalysis or other drug test of any employee suspected of using or being under the influence of drugs. Refusing a drug test by the employee normally results in discharge.

DATE

SIGNATURE (DO NOT PRINT)