

Choice Health Care, Inc.  
**APPLICATION FOR EMPLOYMENT**

PLEASE PRINT ALL INFORMATION REQUESTED  
 "This application is good for 1 calendar year" Consideration for  
 employment after 1 year requires new application"

"Choice Health Care, Inc. is an equal opportunity employer and does not discriminate against  
 otherwise qualified applicants on the basis of race, color, creed, religion, gender, national origin, age,  
 disability, sex, marital or veteran status, or any other legally protected status"

APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS				
PLEASE COMPLETE ALL PAGES			DATE:	
Name – Last	First	Middle	Other Names Used	
Present Address:				
Present City, State Zip				
How Long	Do you have the legal right to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Telephone	If under 18, please list age:			
Position applied for:	<b>Days/hours available to work</b>			
	No Preference		Thursday	
Salary desired:	Monday		Friday	
	Tuesday		Saturday	
Do you have any friends or relatives in our employ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wednesday		Sunday	
How many hours can you work?		Can you work nights/weekends		
Employment desired	Full Time Only	Part Time Only		Full or Part Time
When available to work?	Have you ever applied or worked for this company before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
EDUCATION				
TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address, use reverse side if necessary)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Other Post Secondary School				
Other Post Secondary School				
HAVE YOU EVER BEEN CONVICTED OF A CRIME "Conviction of a crime is not an automatic bar to employment"		No		Yes
If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation.				
DO YOU HAVE A DRIVER'S LICENSE?		No		Yes



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<b>Work Experience</b>		Please list your work experience for the past five years beginning with your most recent job held. If you were self-employed, give firm name. Attach additional sheets if necessary.		
Name of employer Address City, State Zip Phone Number	Name of last supervisor	Employment dates	Pay or salary	
		From To	Start Final	
Your last job title				
Reason for leaving (be specific)				
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.				
Name of employer Address City, State Zip Phone Number	Name of last supervisor	Employment dates	Pay or salary	
		From To	Start Final	
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May we contact your present employer?	No	Yes	
Did you complete this application yourself?	No	Yes	
If not, who did?			

I certify that all the information on this application is true and correct to the best of my knowledge and understand that falsification, misrepresentation or omission of information on this application is grounds for dismissal.

I authorize all references listed in this application to give you any and all information that they may have, and release all parties from all liability for any damage that may result from furnishing same to you.

Choice Health Care, Inc. has the right to require a medical examination and/or perform a background investigation as it deems necessary, including but not limited to, an investigation of police records and a protective services background check. By completing and signing this form, I authorize, without reservation, any party, including but not limited to, employers, law enforcement agencies, state agencies, institutions and private information bureaus or repositories, contacted by Choice Health Care, Inc. to furnish any or all of the above listed information. My signature below releases Choice Health Care, Inc. from any and all liability for damages arising from the investigation and disclosure of the requested information. Further, it releases and discharges all liability from all companies, agencies, officials, officers, employees and other persons, who, in good faith, provide to Choice Health Care, Inc. the above mentioned information as requested, in order to successfully complete a background investigation.

In consideration of my employment, I agree to conform to the rules and regulations of Choice Health Care, Inc. and my employment and compensation can be terminated at-will with or without cause, and with or without notice, at any time, at the option of either the company or myself and without notice or liability for wages or salary except such earned at the date of such termination. I understand that no manager, supervisor or representative of management, other than an authorized executive has any authority to enter into an agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name