APPLICATION FOR EMPLOYMENT

DATE OF APPLICATION:____________________

LAST NAME | FIRST | MIDDLE | MAIDEN | OTHER NAMES USED

PRESENT ADDRESS: | STREET ADDRESS/APT. # | CITY | STATE | ZIP | HOME PHONE / MOBILE

IF HIRED, CAN YOU PRESENT EVIDENCE OF U.S. CITIZENSHIP OR LEGAL RIGHT TO LIVE AND WORK IN THIS COUNTRY?
☐ YES ☐ NO

SOCIAL SECURITY# DRIVERS LICENSE#

POSITION OR TYPE OF WORK APPLYING FOR:

HOW DID YOU HEAR ABOUT EMPLOYMENT AT CYPRESS BASIN HOSPICE?

PRESENTLY EMPLOYED: ☐ YES ☐ NO

MAY WE CONTACT YOUR EMPLOYER? ☐ YES ☐ NO

SEEKING: ☐ FULL TIME ☐ PART TIME ☐ PRN ☐ TEMPORARY

DATE AVAILABLE FOR WORK: SALARY DESIRED:

TRANING/EDUCATION
PLEASE INDICATE ANY EDUCATIONAL, VOCATIONAL, ON-THE-JOB, OR OTHER TRAINING YOU HAVE RECEIVED WHICH WILL AID US IN PLACING YOU IN THE POSITION THAT BEST MEETS YOUR QUALIFICATIONS AND/OR IN DETERMINING YOUR QUALIFICATIONS FOR THE POSTION WHICH YOU ARE APPLYING.

☐ YES ☐ NO

HIGH SCHOOL NAME | LOCATION | GRADUATED?

COLLEGE NAME | LOCATION | DEGREE | MINOR/MAJOR

GRADUATE SCHOOL NAME | LOCATION | DEGREE | MINOR/MAJOR

OTHER SCHOOLS, SPECIAL TRAINING OR SKILLS, INCLUDING LANGUAGES:

PROFESSIONAL LICENSE OR CERTIFICATION:	TYPE	STATE ISSUED	NUMBER	DATE RECEIVED	DATE EXPIRES

TEXAS LAW PERMITS OBTAINING RECORD OF CONVICTIONS, DEFERRED ADJUDICATIONS OF FELONY CHARGES AND CURRENT OFFENSES. **I UNDERSTAND A CRIMINAL HISTORY CHECK MAY BE DONE.** ☐ **YES** ____________INITIAL

HAVE YOU EVER BEEN CONVICTED OF OR PLEAD GUILTY TO A FELONY? ☐ YES ☐ NO **---IF YES PLEASE EXPLAIN**

(OVER)

Have you ever been excluded from the Medicare/Medicaid Program

☐ Yes ☐ No

WORK EXPERIENCE: Work experience must be documented on this form

ACCOUNT FOR ALL PERIODS OF UNEMPLOYMENT

Present/Last Employer:		Phone:	
Address:		City/State/Zip:	
Supervisor:			
Start Date:	Left Date:	Beginning Pay:	Ending Pay:
Job Title:		Duties:	
Reason for Leaving:			

Name of Employer:		Phone:	
Address:		City/State/Zip:	
Supervisor:			
Start Date:	Left Date:	Beginning Pay:	Ending Pay:
Job Title:		Duties:	
Reason for Leaving:			

Name of Employer:		Phone:	
Address:		City/State/Zip:	
Supervisor:			
Start Date:	Left Date:	Beginning Pay:	Ending Pay:
Job Title:		Duties:	
Reason for Leaving:			

PLEASE READ AND SIGN THE FOLLOWING EMPLOYMENT AGREEMENT

I certify that the information on this form is true and correct to the best of my knowledge and that any misrepresentation or willful omission of facts will be cause for rejection of this application or termination of employment. I hereby authorize Cypress Basin Hospice, Inc. to conduct searches and checks on work history, personal references, driving history, criminal conviction records and the Texas Department of Human Services Nurse Aid Registry and Employee Misconduct Registry (when applicable) to determine my acceptability for employment. **I understand that if I am listed on the Employee Misconduct Registry, then I will not be eligible for employment with this agency**. I understand, and agree, that as a condition of employment I may be required to pass scheduled physical examinations as they relate to my ability to discharge my duties. I understand I may also be required to pass a drug test. I understand that any employment relationship with this employer is “At Will”, which means that the employee may resign at any time and the employer may discharge the employee at any time, with or without cause. I also understand that this at-will employment relationship may not be changed by any written document or by any behavior, unless the change is specifically acknowledged in writing by **Cypress Basin Hospice, Inc.**

I further agree to observe all rules, regulations, and policies of **Cypress Basin Hospice, Inc.**
Cypress Basin Hospice, Inc., ensures applicants and employees are provided equal employment and advancement opportunities without regard to race, religion, gender, national origin, sexual orientation, or disability status.

Signature: **Date:**

Cypress Basin Hospice, Inc.

Promoting quality end-of-life care through holistic compassionate support

207 Morgan St. * Mt. Pleasant, TX 75455 * 903-577-1510 * Fax: 903-577-1510

AUTHORIZATION FOR EMPLOYMENT VERIFICATION

(Please return to Human Resources-Cypress Basin Hospice)

Company Name____

Attn:________________________________Title:______________________________

Telephone: **(** **)**______________________Fax: **(** **)**______________________

I,________________________________authorize the release of information requested below concerning
(Please Print)
my employment with **Cypress Basin Hospice, Inc.**

Applicant Signature:____

Date:____________________Social Security #:______________________________

The above participant is seeking employment for the position of____________________________
with Cypress Basin Hospice, Inc. The applicant has authorized your release of this information with the above signature.

Dates of employment: From____________________ To______________________
Month/Year Month/Year

Please √ appropriate box	**Excellent**	**Good**	**Average**	**Poor**	**Unknown**	**N/A**
Job knowledge						
Performance Quality						
Cooperation						
Job Responsibility						
Dependability						
Professional conduct						
Relationships with co-workers						
Relationships with supervisors						

Is this employee eligible for rehire? □ Yes □ No □ No comment

Name and title of company representative: ____________________________________
(Please Print)

Signature:__________________________________ **Date**:________________________

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Please √ appropriate box	**Excellent**	**Good**	**Average**	**Poor**	**Unknown**	**N/A**
Job knowledge						
Performance Quality						
Cooperation						
Job Responsibility						
Dependability						
Professional conduct						
Relationships with co-workers						
Relationships with supervisors						

Is this employee eligible for rehire? □ Yes □ No □ No comment

Name and title of company representative: ______________________________
(Please Print)

Signature:______________________________ **Date**:______________________