

Application for Employment PRE-EMPLOYMENT QUESTIONNAIRE EQUAL OPPORTUNITY EMPLOYER

Personal Information

DATE _____

NAME (LAST NAME FIRST)		SOCIAL SECURITY NO.	
PRESENT ADDRESS	CITY	STATE	ZIP CODE
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
PHONE NO.	SECONDARY PHONE NO.	REFERRED BY	

Employment Desired

POSITION	DATE YOU CAN START	SALARY DESIRED
ARE YOU EMPLOYED NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO
EVER APPLIED TO THIS COMPANY BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE	WHEN
EVER WORKED FOR THIS COMPANY BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE	WHEN
REASON FOR LEAVING		
		NAME OF LAST SUPERVISOR AT THIS COMPANY
HOW DID YOU FIND OUT ABOUT THIS POSITION? <input type="checkbox"/> EMPLOYMENT AGENCY <input type="checkbox"/> NEWSPAPER ADVERTISING <input type="checkbox"/> FRIEND <input type="checkbox"/> ONLINE AD <input type="checkbox"/> OTHER		
<input type="checkbox"/> STATE EMPLOYMENT OFFICE <input type="checkbox"/> COLLEGE PLACEMENT SERVICE <input type="checkbox"/> WALK IN <input type="checkbox"/> WEBSITE		

Education History

	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE	SUBJECTS STUDIED
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS, OR CORRESPONDENCE SCHOOL				

General Information

SUBJECT OF SPECIAL STUDY/RESEARCH WORK
SPECIAL TRAINING, CERTIFICATIONS, LICENSES
SPECIAL SKILLS, FOREIGN LANGUAGES, ETC.

Military Service Record

HAVE YOU EVER SERVED IN THE U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO	BRANCH OF SERVICE
DISCHARGE DATE	RANK

LAST NAME FIRST MIDDLE INITIAL

Former Employers (LIST BELOW LAST THREE EMPLOYERS, STARTING WITH MOST RECENT)

NAME OF PRESENT OR LAST EMPLOYER			
ADDRESS		CITY	STATE ZIP
STARTING DATE	LEAVING DATE		JOB TITLE
WEEKLY STARTING SALARY \$	WEEKLY FINAL SALARY \$	MAY WE CONTACT YOUR SUPERVISOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF PREVIOUS EMPLOYER			
ADDRESS		CITY	STATE ZIP
STARTING DATE	LEAVING DATE		JOB TITLE
WEEKLY STARTING SALARY \$	WEEKLY FINAL SALARY \$	MAY WE CONTACT YOUR SUPERVISOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF PREVIOUS EMPLOYER			
ADDRESS		CITY	STATE ZIP
STARTING DATE	LEAVING DATE		JOB TITLE
WEEKLY STARTING SALARY \$	WEEKLY FINAL SALARY \$	MAY WE CONTACT YOUR SUPERVISOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK			
REASON FOR LEAVING			

References (LIST PROFESSIONAL REFERENCES WHOM WE MAY CONTACT)

NAME	ADDRESS	BUSINESS	PHONE

Special Purpose Questions

DO NOT ANSWER ANY OF THE QUESTIONS IN THIS BOX UNLESS THE EMPLOYER HAS CHECKED THE BOX PRECEDING A QUESTION, THEREBY INDICATING THAT THE INFORMATION IS REQUIRED FOR A BONA FIDE OCCUPATIONAL QUALIFICATION, OR DICTATED BY NATIONAL SECURITY LAWS, OR IS NEEDED FOR OTHER LEGALLY PERMISSIBLE REASONS.

Height _____ Feet _____ Inches Weight _____ Lbs. Are you a U.S. citizen? Yes No

Have you been convicted of a Felony or Misdemeanor within the last 5 years? Yes No. Describe _____

You will not be denied employment solely because of a conviction record, unless the offense is related to the job for which you have applied.

I understand and agree that I may be required to take one or more: physical examination; drug test; lie detector test, as a condition of hiring or continued employment. I agree to consent to take such test(s) at such time as designated by the Company and to release the Company, its directors, officers, agents or employees from any claim arising in connection with the use of such test(s). Yes No

I have been advised that lie detector tests, as a condition of hiring or continued employment, are prohibited by law. Yes No

Are you able to perform each of the following job functions with or without an accommodation? Yes No

JOB FUNCTION #1 _____

If you can perform the function with an accommodation, explain how you would perform the tasks, and with what accommodation?

JOB FUNCTION #2 _____ Yes No

If you can perform the function with an accommodation, explain how you would perform the tasks, and with what accommodation?

JOB FUNCTION #3 _____ Yes No

If you can perform the function with an accommodation, explain how you would perform the tasks, and with what accommodation?

Were you ever seriously injured? Yes No Give details _____

What foreign languages do you speak fluently? _____

What foreign languages do you write fluently? _____

What foreign languages do you read fluently? _____

Authorization

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws."

DATE _____

SIGNATURE _____

APPLICANT DISCLOSURE/RELEASE AUTHORIZATION FOR BACKGROUND INVESTIGATION

I understand and hereby authorize without reservation **BROOKS HOME HEALTH CARE** and its contract agent **BRADLEY SCREENING** to procure a consumer report and /or an investigative consumer report for my employment consideration and to make an independent investigation of my background, references, character, past / present employment, education, motor vehicle records, drug screening records, criminal and police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my application, resume, or in other supporting documentation and / or obtaining other information which may be material to my qualifications. These reports will be used for employment purposes only.

_____ (Initials)

I understand that **BROOKS HOME HEALTH CARE** and / or its contracted agent **BRADLEY SCREENING** will adhere to applicable state and federal statues concerning the securing of the information, handling, and release of information obtained in the investigation. I further understand, under the guidelines set forth in the federal Fair Credit Reporting Act, I have the right to request additional disclosures as to the nature and scope of the investigation and will be provided a copy of the consumer rights and defined by the Federal Trade Commission. _____ (Initials)

The following is a true and complete legal name and all information on this document is true and correct to the best of my knowledge. I understand that all information requested below is for the sole purpose of gathering information accurately and for positive identification and will not be used to discriminate against me in a violation of any law. I understand any initial offer will be contingent until all information is obtained and processed and be subsequently withdrawn based on results of this investigation. I further understand this signed periodic background investigations as a requirement of my continued qualifications. _____ (Initials)

**** A telephonic facsimile (FAX) or a photographic copy of this authorization shall be as valid as the original.

FIRST (PRINT) MIDDLE LAST

MAIDEN NAME LIST ANY OTHER NAMES USED

DATE OF BIRTH SEX RACE SOCIAL SECURITY NUMBER

DRIVERS LICENSE STATE OF LICENSE EXPIRATION DATE

PRESENT ADDRESS CITY / STATE / ZIP COUNTY HOWLONG THERE

LIST ANY FORMER ADDRESSES YOU HAVE HAD IN THE PAST 7 YEARS?

FORMER ADDRESS CITY / STATE / ZIP COUNTY

******* BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE DISCLOSURE AND RELEASE FOR INFORMATION**

APPLICANT'S SIGNATURE (PLEASE DO NOT PRINT) DATE

**BROOKS HOME HEALTHCARE
 5003 LORI CIRCLE NW
 HUNTSVILLE, AL 35810**