

Affordable Home Health Care DBA
 Summit Home Care
 170 Taylor Station Rd Suite 220
 Columbus, Ohio 43213
 Ph: (614)-866-8158 Fax: (614)-866-8160



EMPLOYEE APPLICATION

Last Name	First	Middle	Date:	
Street Address			Home Telephone	
City, State, Zip			Cell Telephone	
Have you ever applied for employment with us? Yes/No		If Yes: Month and Year	Email	
Position Desired			Pay Expected	
Outreach Coordinator/Referred by: Name:			When will you be available to begin work?	
Employment Desired:	Full-Time	Part Time	Floater/Temporary/PRN	
Specify days and hours available:				
Other Special Training or Skills (certifications, languages, ect.)				
Are you a US citizen? Yes/No				
EDUCATIONAL BACKGROUND:	Name and Location of School	Course of Study	Years Completed	Degree/Diploma
High School (or GED Equivalent)				
College(s)				
Business/Trade/Technical				
Did Not Graduate from High School				
Licenses, Registration and Certificates (Be sure to include any valid drivers license or commercial drivers license, if required for job)				
License/Certification Issued By:		Field/Trade Specialization: License/Certification#: Expires:		
Affordable Home Health Care, LLC DBA Summit Orthopaedic Home Care is an Equal Opportunity Employer. This application for employment will be considered for current openings only. Future consideration will depend on reapplication. An incomplete or incorrectly completed application will not be considered.				
BELOW AREA-COMPANY USE ONLY				
Interview Date:	Department:		Shift:	
Start Date:	Job Title:		Status:	
NAME:	SOCIAL SECURITY #:		DATE OR BIRTH:	

EMPLOYMENT HISTORY

List below ALL former employers, beginning with most recent (explain gaps in employment and please use additional sheets of paper, if needed). Please include any other last names that were used at past employments. (necessary for reference checks)

1. Company Name	Telephone #:
Address:	Employment Date: (Month and Year) From: ___/___/___ to ___/___/___
Name of Supervisor	Hourly/Salary: Start \$_____ to \$_____
Job Title and Description:	Reason for leaving
2. Company Name	Telephone #:
Address:	Employment Date: (Month and Year) From: ___/___/___ to ___/___/___
Name of Supervisor	Hourly/Salary: Start \$_____ to \$_____
Job Title and Description:	Reason for leaving
3. Company Name	Telephone #:
Address:	Employment Date: (Month and Year) From: ___/___/___ to ___/___/___
Name of Supervisor	Hourly/Salary: Start \$_____ to \$_____
Job Title and Description:	Reason for leaving
4. Company Name	Telephone #:
Address:	Employment Date: (Month and Year) From: ___/___/___ to ___/___/___
Name of Supervisor	Hourly/Salary: Start \$_____ to \$_____
Job Title and Description:	Reason for leaving
PERSONAL REFERENCES (non-relative)	
1. Name:	Phone #: Email (preferred):
2. Name:	Phone#: Email (preferred):
Have you ever been convicted of any crimes? Yes/No	If Yes, please provide date(s) and explain offense(s)

ADDENDUM TO EMPLOYMENT APPLICATION

The Ohio Administrative Code (5123:2-.05) requires that home health care companies ascertain from applicants for employment that have not been convicted or plead guilty of the offenses listed below. Your signature below indicates that you have not committed nor plead guilty of:

Aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, failing to provide for a functionally impaired person, aggravated menacing, patient abuse and neglect, kidnapping, abduction, criminal child enticement, rape, sexual batter, unlawful sexual conduct with a minor, gross sexual imposition, importuning, voyeurism, public indecency, compelling prostitution, promoting prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually oriented materials involving a minor, illegal use of minor in nudity-oriented material or performance, aggravated robbery, robbery, aggravated burglary, burglary, unlawful abortion, endangering children, contributing to the unruliness of delinquency of a child, domestic violence, carrying a concealed weapon, having weapons while under disability, improperly discharging a firearm at or into a habitation or school, corrupting others with drugs, trafficking in drugs, illegal manufacture of drugs of cultivation of marijuana, funding of drugs or marijuana trafficking, illegal administration or distribution of anabolic steroids, placing harmful objects in food or confections, child stealing, possession of drugs, or felonious sexual penetration.

I, _____ have read the contents of the addendum to my application for employment with Affordable Home Health Care, LLC. DBA Summit Orthopaedic Home Care. I also understand that I am required by law to notify Affordable Home Health Care, LLC. DBA Summit Orthopaedic Home Care within 14 days if I receive formal charges, convictions, or make a guilty plea to any one of the disqualifying offenses listed above.

I, _____ give Affordable Home Health Care, LLC. DBA Summit Orthopaedic Home Care the right to prosecute me if it is determined in a court of law that I have committed a crime during the hours of my duty with Affordable Home Health Care, LLC. DBA Summit Orthopaedic Home Care as in accordance with the Declaration of Arrest and Convictions Statement Code of Federal Regulations. By signing this statement, I also give Affordable Home Health Care, LLC. DBA Summit Orthopaedic Home Care the right to request a police background investigation.

Signature of Employee or Applicant

Date

Print Name

APPLICANT STATEMENT

1. My signature authorizes Affordable Home Health Care, LLC. DBA Summit Orthopaedic Home Care or its authorized agents to conduct a thorough investigation of all statements, written and oral, made by me during the employment application process, including without limitation, information concerning my employment positions, law enforcement record, driving record, and educational background. I hereby authorize all persons, companies or other entities connected with any such informational request, including without limitations, current or prior employers and law enforcement agencies to provide any and all information they may have regarding me or my employment. I release and agree to indemnify Affordable Home Health Care, LLC. DBA Summit Orthopaedic Home Care its authorized agents , and its employees, and all other persons, companies, and other entities from any and all liability arising out of such investigation, including without limitation any liability for furnishing information of for taking any action based on the information provided.
2. I hereby certify that all responses set forth during my employment application process are true and complete. I understand and agree that any falsification, misrepresentation, or omission either on the employment application form or in my responses to questions asked during the interviewing or examination process may disqualify me from further consideration for employment, or if employed by AHHC, LLC. DBA Summit Orthopaedic Home Care will subject me to immediate termination, whenever the falsification or omission is discovered. In this regard, where an item is left blank on the employment application, it is because there is no information within its scope.
3. I understand that a drug and/or alcohol screen may be required before and during my employment. In addition, I authorize a medical examination, including a drug and/or alcohol screen, by an examiner selected by AHHC, LLC. DBA Summit Orthopaedic Home Care if I am made a contingent offer of employment. I release and agree to indemnify AHHC, LLC. DBA Summit Orthopaedic Home Care its authorized agents, and its employees, and all other persons, companies, and other entities from any and all liability arising out of any medical examination or drug/alcohol screen or for the taking of any action based on the results of any medical examination of drug/alcohol screen.
4. I agree and consent that AHHC, LLC. DBA Summit Orthopaedic Home Care may inspect any AHHC, LLC. DBA Summit Orthopaedic Home Care property at any time for any reason, without notice. This property includes, without limitations, work stations, computers, offices, desks, lockers, voicemail, and filing cabinets. Additionally, I agree and consent that any personal items I bring AHHC, LLC. DBA Summit Orthopaedic Home Care are subject to inspection at any time and for any reason, without prior notice.
5. I certify that I am a citizen of the United States, or, if not, I can provide the required documentation permitting me to work in the United States.
6. In consideration of AHHC, LLC. DBA Summit Orthopaedic Home Care review of my application, I agree that any claim or lawsuit arising out of my application for employment with, my employment with or subsequent separation from AHHC, LLC. DBA Summit Orthopaedic Home Care or any of its divisions must be filed no more that one hundred and eighty (180) calendar days after the date the employment action that is the subject of the claim or lawsuit. While I understand that the statue of limitations for claims or actions arising out of an employment action may be longer that 180 calendar days, I agree to be bound by the 180 calendar day period of limitations set fourth herein, and I waive any Statute of Limitations to the Contrary. Should a court determine in some future lawsuit that this provision allows an unreasonably short period of time to commence a lawsuit, the court shall enforce this provision as far as possible and shall declare the lawsuit barred unless it was brought within the minimum reasonable time within which the suit should have been commenced.
7. I understand and agree if I am employed by AHHC, LLC. DBA Summit Orthopaedic Home Care my employment is at will so that I may terminate my employment at any time and for any or no reason. Likewise, AHHC, LLC. DBA Summit Orthopaedic Home Care can terminate my employment at any time and for any or no reason. I also understand and agree that nothing contained in AHHC, LLC. DBA Summit Orthopaedic Home Care employment application or in the

granting or conducting of an interview or anything set fourth in any oral or written statement, communication, or policy now or in the future constitutes or creates or is intended to constitute or to create a contract or promise between me and AHHC, LLC. DBA Summit Orthopaedic Home Care for employment, hours of work, or for the providing of benefits. Moreover, I acknowledge that AHHC, LLC. DBA Summit Orthopaedic Home Care may modify, revoke, suspend, terminate or change any or all of its plans, policies, of benefits that have been made to me. I further understand and agree that no such promise or guarantee is binding on AHHC, LLC. DBA Summit Orthopaedic Home Care because no employee except Management has any authority to create an employment agreement binding on AHHC, LLC. DBA Summit Orthopaedic Home Care which differs from an employment at will relationship.

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts is cause for immediate dismissal.

Applicant's Signature

Date