EMPLOYMENT APPLICATION

GHHS Healthcare, LLC d.b.a. Georgia Home Health Services (GHHS) is a Drug Free Workplace and Equal Opportunity Provider.

General:

Position(s) and Location(s) you are applying for:_____

Date Submitted: _____

- Please complete this application in its entirety.
- Incomplete applications will not be considered.
- You may attach supporting documents such as your resume or cover letter.

Where did you hear about this position?

□ Friend/ Name: _____

□ Relative/ Name: _____

□ Internet/ If so, where? _____

□ GHHS Website

□ Walk-in

□ Other: _____

□ Employee/ Name: _____

Important Information:

Due to state and federal regulations along with GHHS's dedication to providing our patients and employees with a safe and comfortable environment, all individuals offered employment at GHHS are required to successfully complete our pre-employment process, which consists of a drug screen, criminal background check, job-related physical evaluation, and verification of education and employment history.

Personal Information:

Name:_____

First Middle Last

List any other names or aliases:_____

Mailing Address:_____

Street (Apt #) City State Zip

Physical Address:_____

Street (Apt #) City State Zip

Phone#: (_____)_____-_____ Email: _____

(Home)

Phone#: (_____)_____-_____ Driver's License State and #: _____

(Cell/Other)

Are you a veteran? □ Yes □ No Military Branch:_____

Social Security #:_____ Date of Birth:_____

Background Information:

We perform criminal background and state law enforcement checks as a condition of employment. If you answer "yes" to any of the background information questions you will NOT be disqualified from employment consideration, except as required by state or federal law. Please note: Failure to fully disclose your background information will render you INELIGIBLE for employment at GHHS. All background checks will be conducted in accordance with the Georgia Long-Term Care Background Check Program (O.C.G.A. §31-7-350 et seq.) and federal OIG exclusion standards.

Have you ever been convicted, pled guilty, nolo contendere, no contest, or had adjudication withheld as to any crime or offense? □ Yes □ No If yes, please explain: _____

Have you ever been a defendant in a civil action for an intentional tort (i.e., assault and battery, false imprisonment, etc.)? □ Yes □ No If yes, please explain: _____

_____

_____

Have your professional certifications ever been suspended, revoked or on probation? □ Yes □ No
If yes, please explain:_____

_____

_____

Have any disciplinary actions ever been initiated and/or are now pending against you by any state licensure board? □ Yes □ No If yes, please explain:_____

_____

_____

Have you had any traffic violations in the past 3 years including accidents or speeding tickets? □ Yes □ No
If yes, please explain:_____

_____

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (i.e. Medicare or Medicaid)? □ Yes □ No If yes, please explain: _____

_____

Additional Information:

1) Please indicate your availability: □ Full Time □ Part Time □ PRN (as needed) □ Nights □ Days
If part time or PRN, please list availability:_____

Would you consider working weekends and/or holidays? □ Yes □ No

2) Date you are available to start work: _____/_____/_____ Desired Compensation: _____

3) Are you able to perform the essential function of the job(s) for which you are applying with or without accommodation? □ Yes □ No

4) Have you ever been terminated or asked by an employer to voluntarily resign? □ Yes □ No

5) Are you at least 18 years of age? □ Yes □ No

6) Are you legally eligible for employment in the United States? □ Yes □ No

7) Have you signed a non-compete, non-piracy or similar agreement and/or contract with a former employer? □ Yes □ No If yes, please attach a copy to this application.

Question:	Yes	No	When applicable, please provide additional information.
Are any of your relatives or domestic partners employed by GHHS?			If yes, state name, relationship, & department:
Have you ever applied for employment at GHHS?			Date: _____/_____ /_____ Position applied for:
Have you ever been employed by GHHS or an affiliate: Georgia Nurse Care or Hearth Hospice?			From: _____/_____/_____ To: _____/_____ /_____

Education:

Name and Location of High School: _____

Did you earn: ☐ Diploma ☐ GED ☐ None

If you answered none, please indicate highest level completed:_____

Additional Education/Training:

Name of Institution: College, University, Professional School, Vocational, Trade, Government, Military etc.	Location (City, State)	Major/Minor or Course of Study	Please list any degree, license, or certificate earned.

Licensure, Certification, Registration (if applicable):

Licensure, Certification, Registration:	Number:	Date Received:	Expiration Date:	State/Licensing Agency:

Emergency Contacts:

Name and Relationship:	Home Number:	Cell Number:	Address:

Professional References:

Name:	Phone Number:	Address:	Occupation:

Please note: The acknowledgment and liability release at the end of this application releases GHHS, any former employers, educational institutions, and any other persons giving references free of liability for any damages caused by the exchange of reference information and any other reasonable and necessary information incident to the employment process.

Georgia Home Health Services is an Equal Opportunity Employer and does not discriminate based on race, color, religion, sex, national origin, age, disability, or any other status protected by applicable law.

Employment History:

- Please describe your work experience for the last 10 years beginning with your current or most recent job. (You may attach a resume detailing the information needed below.)
- Please fill out the entire box for each employer
- This application will not be considered complete if information is missing from this section.

(1) Name of Present or Last Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ ☐FT ☐PT ☐ PRN Supervisor's Name:_____

Duties and Responsibilites:_____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

May we contact your current employer: ☐ Yes ☐ No If no, why?_____

(2) Name of Next Previous Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ ☐FT ☐PT ☐ PRN Supervisor's Name:_____

Duties and Responsibilities: _____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

(3) Name of Next Previous Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ ☐FT ☐PT ☐ PRN Supervisor's Name:_____

Duties and Responsibilites:_____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

(4) Name of Next Previous Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ ☐FT ☐PT ☐ PRN Supervisor's Name:_____

Duties and Responsibilites:_____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

Volunteer Experience:

Name and Address of Organization:	Period of Service (month/year):	Type of Organization:	Responsibilities:

Statement of Acknowledgment and Liability Release:

By signing below, I hereby attest that the signature below is the signature version of the printed name listed above it. Any medical record entries or other documents with that signature are true, accurate, and complete to the best of my knowledge. I understand that any false information, omissions, or misrepresentations of facts called for in this application or any supplements thereto, is cause for rejection of my application or discharge at any time during my employment. I understand that as a condition of employment I will be required to complete the organization's pre-employment health and background screening. I understand that any offer of employment is contingent on my producing appropriate documentation verifying my identity and employment authorization, as required under the Immigration Reform and Control Act. I understand that my employment is terminable at-will, that I am not being employed for any specified time, and that this application is not and is not intended to be a contract for continued employment. If I am employed, I agree to abide by and observe all rules and regulations of the organization. **I voluntarily authorize my former employers, schools and persons named herein to give information regarding me, whether or not such information is part of their records. I hereby release said organizations or persons from any liability or damages whatsoever for issuing this information.**

Lastly, under GA Rule 290-5-54-.09(3)(a)1, I declare that I have never been shown to have abused, neglected, sexually assaulted, exploited or deprived any person OR caused serious injury as a result of intentional or grossly negligent misconduct.

This form may be photocopied or reproduced as a facsimile, and these copies will be as effective a release or consent as the original which I signed.

If you have any questions regarding this application. Please email us at jobs@gahhs.com or contact the appropriate office below.

Valdosta
P: 229-247-4663
F: 229-247-4663

Tifton
P: 229-382-8443
F: 229-382-8443

_____

Applicant's Printed Name

_____	_____
Applicant's Signature	**Date**