

**PRIMA HOME HEALTH, INC.**

14101 Willard Rd, Suite C

Chantilly, VA 20151

Tel: 703-955-7800

Fax: 703-263-3119

EMPLOYMENT APPLICATION

APPLICANT INFORMATION															
Last Name						First				M.I.		Date			
Street Address										Apartment/Unit #					
City						State				ZIP					
Phone						E-mail Address									
Date Available						Social Security No.				Desired Salary					
Position Applied for															
Are you a citizen of the United States?		YES <input type="checkbox"/>		NO <input type="checkbox"/>		If no, are you authorized to work in the U.S.?				YES <input type="checkbox"/>		NO <input type="checkbox"/>			
Have you ever worked for this company?		YES <input type="checkbox"/>		NO <input type="checkbox"/>		If so, when?									
Have you ever been convicted of a felony?		YES <input type="checkbox"/>		NO <input type="checkbox"/>		If yes, explain									
EDUCATION															
High School						Address									
From		To		Did you graduate?		YES <input type="checkbox"/>		NO <input type="checkbox"/>		Degree					
College						Address									
From		To		Did you graduate?		YES <input type="checkbox"/>		NO <input type="checkbox"/>		Degree					
Other						Address									
From		To		Did you graduate?		YES <input type="checkbox"/>		NO <input type="checkbox"/>		Degree					
REFERENCES															
<i>Please list three professional references.</i>															
Full Name						Relationship									
Company						Phone									
Address															
Full Name						Relationship									
Company						Phone									
Address															
Full Name						Relationship									
Company						Phone									
Address															

PREVIOUS EMPLOYMENT			
Company		Phone	
Address		Supervisor	
Job Title	Starting Salary	\$	Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Company		Phone	
Address		Supervisor	
Job Title	Starting Salary	\$	Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Company		Phone	
Address		Supervisor	
Job Title	Starting Salary	\$	Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MILITARY SERVICE			
Branch		From	To
Rank at Discharge		Type of Discharge	
If other than honorable, explain			
DISCLAIMER AND SIGNATURE			
I certify that my answers are true and complete to the best of my knowledge.			
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.			
Signature		Date	

DISCLOSURE OF CRIMINAL CHARGES FORM

By my signature below, I affirm that I

_____ **DO** have criminal and civil charges against me in the Commonwealth of Virginia.

_____ **DO NOT** have criminal and civil charges pending against me in the Commonwealth of Virginia.

If you have criminal charges against you in Commonwealth of Virginia or any other state in the U.S, please describe the nature of the charge and when it took place.

Please print legibly or type the following information:

Name: _____
Last First Middle Maiden

Date of Birth: _____ Sex: _____

I certify that the information I provided above is true to the best of my knowledge. I also understand that providing false information in this form may result in denial and or termination of employment with Prima Home Health.

Applicant's Signature: _____ Date: _____

CRIMINAL BACKGROUND CHECK RELEASE OF INFORMATION AUTHORIZATION FORM

By my signature below, I authorize the Virginia State Police to perform a criminal history record information check relative to my application for employment or volunteer services with Prima Home Health Agency pursuant to Virginia State law 32.1 126.01 and 32.1.126.9:1).

Please print legibly or type the following information:

Name: _____
Last First Middle Maiden

Previous Name(s) including previous married name(s) and aliases: _____

Address: _____

If applicant has lived at the above address for less than two (2) years, please list previous address(es) below:

Social Security #: _____ Date of Birth: _____ Sex: _____

Place of Birth: _____
City County State Country

I understand that the Virginia State Police and its officials and employees shall not be held legally accountable in any way for providing this information to the above named healthcare provider, and I hereby release said Agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the healthcare provider cannot provide me with a copy of the results of this criminal history record check.

Applicant's Signature: _____ Date: _____

This request form must be accompanied by a transmittal letter from the authorized official or individual requesting criminal history record information. This request must be mailed to:

Virginia Department of State Police
P. O. Box 85076
Richmond, VA 23261-5076