



EMPLOYMENT APPLICATION

P.O. Box 6042
Brookings, OR 97415
(541) 469-0405
800-535-9472
careers@coastalhh.org

INSTRUCTIONS: ALL APPLICATIONS MUST BE SUBMITTED ON THIS APPLICATION FORM. THIS APPLICATION MUST BE COMPLETED IN SUFFICIENT DETAIL TO ALLOW COMPREHENSIVE REVIEW AND EVALUATION OF YOUR QUALIFICATIONS FOR THE POSITION APPLIED FOR.

Position you are applying for: _____ **Date:** _____

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

_____ Home Phone Work or Message Phone Cell Phone

May we contact you at your work phone number? YES NO Email Address: _____

Please note: If you are offered a position with Coastal Home Health & Hospice, your employment is contingent upon verified eligibility for employment in the United States. You will be required to complete the Federal FORM I-9 which requires that you submit identification in accordance with the Immigration Reform and Control Act.

Please indicate (X) which of the following types of work you are willing to accept:

- | | |
|--|--|
| <input type="checkbox"/> Regular full-time | <input type="checkbox"/> Regular part-time |
| <input type="checkbox"/> Temporary | <input type="checkbox"/> Irregular |
| <input type="checkbox"/> Seasonal | |

REFERENCES (Work Related or personal who are **not related to you and are **not** previous supervisors)**

1. _____
NAME PHONE YEARS KNOWN
2. _____
NAME PHONE YEARS KNOWN
3. _____
NAME PHONE YEARS KNOWN

COASTAL HOME HEALTH & HOSPICE IS AN EQUAL OPPORTUNITY EMPLOYER

CHHH does not discriminate against any person on the basis of gender, race, age, religion, cultural background, disability, sexual orientation, color, national origin, military status or other classes protected by state or federal law.

EDUCATION AND TRAINING: Do you have a high school diploma, GED or equivalent? YES NO

Please list all colleges, universities, military, trade, business or other schools attended.

NAME AND LOCATION OF SCHOOL	MAJOR OR TYPE OF TRAINING	YEARS COMPLETED	DEGREE OR CERTIFICATE OBTAINED

LICENSES/CERTIFICATES: List professional license, driver license or other licenses or certifications you possess as required by the position applied for.

TITLE	NUMBER	ISSUING AGENCY	DATE ISSUED/DATE OF EXPIRATION

ADDITIONAL INFORMATION:

List professional, trade, business or civic associations and any offices held.

EXCLUDE MEMBERSHIPS THAT WOULD REVEAL RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, CITIZENSHIP, AGE, MENTAL OR PHYSICAL DISABILITIES, OR ANY OTHER SIMILARLY PROTECTED STATUS.

ORGANIZATION	OFFICE HELD

List special accomplishments, publications, awards, etc.

EXCLUDE MEMBERSHIPS THAT WOULD REVEAL RACE, COLOR RELIGION, SEX, NATIONAL ORIGIN, CITIZENSHIP, AGE, MENTAL OR PHYSICAL DISABILITIES, OR ANY OTHER SIMILARLY PROTECTED STATUS.

List any additional information you would like us to consider.

EXPERIENCE:

Beginning with your present or most recent job, list, in chronological order, your complete work experience, including paid and volunteer positions, military and intern experience. Please attach a separate sheet or sheets if necessary. The information provided must be complete and accurate. Explain any gaps in employment in Comments section on the next page.

A resume may be submitted but will not be accepted as a substitute for completing this section.

Name and Address of Employer:		Supervisor's Name, Title, Phone Number:	
		May We Contact?	
YOUR TITLE:		YOUR DUTIES AND RESPONSIBILITIES:	
FROM: MO. YR.	TO: MO. YR.		
MONTHLY SALARY:			
TOTAL YEARS/MOS.:	<input type="checkbox"/> VOLUNTEER	REASON FOR LEAVING:	

Name and Address of Employer:		Supervisor's Name, Title, Phone Number:	
		May We Contact?	
YOUR TITLE:		YOUR DUTIES AND RESPONSIBILITIES:	
FROM: MO. YR.	TO: MO. YR.		
MONTHLY SALARY:			
TOTAL YEARS/MOS.:	<input type="checkbox"/> VOLUNTEER	REASON FOR LEAVING:	

Name and Address of Employer:		Supervisor's Name, Title, Phone Number:	
		May We Contact?	
YOUR TITLE:		YOUR DUTIES AND RESPONSIBILITIES:	
FROM: MO. YR.	TO: MO. YR.		
MONTHLY SALARY:			
TOTAL YEARS/MOS.:	<input type="checkbox"/> VOLUNTEER	REASON FOR LEAVING:	

Comments INCLUDING EXPLANATION OF ANY GAPS IN EMPLOYMENT

SKILLS/ABILITIES: List any skills/abilities you have which are pertinent to the position applied for.

CERTIFICATION, AUTHORIZATION AND RELEASE: *I certify that all information on this Application is accurate, complete and true to the best of my knowledge. I understand that any information that is found to be false, inaccurate, incomplete or misrepresented in any respect will be sufficient cause to (i) cancel further consideration of this application, or (ii) immediately discharge me from the employer's service when it is discovered.*

I expressly authorize, without reservation, Coastal Home Health & Hospice (CHHH), its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities, and education institutions and to otherwise verify the accuracy of all information provided by me in this application, resume' or job interview. I hereby waive any and all rights and claims I may have regarding Coastal Home Health & Hospice, its agents, employees or representatives for seeking, gathering and using such information in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that CHHH does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by applicable local, state or federal law.

I understand that this application remains current unless I notify CHHH to remove my application, or if I provide updated information. Should a position not be available for which I currently qualify or am not hired, my application will remain with CHHH for a period of six (6) months unless I notify CHHH to remove me from consideration of future employment prior to that date.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and CCHHH reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration.

Signature _____

Date _____

APPLICANT AUTHORIZATION FOR REFERENCE CHECKS

I hereby authorize my past employers to release information to Coastal Home Health & Hospice regarding my employment. This release of information covers my employment record in general, including information on the following questions:

1. Dates of employment;
2. Position(s) held;
3. The quality and quantity of my work;
4. My attendance habits (excluding workers' compensation, pregnancy, disability FMLA and other protected absences);
5. My relationship with co-workers, supervisors and managers;
6. My attitude toward work (cooperative? positive? etc.);
7. Reason for leaving and eligibility for rehire (would the employer rehire if they had to do it all over again?);
8. Willingness to comply with policies and standards;
9. Strong and weak points;
10. Whether I have had outbursts of temper, threatened, provoked fights with or assaulted others, engaging in hostile or violent behavior;
11. Other relevant information regarding my performance, skills, ability, suitability for employment sought, etc.

I agree that all former employers who provide such information are indemnified and released from liability arising from such disclosures. I also understand that if I do not sign this Authorization, my application will be rejected.

Print Name

Signature

Date