**EMPLOYMENT APPLICATION**

*7665 N. Port Washington Road, STE 102, Glendale, WI 5321//Phone: 414-797-2254//Fax: 414-797-4544*

## Applicant Information

| | | | | |
|---|---|---|---|---|
| Full Name | *Last Name* | *First Name* | *M.I.* | *Date* |
| Address | *Street Address* | | *Apartment/Unit #* | |
| | *City* | | *State* | ***Zip Code*** |

| | | | |
|---|---|---|---|
| Date of birth | Cell Phone | Home Phone | Email Address |
| Social Security Number | Emergency Contact Name | Relationship | Phone Number |

| | | | | | | |
|---|---|---|---|---|---|---|
| Date Available | Desired Pay | Position Applied For | CNA | Therapy | Nursing | |
| | | Office Staff | Other Position | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Type of employment | Full time ☐ | Part time ☐ | Casual ☐ | Mon ☐ | Tues ☐ | Wed ☐ | Thu ☐ | Fri ☐ | Sat ☐ | Sun ☐ |

| | | | | |
|---|---|---|---|---|
| Are you a citizen of the United States? | YES ☐ | NO ☐ | If no, are you authorized to work in the U.S.? | YES ☐ NO ☐ |
| Have you ever worked for this company? | YES ☐ | NO ☐ | If yes, when? | Why did you leave? |
| Is there a specific reason you are applying for employment at this company? | YES ☐ | NO ☐ | Please briefly explain why: | |
| Have you ever been convicted of a crime in the last seven years? (conviction will not necessarily be a disqualification for employment) | YES ☐ | NO ☐ | If yes, explain: | |
| If considered for employment, will you agree to allow a criminal background check? | YES ☐ | NO ☐ | | |
| If considered for employment, will you be able to provide a copy of a valid driver's license? | YES ☐ | NO ☐ | N/A ☐ | |
| In the past twelve (12) months, do you have three (3) or more moving violations on your driving record? | YES ☐ | NO ☐ | | |
| If currently employed, may we contact your current employer? | YES ☐ | NO ☐ | Name of Employer – Phone Number – Supervisor Name | |
| Do you have any friends or family employed at this company? | YES ☐ | NO ☐ | Name(s) | |
| Did someone refer you to this company? | YES ☐ | NO ☐ | Name(s) | |

## Education - *List Previous Three (3) Educational institutions attended, beginning with the most recent*

| SCHOOL | CITY/STATE | GRADUATED | | YEAR | DEGREE/DIPLOMA Earned |
|---|---|---|---|---|---|
| | | YES ☐ | NO ☐ | | |
| | | YES ☐ | NO ☐ | | |
| | | YES ☐ | NO ☐ | | |

| Nursing or Relevant Designation, Licenses or Registrations | | | | | | |
|---|---|---|---|---|---|---|
| **Type** | | | | **Date/State of Most Recent Registration** | **Valid in State of WI** | |
| CNA | N/A ☐ | YES ☐ | NO ☐ | | YES ☐ | NO ☐ |
| First Aid | N/A ☐ | YES ☐ | NO ☐ | | YES ☐ | NO ☐ |
| CPR | N/A ☐ | YES ☐ | NO ☐ | | YES ☐ | NO ☐ |
| LPN | N/A ☐ | YES ☐ | NO ☐ | | YES ☐ | NO ☐ |
| Nursing | N/A ☐ | YES ☐ | NO ☐ | | YES ☐ | NO ☐ |
| Therapy | N/A ☐ | YES ☐ | NO ☐ | Type: | YES ☐ | NO ☐ |
| Other | | | | | | |
| Other Certifications/qualifications | | | | | | |

| References | |
|---|---|
| ***Please list three references (no relatives please)*** ***Due to HIPAA Privacy laws, no former clients/patients unless you have their written permission.*** | |
| Full Name | Relationship |
| Company | Phone |
| Address | |
| | |
| Full Name | Relationship |
| Company | Phone |
| Address | |
| | |
| Full Name | Relationship |
| Company | Phone |
| Address | |

| Employment Background<br>Provide the following information beginning with the most recent employer. | | | |
|---|---|---|---|
| Employer | | Phone | |
| Address | | Supervisor | |
| Job Title | Starting Salary | Ending Salary | |
| Summarize type of work and responsibilities | | | |
| From | To | Reason for Leaving | |
| May we contact your previous supervisor for a reference? | YES ☐ | NO ☐ Why Not? | |

| Employment Background (continued) | | | |
|---|---|---|---|
| Employer | | Phone | |
| Address | | Supervisor | |
| Job Title | Starting Salary | Ending Salary | |
| Summarize type of work and responsibilities | | | |
| From | To | Reason for Leaving | |
| Mary we contact your previous supervisor for a reference? | YES ☐ | NO ☐ Why Not? | |

| | | | |
|---|---|---|---|
| Employer | | Phone | |
| Address | | Supervisor | |
| Job Title | Starting Salary | Ending Salary | |
| Summarize type of work and responsibilities | | | |
| From | To | Reason for Leaving | |
| May we contact your previous supervisor for a reference? | YES ☐ | NO ☐ Why Not? | |

## Disclaimer and Signature

*I certify that my answers are true and complete to the best of my knowledge. The information contained within this application or any cover letter or resume attached is not shared with any third parties. The information is used by the employer only. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release of employment from Miracle Home Health of Wisconsin. I authorize Miracle Home Health of Wisconsin to verify the information on this application.*

| Applicant's Signature | Date |
|---|---|
| | |

## For Office Use Only

| Date Application Received | Date Applicant Contacted |
|---|---|
| | |
| Comments | |
| | |

| Reviewed by | Date |
|---|---|
| Reviewed by | Date |

***This information is being requested in accordance with federal regulations. The information is voluntary and will not be used when considering you for employment with Miracle Home Health of Wisconsin***

**Military Service**

| Branch: | | From | To |
|---|---|---|---|
| Rank at Discharge | | Type of Discharge | |
| If other than honorable, explain | | | |

**Racial or Ethnic Group**

☐ American Indian/Alaskan ☐ Asian/Pacific Islander ☐ Black/African American

☐ Hispanic/Latino ☐ White/Caucasian ☐ Other

**Gender**

☐ Female ☐ Male

**Military Service**

☐ Pre-Vietnam Era ☐ Vietnam Era

☐ Post-Vietnam Era ☐ Disabled Veteran

Miracle Home Health of Wisconsin employees are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity.

Persons with disabilities who require alternative means of communication for information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact Miracle Home Health of Wisconsin or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact the Federal Relay Service at (800) 877-8339. Additionally, information may be made available in languages other than English.