QUALIFICATIONS:

Must be at least 18 years of age
Must be able to read, write, and follow instructions
Must meet one of the following experience categories;

1. Has at least 6 months paid experience as an agency homemaker, Nurse Aide, Maid.
2. Has at least one year experience (Paid or Unpaid) Caring for children, Elderly, Infirm.
3. Has successfully completed training as a Certified Nurse Aide, LPN, or RN

High School Education or equivalent.
Must be able to operate a vehicle; have a valid driver's license in good standing
Ability to lift at a minimum of 25 pounds.
Ability to observe and record behavioral data.
Ability to communicate clearly with staff and consumers through use of telephone and other verbal means.
Ability to follow necessary procedures in case of fire/tornado or other emergency situation.
Ability to successfully complete required in-service training for this position
Must be free from communicable diseases.
Knowledge and experience of working with people with developmental disabilities is helpful.

I received a copy of my job description on ___/_____/___ and I_____

Date *Signature of Applicant*

agree that I meet the above qualifications the position.

Authorization to submit request to Family Care Safety Registry & screen against the Employee Disqualification List.

I. / /_____authorize management of Thompson

Signature of Applicant *Date*

Home Health Team. LLC to submit on my behalf. a request to the Family Care Safety Registry and screened against the **E**mployee **D**isqualification **L**ist. I am aware that a copy of the results will be sent to the address on file with Thompson Home Health Team. LLC as of this date and that Thompson Home health Team LLC shall also receive a copy of my results.

THOMPSON HOME HEALTH TEAM application for employment *1 of 3*

Thompson Home Health Team is an equal opportunity employer and does not discriminate in hiring on the basis of race, color, religion, creed, national origin, sex, ancestry, handicap as defined by law, or on the basis of age as defined by Federal and State Laws, except when age or physical requirements constitute a bonafide occupational qualification necessary to proper and efficient operations or as provided by law. No question on this application is intended to secure information to be used for such discrimination.

PLEASE PRINT NAME: Last First Middle	Date:
Social Security Number:	Home Phone:
Permanent Address City: State: Zip code:	Alternative Phone:
Recent Address: City: State: Zip code	

Position Applying For:	Date Available for Work:	Currently Employed:
Type of Employment Desired: Full Time Part Time	What shift are you willing to work? Day Evening Night Rotating	Will you work holidays and weekends? Yes or No Will you work overtime? Yes or No

Have you ever worked for THHT LLC?(*specify*)	
Who referred you to THHT LLC?	Are you related to anyone whom is/or was employed by THHT LLC? Name:
Are you a U.S. citizen or do you hold a permanent residence visa? Yes or No	Are you over age 18? Yes or No

Disclose any convictions, findings of guilt, please of guilt, please of nolo contenders except miner traffic offence and disclosure if listed on the Employee Disqualification List.

Do you consent to a pre-employment criminal record check? Yes or No *(if no, please specify details)*

Do you consent to close record check pursuant to section 610.120 RSMO? Yes or No *(if no, please specify details)*

Have you used alias names or social security numbers? Yes or No *(if yes, please specify details)*

A conviction is not necessarily a bar of employment

Emergency Contact: _____ *(how is this person related to you)*_____

Address:_____

Education, Licenses, and Certifications

Highest grade completed: 9 10 11 12		
College: FR SO JR SR	Major:	Minor:
Special skills or Training:		
CNA:	Current:	Number of years certified:
RN:	Current:	Number of years registered:
LPN:	Current:	Number of years Licensed:
Where did you receive your RN, LPN, Or CNA license and/ or certification?		
Have you ever had your RN or LPN license revoked? Yes or No (if yes please explain)		
None Certified: Do you have experience in, in-home health care? Yes or No		

THOMPSON HOME HEALTH TEAM LLC application for employment 2 *of 3*

EMPLOYMENT HISTORY Give past employment record as completely as possible, starting with your present or latest employer, including summer and part-time employment.

Employer:			Title:
Address:			Phone:
Type of Business			Hours per week:
Start Date:	End Date:	Supervisor	
Start Salary:	End Salary:	May We contact your employer? Yes or No	
Duties:			
Reason For Leaving:			

Employer:			Title:
Address:			Phone:
Type of Business			Hours per week
Start Date:	End Date:	Supervisor	
Start Salary:	End Salary:	May We contact your employer? Yes or No	
Duties:			
Reason For Leaving:			

Employer:			Title:
Address:			Phone:
Type of Business			Hours per week:
Start Date:	End Date:	Supervisor	
Start Salary:	End Salary:	May We contact your employer? Yes or No	
Duties:			
Reason For Leaving:			

Employer:			Title:
Address:			Phone:
Type of Business			Hours per week:
Start Date:	End Date:	Supervisor	
Start Salary:	End Salary:	May We contact your employer? Yes or No	
Duties:			
Reason For Leaving:			

Have you ever worked for any company listed under a different name? Yes or NO ***(if yes, please state name used)***
Have you ever been involuntarily terminated from a position or have been asked to find other employment? If so, please state the company and circumstances

THOMPSON HOME HEALTH TEAM LLC application for employment *3 of 3*

References: *(Please provide four references not related to you)*

Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:

Do you have any physical limitations that will preclude you from performing certain kinds of work? Yes or No *(If yes, specify work limitations)*

CERTIFICATION

In consideration of my employment, I agree to conform to the rules and regulations of Management and understand my employment and compensation can be terminated, at the option of either myself or Thompson Home Health Team LLC at any time. I understand that no representative of the Company, other than an officer of Thompson Home Health Team LLC has the authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing. I voluntarily authorize Thompson Home Health Team LLC to make a thorough investigation of my past employment and education; and agree to release from all liability or responsibility all persons or organizations supplying such information, and agree that if, in the judgment of Thompson Home Health Team LLC, any misrepresentation has been made by me herein or the results of such investigations are not satisfactory, any offer of employment made may be withdrawn. I understand that any offer of employment with Thompson Home Health Team LLC is contingent upon passing any required physical examination and drug and alcohol screen. I understand that I may be required to work weekends, holidays, and overtime and hereby agree to do so, except as specifically indicated in this application.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENT AND FULLY UNDERSTAND THE SAME.

Applicant Signature:_____ Date:_____

Office Use Only

Date of Application Submission:	Staff Member's Initial:
Date of FCSR Registry Check: / / Findings: Yes ☐ No ☐ Conformation # _____	Staff Member's Initial:
Applicant Employable: ☐ Yes ☐ No If not employable please explain	Staff Member's Initial:
☐ Applicant was found in FCSR, yet has Good Cause Waiver: Status of Good Caue waiver_____ Date verfied / /	Staff Member's Initial:
☐ Applicant subbmitted application for Good Cause Waiver and awaiting status Date of submimssion / / Date verfied: / /	Staff Member's Initial:
Date of Drug Screening Submission:	Staff Member's Initial:
Hire Date: Employee Pin number _____	Staff Member's Initial:
Pay Rate:	Staff Member's Initial: