APPLICATION FOR EMPLOYMENT

Complete entire application to ensure processing. Please type or print clearly.

TODAY'S DATE:

PERSONAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

OTHER NAMES YOU ARE KNOWN BY: ARE YOU UNDER 18? ☐ YES ☐ NO

HOME ADDRESS	CITY	STATE	ZIP CODE

CELL PHONE:	HOME PHONE:	EMAIL:

POSITION APPLYING FOR: _____ **DATE AVAILABLE:** _____

Check days you are available to work: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Are you available to work holidays? ☐ Yes ☐ No Are you available to work overtime? ☐ Yes ☐ No

Check the type of assignment you are available for: ☐ Full-time ☐ Part-time ☐ On-Call ☐ Per Diem

Check the type of assignment you are available for: ☐ Mornings ☐ Days ☐ Evenings ☐ Nights

Can you, after employment, submit verification of your identity and legal right to work in the United States? ☐ Yes ☐ No

How were you referred to SunLife? _____

Have you ever been employed at SunLife? ☐ Yes ☐ No If yes, give dates of employment _____

Are you related to a current SunLife employee? ☐ Yes ☐ No If yes, name and relationship to you _____

Do you have an automobile or another form of dependable transportation? ☐ Yes ☐ No

If you have an automobile, do you have proof of current auto insurance coverage? ☐ Yes ☐ No

Have you ever been convicted of or entered a plea of guilty or no contest to any felony or misdemeanor (other than a minor traffic violation)? (Do not indicate any conviction that has been judicially dismissed, expunged, sealed or eradicated) ***NOTE:*** *A conviction is not necessarily a bar to to employment. Each case is considered individually and evaluated on the basis of the nature of the crime and the position you are applying for.*

☐ Yes ☐ No If Yes, please describe the details of all offenses including nature, circumstances, and dates. Attach additional sheets if necessary.

Have you ever had a health-care related license/certificate revoked, suspended, placed on probation, under investigation or otherwise disciplined or voluntarily surrendered in any way? ☐ Yes ☐ No If yes, please explain. Attach additional sheets if necessary. _____

LANGUAGES

☐ Speak ☐ Read ☐ Write	☐ Speak ☐ Read ☐ Write	☐ Speak ☐ Read ☐ Write

EDUCATION

	NAME OF SCHOOL	CITY/STATE	GRADUATE? Y/N	DEGREE RECEIVED	COURSE OF STUDY
HIGH SCHOOL					
COLLEGE					
OTHER					
OTHER					

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PROFESSIONAL EXPERIENCE *(Do NOT reference as "See Resume". You may attach resume.)*

EMPLOYER NAME		DATES OF EMPLOYMENT FROM: TO:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
TELEPHONE:	POSITION:	PAY RATE/SALARY:	NAME OF SUPERVISOR:
DUTIES:			
REASON FOR LEAVING		MAY WE CONTACT? ☐ YES ☐ NO IF NO, WHY NOT?	

EMPLOYER NAME		DATES OF EMPLOYMENT FROM: TO:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
TELEPHONE:	POSITION:	PAY RATE/SALARY:	NAME OF SUPERVISOR:
DUTIES:			
REASON FOR LEAVING		MAY WE CONTACT? ☐ YES ☐ NO IF NO, WHY NOT?	

EMPLOYER NAME		DATES OF EMPLOYMENT FROM: TO:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
TELEPHONE:	POSITION:	PAY RATE/SALARY:	NAME OF SUPERVISOR:
DUTIES:			
REASON FOR LEAVING		MAY WE CONTACT? ☐ YES ☐ NO IF NO, WHY NOT?	

EMPLOYER NAME		DATES OF EMPLOYMENT FROM: TO:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
TELEPHONE:	POSITION:	PAY RATE/SALARY:	NAME OF SUPERVISOR:
DUTIES:			
REASON FOR LEAVING		MAY WE CONTACT? ☐ YES ☐ NO IF NO, WHY NOT?	

EMPLOYER NAME		DATES OF EMPLOYMENT FROM: TO:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
TELEPHONE:	POSITION:	PAY RATE/SALARY:	NAME OF SUPERVISOR:
DUTIES:			
REASON FOR LEAVING		MAY WE CONTACT? ☐ YES ☐ NO IF NO, WHY NOT?	

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WORK EXPERIENCE / SKILLS

Please list the number of years you have in experience for each category and are clinically competent to work.

YEARS		YEARS		YEARS		YEARS	
	Medical Intensive Care Unit		Burn Unit		Pediatrics		Catheterization Laboratory
	Neonatal Intensive Care Unit		Critical Care		Oncology		Telemetry
	Post Anesthesia Care Unit		Progressive Care Unit		Neurology		Dialysis
	Surgical Intensive Care Unit		Coronary Care Unit		Orthopedics		Mental Health
	Geriatric Intensive Care Unit		Medical /Surgical Unit		Otolaryngology (ENT)		Detox/Drug Rehab
	Pediatric Intensive Care Unit		Stepdown Unit		Labor and Delivery		Home Health
	Cardiovascular Intensive Care Unit		Open Heart		Post Partum		Case Manager
	Cardiovascular Operating Room		Radiology		Newborn Nursery		Emergency Room
	Operating Room		Recovery Room		Intermittent Care		IV Therapy
	Hospice		Nursing Home		Private Duty		Assisted Living
	Residential Treatment		Other:		Other:		Other:

CERTIFICATIONS/LICENSES

☐	Cardiopulmonary Resuscitation (CPR)	Exp. Date:	☐	First Aid	Exp. Date:
☐	Basic Cardiac Life Support (BCLS)	Exp. Date:	☐	Emergency Medical Technician	Exp. Date:
☐	Advanced Cardiac Life Support (ACLS)	Exp. Date:	☐	Intravenous Therapy (IV)	Exp. Date:
☐	Pediatric Advances Life Support (PALS)	Exp. Date:	☐	Phlebotomy	Exp. Date:
☐	Neonatal Advanced Life Support (NALS)	Exp. Date:	☐	Other:	Exp. Date:

License Type:	License or Certification #:	State:	Expiration Date:
License Type:	License or Certification #:	State:	Expiration Date:
License Type:	License or Certification #:	State:	Expiration Date:
License Type:	License or Certification #:	State:	Expiration Date:

Are you able to work with pets? ☐ Yes ☐ No Comments: _____

Are you able to work with smokers? ☐ Yes ☐ No Comments: _____

Are you able to lift 50 pounds unassisted? ☐ Yes ☐ No Comments: _____

PLEASE PROVIDE INFORMATION ON AT LEAST THREE PROFESSIONAL REFERENCES.

NAME	PHONE NUMBER	EMAIL	RELATIONSHIP	YEARS KNOWN

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PLEASE LIST ANY WORK-RELATED INFORMATION YOU THINK WOULD BE HELPFUL IN CONSIDERING YOU FOR EMPLOYMENT (i.e. professional licenses, specialized training, skills, certifications, etc.) *You may exclude memberships which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status.*

In signing this application, I certify that I have read and fully understand the questions asked in this application. I certify, under penalty of perjury under the laws of the State of Arizona, that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I understand that this Application is not nor is it intended to be a contract of employment, and that if hired, I will be an employee at will and employed for no definite period of time. I understand that either SunLife Home Health, LLC. or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of SunLife Home Health, LLC., SLHC, Inc., or SunLife Management, Inc. at any time, can constitute a contract of employment.

SunLife Home Health, LLC. is a nicotine, drug and alcohol free workplace, and conducts post-offer, pre-employment nicotine, drug, and alcohol testing for select positions at the Company's expense. I understand that an offer of employment is contingent upon successful completion of a pre-employment nicotine/drug/alcohol test. All employees are subject to random, post-accident and reasonable suspicion nicotine/drug/alcohol testing. Employees testing positive for nicotine, illegal drugs, unauthorized prescribed drugs, or alcohol will be subject to termination. By signing below, I am willing to submit to a physical examination, including the analysis for the detection of the use of nicotine or unlawful drugs or substances in accordance with applicable laws.

SunLife Home Health, LLC. conducts employment verification and background checks including, but not limited to, employment history, work references, driving records (for applicable positions), criminal records, civil records, and educational records. By signing below, I give SunLife Home Health, LLC. permission to use any information in this application to enable it and its agents to verify the information contained in this application. I also understand that in connection with my application for employment or my employment, SunLife Home Health, LLC. may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release SunLife Home Health, LLC., SLHC, Inc., and SunLife Management, Inc., its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

Individuals applying for positions requiring the use of an automobile for Company business are hired contingent upon a satisfactory Motor Vehicle Record. Applicants found to have unacceptable driver's records will not be considered. If employed, I agree to provide evidence of an acceptable record as well as proof of auto insurance liability coverage. Employees in positions requiring the use of an automobile must maintain a valid drivers license, proof of auto liability insurance, and a good drivers record.

I understand that SunLife Home Health, LLC. is not involved in the day-to-day supervision or decision concerning patient care. This remains with me, as a Professional, as part of my practice. I fully indemnify SunLife Home Health, LLC., SLHC, Inc., and SunLife Management, Inc., against any and all liability and responsibility associated with my professional duties. By signing below, I agree to maintain my license, professional liability coverage and other responsibilities as required by law.

In consideration of my employment and of my being considered for employment by SunLife Home Health, LLC., I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I certify that I have read and understand the above information.

_____ _____

Applicant Signature *Date*

SunLife is an equal opportunity employer, dedicated to a policy of non-discrimination in employment on any basis including race, color, age, sex, religion, national origin, the presence of mental, physical, or sensory disability, sexual orientation, or any other basis prohibited by federal, state, or provincial law.

NOTE: PLEASE MAKE SURE YOU HAVE COMPLETED ALL AREAS OF THE APPLICATION AND CHECKED ALL THE APPROPRIATE BOXES BEFORE SUBMITTING THE APPLICATION. SUBMITTING AN INCOMPLETE OR ILLEGIBLE APPLICATION WILL DELAY OR PREVENT PROCESSING.

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APPLICANT DISCLOSURE AND RELEASE FOR CONSUMER AND INVESTIGATIVE REPORTS AND REFERENCES:

(Under the provisions of the Fair Credit Reporting Act (15 USC at 1681-1681u) as amended, before we can seek such reports, we must have your written permission to obtain the information. Section 604 "(b) of FCRA provides conditions for furnishing and using consumer reports for employment purposes.)

I hereby authorize SunLife Home Health, LLC., or any independent investigating agency, to conduct a thorough investigation of my personal and professional background, including credit, criminal and driving records as defined by the Fair Credit Reporting Act (FCRA). These above mentioned background information checks may include, but are not limited to, employment and education verifications, social security verification, driving record information, personal references, personal interviews, and my personal credit history. I further understand that an acceptable credit report and/or background check will allow me to continue the pre-employment process and that an unacceptable credit and/or background check may result in the discontinuation of my pre-employment process. I also authorize present and former employers, corporations, co-workers, references, credit reporting agencies, educational institutions, licensing bodies, courts, law enforcement agencies, governmental agencies or departments, and military services to provide information about my background to SunLife Home Health, LLC. with regard to any of the subjects covered by my application.

I understand if I am hired prior to the completion of the background check, that an unacceptable background check will result in my termination. I understand that the credit report I have authorized above may include information derived from any credit bureau and any other public records or other information bearing on my credit standing, credit capacity, credit worthiness, character, general reputation, personal characteristics, trustworthiness and/or mode of living. I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any credit report and/or criminal background search prepared on me upon my written request within a reasonable time after the date of such search, and that I am also entitled to a copy of your Rights under the Fair Credit Reporting Act. I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to SunLife Home Health, LLC., including but not limited to, any courthouse, any public agency, and all law enforcement agencies and any and all credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources. I hereby release SunLife Home Health, LLC., SLHC, Inc., SunLife Management, Inc., and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands of whatever kind, by me, my heirs or others making such claim or demand on my behalf, for procuring, selling, providing, brokering and/or assisting with compilation or preparation of the credit reports and/or background information check hereby authorized.

I understand that this Disclosure and Release Form shall remain in effect for the duration of my employment with SunLife Home Health, LLC.. I agree that this Disclosure and Release will be valid, now or in the future, in original, faxed, copied or electronic form. Further, I certify that the information contained on this Disclosure and Release Form is true and correct and that my application or employment will be terminated based on any false, omitted or fraudulent information. I understand that my date of birth will be used solely for identification purposes.

LAST NAME | FIRST NAME | MIDDLE NAME

OTHER NAMES YOU ARE KNOWN BY:

PRESENT ADDRESS | CITY | STATE | ZIP CODE

SOCIAL SECURITY NUMBER | DATE OF BIRTH:

PREVIOUS CITIES/STATES OF RESIDENCE DURING THE LAST 7 YEARS

DRIVERS LICENSE # | STATE OF ISSUANCE | EXPIRATION DATE

APPLICANT SIGNATURE | DATE

NOTE: SUBMITTING AN INCOMPLETE OR ILLEGIBLE FORM MAY DELAY THE BACKGROUND CHECK RESULTS.

The Age Discrimination in Employment Act of 1967 and the Arizona Civil Rights Act prohibit discrimination on the basis of age with respect to individuals who are at least 40 years of age. Your date of birth is required on this form in order to confirm your identity for purposes of completing an accurate background investigation, and is not provided to the hiring official for any purpose in connection with consideration of your application for employment