

**HOSPICE OF McDOWELL COUNTY, INC.  
APPLICATION FOR EMPLOYMENT**



575 Airport Road  
Marion, NC 28752

**EQUAL EMPLOYMENT OPPORTUNITY EMPLOYER**

Hospice of McDowell County, Inc., considers applicants for all positions whether paid or volunteer without regard to race, color, religion, sex, national origin, medical condition or handicap, or any other characteristic protected by law.

This application is current for six (6) months only. At the conclusion of that time, if you have not been offered employment and still wish to be considered for employment, it will be necessary for you to reapply when we are again accepting applications.

The receipt of this application implies that the application will be reviewed; however, it does not imply that the applicant will be hired.

Last Name Middle	First	Social Security No.		
Present Address Code	City	State	Zip	Telephone No. (Home): _____ Telephone No. (Work): _____ E-Mail Address: _____
Permanent Address Code	City	State	Zip	Telephone No. (Home): _____ Telephone No. (Work): _____ E-Mail Address: _____
Do you foresee any physical/mental handicap that would substantially limit your ability to perform the job you are applying for? If yes, explain:				Do you speak any foreign languages? If so, please list.

Position Applied For	Salary Desired
How were you referred to Hospice?	Are you applying for: Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Regular <input type="checkbox"/> Temporary <input type="checkbox"/>
Relatives or friends employed by this organization? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date available for work:
Have you ever been employed by this organization? When? Are you 18 years old or younger? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you available to work: Weekends/Holidays Yes <input type="checkbox"/> No <input type="checkbox"/> On Call Yes <input type="checkbox"/> No <input type="checkbox"/>

Long range occupation goals:

Are you prevented from lawful employment because of your Visa or Immigration status?  
Yes  No  Please indicate Visa type or other Immigration status, if applicable:  
Visa type \_\_\_\_\_ Other \_\_\_\_\_

Were you ever convicted of a Felony? Yes  No  If yes, explain:

School	Name & Address of School	Course of Study	Circle last year completed	Did you Graduate?	List Diploma Degree
High			1 2 3 4	Yes <input type="checkbox"/> No <input type="checkbox"/>	
College			1 2 3 4	Yes <input type="checkbox"/> No <input type="checkbox"/>	
College			1 2 3 4	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Other Business College, Special Courses (include Military Training, Post Graduate and Nursing)

Area of Specialization or major interest: \_\_\_\_\_ Typing: approx. WPM

List Health Care, Business, or Industrial equipment operated:

**Professional Licenses and/or Certifications:**

Are you currently: \_\_\_\_\_ Registered \_\_\_\_\_ Licensed \_\_\_\_\_ Certified  
Eligible For: \_\_\_\_\_ Registration \_\_\_\_\_ Licensure \_\_\_\_\_ Certification

If Licensed Registered or Certified:

Type	State Issued	Date	No.
Type	State Issued	Date	No.
Type	State Issued	Date	No.

**PLEASE list name, address and phone number of previous employers with most recent employer first.**

FROM: \_\_\_\_\_ TO: \_\_\_\_\_ Immediate Supervisor: \_\_\_\_\_ Last Salary: \_\_\_\_\_

Job Title: \_\_\_\_\_ Employer Name Address & Phone: \_\_\_\_\_  
\_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Reasons for Leaving: \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_ Immediate Supervisor: \_\_\_\_\_ Last Salary: \_\_\_\_\_

Job Title: \_\_\_\_\_ Employer Name Address & Phone: \_\_\_\_\_  
\_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Reasons for Leaving: \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_ Immediate Supervisor: \_\_\_\_\_ Last Salary: \_\_\_\_\_

Job Title: \_\_\_\_\_ Employer Name Address & Phone: \_\_\_\_\_  
\_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Reasons for Leaving: \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_ Immediate Supervisor: \_\_\_\_\_ Last Salary: \_\_\_\_\_

Job Title: \_\_\_\_\_ Employer Name Address & Phone: \_\_\_\_\_  
\_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Reasons for Leaving: \_\_\_\_\_

State if you do not want us to contact any of the above listed former employers and the reason you do not want each contacted.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Can we run a detailed employment check, including but not limited to a check with your previous employers? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please sign here to authorize reference check

Did you serve in the U.S. Armed Services? Yes \_\_\_\_ No \_\_\_\_ What Branch?

Have you volunteered your time or services? Yes \_\_\_\_ No \_\_\_\_ Where?

Briefly describe duties and skills acquired through volunteer or military services: (include dates)

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List at least three (3) references who are not relatives or employers:

<b>Name &amp; Relationship</b>	<b>Title</b>	<b>Company Name &amp; Address</b>	<b>Telephone No.</b>

I authorize Hospice of McDowell County, Inc., to make inquiries about my competency to fulfill the qualifications for the job or jobs for which I may be considered. As part of this authorization, I specifically permit the inspection of any relevant records of previous or current employers, of schools I have attended, or of any insurers or previous insurers, of licensing or certifying bodies, or other relevant records. I consent to the release of such information to Hospice of McDowell County, Inc., and I release from liability any one who provides such information in good faith and without malice.

I also authorize Hospice of McDowell County, Inc., to release to any employer to which I may make application pertinent information about my employment, if any, at Hospice of McDowell County, Inc.

Falsification of information indicated on this application, may be grounds for immediate dismissal.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Make any comments you feel are pertinent to your application.

**HOSPICE OF McDOWELL COUNTY, INC.  
RECORDS CHECK AUTHORIZATION FORM**

I, \_\_\_\_\_, understand that in preparation for becoming an applicant, Hospice of McDowell County is required to conduct a criminal records check to verify my suitability for employment.

I further understand that if Hospice of McDowell County engages a consumer-reporting agency to report on my background or personal history, I hereby authorize the organization to do so.

Hospice of McDowell County will use the report solely for agency purposes related to becoming an employee with this agency.

Information needed for records check (completed by applicant):

Full name: \_\_\_\_\_

Other Names used: \_\_\_\_\_

Maiden name: \_\_\_\_\_

Copy of driver's license \_\_\_\_\_

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Address (if different than what is on application):

\_\_\_\_\_

\_\_\_\_\_  
Signature of Job Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Hospice Representative

\_\_\_\_\_  
Date

**HOSPICE OF McDOWELL COUNTY, INC.  
CONSENT AND RELEASE OF LIABILITY  
FOR DRUG TESTING**

I understand that as a condition of employment with **Hospice of McDowell County** (Hospice), I may be required to submit a sample of my urine and/or blood for chemical analysis. I understand that the analysis will be conducted by a certified laboratory. The purpose of this analysis is to check for the presence of illegal or non-prescription drugs in my system. (Reference Policy 05.01.11, *Standards of Conduct*, Section VI)

I hereby give permission for any certified laboratory to release the results of these tests to Hospice. I consent freely and voluntarily to this request for a urine and/or blood specimen. I hereby release Hospice from any liability arising from this request to furnish urine and/ or blood samples, the testing of the urine and/or blood samples and any decision made concerning my application for employment or employment which may be based in whole or in part upon the results of the test analysis.

I understand that the presence of any illegal or non-prescription drug or alcohol in my system may result in the denial of employment with **Hospice of McDowell County**, I further understand that employment with Hospice may be conditioned upon my willingness to submit to drug and/or alcohol testing required by Hospice.

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Signature of Applicant

Date

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Witness

Date