

**ACCLAIM HOME HEALTH CARE INC**  
120 STAFFORD STREET, SUITE 206  
WORCESTER, MA 01603  
PHONE: 508 459 6937 FAX: 508 459 4154

**EMPLOYMENT APPLICATION**

Date of Application \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name \_\_\_\_\_

Phones (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Home Address \_\_\_\_\_ Street/City/Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ (attach a copy)

Position Applied For: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Are you under 18? Yes No

If Yes can you furnish a Work Permit? \_\_\_\_\_

Are you employed now? \_\_\_\_\_

May we contact your current employer? \_\_\_\_\_

Are you a United States Citizen? Yes No

If **No** do you have a valid Work Permit? \_\_\_\_\_ Expiry Date \_\_\_\_\_

On what date can you start work \_\_\_\_\_

Do you have a Massachusetts driving license # \_\_\_\_\_ (attach a copy)

Are you Multilingual? If so Languages proficient in \_\_\_\_\_

Are you a Veteran of the U.S. Military Yes No

If Yes what Branch \_\_\_\_\_

Describe Special Skills acquired while in the Service \_\_\_\_\_

**PROFESSIONAL REFERENCES.** Please, list previous supervisors, co-workers, instructors (**Do not list family members, neighbors, etc**)

Name \_\_\_\_\_ Business Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Best time to reach \_\_\_\_\_

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**Employment Experience**

Start with Current Employer or last employer. Include any Military Service and Volunteer work

1. Employer \_\_\_\_\_ (Phone) \_\_\_\_\_  
Address: \_\_\_\_\_  
Job Title \_\_\_\_\_ Supervisor \_\_\_\_\_  
Dates Employed : From \_\_\_\_\_ To \_\_\_\_\_ Hourly Salary \_\_\_\_\_  
Duties Performed \_\_\_\_\_  
Reason for Leaving \_\_\_\_\_

2. Employer \_\_\_\_\_ (Phone) \_\_\_\_\_  
Address: \_\_\_\_\_  
Job Title \_\_\_\_\_ Supervisor \_\_\_\_\_  
Dates Employed : From \_\_\_\_\_ To \_\_\_\_\_ Hourly Salary \_\_\_\_\_  
Duties Performed \_\_\_\_\_  
Reason for Leaving \_\_\_\_\_

3. Employer \_\_\_\_\_ (Phone) \_\_\_\_\_  
Address: \_\_\_\_\_  
Job Title \_\_\_\_\_ Supervisor \_\_\_\_\_  
Dates Employed : From \_\_\_\_\_ To \_\_\_\_\_ Hourly Salary \_\_\_\_\_  
Duties Performed \_\_\_\_\_

Any Special Certification/ Skills \_\_\_\_\_

**Educational Background**

High School: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_  
Vocational Training / other: \_\_\_\_\_ Date of Graduation \_\_\_\_\_  
College: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_  
College: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_  
Graduate School: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_  
Honors / awards: \_\_\_\_\_

**Membership in professional or civic organization:** (Please exclude any which may disclose your race, color, religion or national origin). \_\_\_\_\_

Attach more information, work experience or Resume to this application.

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It is my understanding that this employment application, or the granting of an interview, does not represent a contract of employment or a promise of future benefits by Acclaim Home Health Care Inc.

I understand and agree that if hired, my employment will be at-will in nature and may be terminated, with or without cause, at any time, by either my employer or myself. I also understand that this written statement supersedes any and all oral representations made by agents or representatives of Acclaim Home Health Care Inc.

**AGREEMENT:** I certify that the information on this application is true, complete and correct. I authorize Acclaim Home Health Care Inc. to investigate my past employment, education and activities and I release from all liability all persons, companies and corporations supplying such information.

I certify that I do not have any history of complaints filed with the Nurses Registry or Board of Registration in Massachusetts or any other state. I understand that false answers, statements or significant omissions made by me on this application shall be sufficient cause for denial of employment or discharge.

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

\_\_\_\_\_  
Date

Attach more information, work experience or Resume to this application.