One on One Care, Inc.

## Application Process

**Complete the application and return it with the following items:**
**(We must have all of the items to accept the application)**

- ☐ **High School Diploma/GED**
- ☐ **Sealed Transcript (from an accredited high school or college)**
- ☐ **Valid Driver's License**
- ☐ **Current Vehicle Insurance (showing effective and expiration date of policy)**
- ☐ **Current Vehicle Registration**
- ☐ **Social Security Card**

**We will copy these items at the front desk. If you are selected for an interview, a member of the One On One Care, Inc. HR department will contact you. If you have not been contacted and it has been 3 months, you are welcome to resubmit an application. Please understand that background checks will be conducted prior to employment.**

| **Internal Use Only** |
|---|
| Department Desired _____<br>Missing Application Elements _____<br>Contact to request missing items date: _____ date: _____ date: _____ |
| ☐ HealthCare Registry Check clear to interview / not able to interview<br>☐ LEIE Database Check clear to interview / not able to interview<br>☐ Background/Driving Record Check clear to interview / not able to interview |
| Interview Scheduled Date:_____ Time: _____ |
| Position Accepted: _____<br>Additional Information: _____<br>_____<br>Tax Forms Complete: YES NO<br>Pay Information Completed: YES NO |

**NOTICE:**

1. **TO BE CONSIDERED FOR EMPLOYMENT, YOU MUST ANSWER ALL QUESTIONS AND COMPLETE ALL SECTIONS OF THIS APPLICATION FORM**.
2. ONE ON ONE CARE, INC. EMPLOYS ONLY US CITIZENS OR ALIENS WHO CAN PROVIDE PROOF OF IDENTITY AND WORK AUTHORIZATION WITHIN 3 WORKING DAYS OF EMPLOYMENT
3. GIVE COMPLETE INFORMATION ON YOUR EDUCATION AND WORK HISTORY ("SEE RESUME" IS NOT ACCEPTABLE.)
4. LIST SEPARATELY EACH JOB HELD AND YOUR DUTIES FOR EACH POSITION WHEN YOU WORKED FOR ONE EMPLOYER AND HELD MORE THAN ONE POSITION.
5. CHECK FOR ACCURACY, SIGN AND DATE YOUR APPLICATION.
6. ANY AND ALL INFORMATION YOU ENTER IS VOLUNTARY.

THANK YOU FOR YOUR INTEREST IN ONE ON ONE CARE, INC. ONE ON ONE CARE, INC. WANTS TO FIND THE BEST QUALIFIED PEOPLE AVAILABLE TO SERVE ITS CONSUMERS. ALTHOUGH EVERYONE WHO APPLIES CANNOT BE HIRED, YOUR APPLICATION WILL BE GIVEN EVERY CONSIDERATION.

# ONE ON ONE CARE, INC.

## Application for Employment

Date of Application

| Social Security Number | Last Name | First Name | Middle Name |
|---|---|---|---|
| | | | |

| Address (Street number and name) | City | County |
|---|---|---|
| | | |

| State | Zip Code | Phone (Home or where you can be reached) | Business Phone |
|---|---|---|---|
| | | | |

Have you ever worked for this agency? ☐ YES ☐ NO

Are you related by blood or marriage to any person now working for the One on One Care, Inc. ☐ YES ☐ NO
If yes, give name, relationship to you and their Job Title:

If subject to Military Selective Service registration, certify compliance by initialing dotted line
.....

Have you ever been convicted of an offense against the law other than a minor traffic violation? (A conviction does not mean you cannot be hired. The offense and how recently you were convicted will be evaluated in relation to the job for which you are applying.)

☐ YES ☐ NO (If yes, explain fully on an additional sheet.)

**Military Service**

Have you served honorably in the Armed Forces of the United States on active duty for reasons other than training? ☐ YES ☐ NO

Do you wish to declare a service-connected disability? ☐ YES ☐ NO

At the time of this application, are you the surviving spouse or dependent of a deceased veteran who died from service-related reasons? ☐ YES ☐ NO

Do you wish to declare eligibility for veterans preference as the spouse of a disabled veteran? ☐ YES ☐ NO

Give dates of your (or spouse's) qualifying active military service:

Entered: _____ Separated: _____ Branch: _____ Rank _____

Are you a member of the Military Reserves? ☐ YES ☐ NO Branch: _____ Rank: _____

**AGENCY USE ONLY:** ELIGIBILITY FOR VETERAN'S PREFERENCE: ☐ YES ☐ NO

CHECK the types of work you will accept: ☐ 1. Permanent full-time ☐ 2. Permanent part-time ☐ 3. Temporary full-time ☐ 4. Temporary part-time ☐ 5. Any of the preceding ☐ 6. Work involving Travel ☐ 7. Shift or Split Shift Work

If you are not available for work now, enter the earliest date you could begin work (mo/day/yr.)_____

Will you accept work anywhere in N.C.? ☐ YES ☐ NO (If no, list below the counties in which you would be willing to work.)

1. 2. 3. 4. 5.

**Jobs Applied For**

Enter below the specific title(s) of the job(s) for which you are applying. Please list no more than three on this application.
1. 2. 3.

**Referral Source**

Please indicate your referral source: _____

If you were referred by the Employment Security Commission (Job Service) please indicate which local office: _____

**Education**

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 Graduate School 1 2 3 4

Under S/Q Hrs., list the hours of credit received and if they were semester (S) or quarter (Q) hours.

| Schools | Name and Location | Dates Attended (mo/yr) From: | To: | Grad? | S/Q Hrs. | Major/Minor Course Work | Type of Degree Received |
|---|---|---|---|---|---|---|---|
| High School | | | | YES ☐ NO ☐ | | | |
| College(s) University (s) | | | | YES ☐ NO ☐ | | | |
| Graduate or Professional | | | | YES ☐ NO ☐ | | | |
| Other educational, vocational school, internships, etc. | | | | YES ☐ NO ☐ | | | |

Special training programs and seminars you have completed in the last five years (list):

If the job(s) applied for calls for specific courses, indicate those courses taken and credits received:

Current professional status: (List fields of work for which you have been registered)

Registration: _____ State: _____ No. _____

Registration: _____ State: _____ No. _____

Membership in professional, honorary, or technical societies (list):

**DO NOT COMPLETE THIS BLOCK**

DEGREES AND PROFESSIONAL CREDENTIALS

☐ Have been verified ☐ Will be verified within 90 days (G.S. 126-30) Person Responsible:

**Equal Opportunity Information**

Agency policy prohibits discrimination based on race, sex, color, creed, national origin, age or disability. Sex or age is a bona fide occupational qualification contingent on consumer needs for some jobs. This information will also be used to help us see how well our recruitment efforts are reaching all segments of the population.

Date of Birth _____ (mo.) (day) (year)

Check One

SEX ☐ M (male) ☐ F (female)

**ETHNIC GROUP**

1. ☐ White (non-Hispanic)
2. ☐ Black (non-Hispanic)
3. ☐ Hispanic (Mexican, Puerto Rican, Cuban, Central or South American, other Spanish origin regardless of race)
4. ☐ Asian (including Pacific Islander)
5. ☐ American Indian (including Alaskan native)

**DISABILITY**: "Disability means, with respect to an individual: (1) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment" (Americans with Disabilities Act of 1990). Persons without a disability should check item A.

The reporting of a **disability is strictly VOLUNTARY**. Persons with disabilities who **DO NOT WISH** to report their disabilities should check item A. Information reported on this form will be kept confidential as required by State law. Public disclosure of this information without your consent would be a violation of G.S.

- **A** ☐ None/Prefer not to report
- **B** ☐ Blind or severely visually impaired
- **C** ☐ Deaf or severely hearing impaired
- **D** ☐ Loss of limited use of arms and/or hands
- **E** ☐ Non-ambulatory (must use wheelchair)
- **F** ☐ Other orthopedic impairment (including amputation, arthritis, back injury, cerebral palsy, spina bifida, etc.)
- **G** ☐ Respiratory impairment
- **H** ☐ Nervous system/Neurological disorder
- **I** ☐ Mentally restored
- **J** ☐ Mental retardation
- **K** ☐ Learning disability
- **L** ☐ Others (heart disease, diabetes, speech impairment)
- **M** ☐ Other (please specify) _____

**Licenses and certifications (List, giving dates and sources of issuance) including Qualified Professional Status:**

**SKILLS**

CHECK the following skills, experiences, etc., which you have:

☐ Driver's License _____ Number State

☐ Chauffeur's License _____ Number State

☐ Car for use at work

☐ Sign Language

☐ Foreign language (specify) _____

☐ Adding Machine/calculator

☐ Typing (specify WPM) _____

☐ Shorthand/speedwriting (specify WPM) _____

☐ Legal transcription

☐ Medical transcription

☐ Braille

☐ Word Processing

☐ Other _____

**WORK HISTORY** (include volunteer experience) Use Additional Sheets if Necessary

| Current or Last Employer: | | Address: | | |
|---|---|---|---|---|
| Job Title: | | Supervisor's Name | Telephone Number | No. Supervised by you: |
| Date Employed (mo/yr) | Starting Salary $ per | Ending or Current Salary $ per | Reason for Leaving | May We Contact Employer YES ☐ NO ☐ |
| Date Separated (mo/yr) | List major duties in order of their importance in the job: | | | |
| Full Time Years Months | | | | |
| Part Time Years Months | | | | |
| If part time, number of hours worked per week: | | | | |

| Employer: | | Address: | | |
|---|---|---|---|---|
| Job Title: | | Supervisor's Name | Telephone Number | No. Supervised by you: |
| Date Employed (mo/yr) | Starting Salary $ per | Ending or Current Salary $ per | Reason for Leaving | |
| Date Separated (mo/yr) | List major duties in order of their importance in the job: | | | |
| Full Time Years Months | | | | |
| Part Time Years Months | | | | |
| If part time, number of hours worked per week: | | | | |

| Employer: | Address: | | | |
|---|---|---|---|---|
| Job Title: | | Supervisor's Name | Telephone Number | No. Supervised by you: |
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| Full Time Years Months | | | | |
| Part Time Years Months | | | | |
| If part time, number of hours worked per week: | | | | |

| Employer: | Address: | | | |
|---|---|---|---|---|
| Job Title: | | Supervisor's Name | Telephone Number | No. Supervised by you: |
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| Full Time Years Months | | | | |
| Part Time Years Months | | | | |
| If part time, number of hours worked per week: | | | | |

Please list three professional references below:

1. Name: _____

   Phone: _____

2. Name: _____

   Phone: _____

3. Name: _____

   Phone: _____

Person to be notified in case of an emergency:

Name: _____ Telephone (___) _____--_____

Address: _____ Relationship: _____

I certify that I have given true, accurate and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration and licensing boards, Health Care Provider Registry, and others to furnish whatever detail is available concerning my qualifications. I authorize investigation of all statements made in this application and understand that false information or documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action or dismissal if I am employed, and (or) criminal action. I further understand that dismissal upon employment shall be mandatory if fraudulent disclosures are given to meet position qualifications (Authority: G.S. 126-30, G.S. 14-122.1.) Note that there are various trainings that are a condition of employment as well as maintaining your drivers license and having transportation to and for work. You will be asked to attend Staff Meetings and Supervisions outside of normal working hours. Filling out the information contained herein has been completely voluntary. By signing this application you indicate an understanding of client confidentiality and commit to adhering to client confidentiality.

_____ _____

Signature of Applicant (unsigned applications will not be processed) Date

# PRE-EMPLOYMENT INQUIRY AUTHORIZATION RELEASE

- Have you ever had any action against your professional license, including restrictions, limitations, denial, revocation, suspension or cancellation in any state? Yes ___ No ___
- Have you ever had your professional liability coverage restricted, limited, denied or non-renewed? Yes ___ No ___
- Has any hospital, HMO, Mental Health Clinic or other health/human service agency ever limited, denied, revoked your professional privileges or allowed you to resign in order to avoid the potential for such actions? Yes ___ No ___
- Have you had any moving violations on your driver's license within the last three years? Yes ___ No ___
- Are you willing to work overtime? Yes ___ No ___
- Are you willing to work in various settings? Yes ___ No ___ Various shifts? Yes ___ No ___
- Are you giving us permission to acquire a Health Care Provider Registry Check? Yes ___ No ___
- Are you giving us permission to acquire a Criminal Background Check? Yes ___ No ___
- Will you take the required TB test annually? Yes ___ No ___
- Will you take the Hepatitis Vaccinations? Yes ___ No ___
- Are you currently granted partial disability by a medical doctor? Yes ___ No ___
- Will you attend meetings and trainings outside of normal working hours? Yes ___ No ___

In connection with my application for employment, I understand that background inquiries may be requested by you or on your behalf that will seek information as to my character, work habits, including oral assessments of my job performance, experiences and abilities, along with reasons for termination of past employment. Further I understand and agree that you may request information from various federal, state and other agencies including public and private sources which maintain records concerning my past activities relating to my driving record, credit history, criminal record, civil matters, previous employment, educational background, professional licensing, as well as workers compensation injuries and other experiences.

I acknowledge that a telephonic facsimile or copy of this release shall be as valid as original. This authorization is valid for any consumer report requested at any time during the tenure of my employment. This release is - valid for all federal, state, county and local agencies and authorities. I understand that I have the right to make a written request within a reasonable period of time for complete and accurate disclosure of information concerning the nature and scope of the investigation.

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of One on One Care, Incorporated, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the Executive of the Company. Both the undersigned and One on One Care, Incorporated may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I also understand that (1) the Company has a drug and alcohol policy that provides for preemployment testing as well as testing after employment; (2) consent to and compliance with such policy is a condition of my employment; and (3) continued employment is based on the successful passing of testing under such policy. I further understand that continued employment may be based on the successful passing of job-related physical examinations and a tuberculosis test.

I further understand that my employment with the Company shall be probationary for a period 100 days, and further that at any time during the probationary period or thereafter, my employment relation with the Company is terminable at will for any reason by either party.

Print Name _____

Social Security # _____ Date of Birth _____

Current Address _____ City _____State _____ Zip _____

List Previous Addresses for the Past 5 Years: _____

_____

Applicant Signature: _____ Date: _____