

(Revised 6/11/10)

SEASONS

A Non Profit Hospice

EMPLOYMENT APPLICATION

WE OFFER EQUAL EMPLOYMENT OPPORTUNITIES TO ALL PERSONS AND DO NOT DISCRIMINATE BASED ON RACE, COLOR, RELIGION, AGE, MARITAL STATUS, SEX, NATIONAL ORIGIN, DISABILITY, OR ANY OTHER LEGALLY PROTECTED STATUS.

4200 E. SKELLY DRIVE, SUITE 150, TULSA, OK 74135
PHONE: 918-745-0222 FAX: 918-745-9652

1831 W. MELVILLE RD, SPRINGFIELD, MO 65803
PHONE: 417-890-5533 FAX: 417-890-5560

PERSONAL DATA

NAME: LAST

FIRST

MI

DATE

ADDRESS

HOME PHONE

CITY, STATE, ZIP CODE

BUSINESS PHONE

HAVE YOU EVER WORKED FOR SEASONS HOSPICE BEFORE? YES ___ NO ___

SOCIAL SECURITY NO.

IF YES, FROM _____ TO _____

DRIVERS LICENSE NO. AND STATE

POSITION(S) REQUESTED

ARE YOU 18 YEARS OF AGE

OR OLDER? YES ___ NO ___

HOW WERE YOU REFERRED TO SEASONS HOSPICE?

___ SEASONS EMPLOYEE ___ NEWSPAPER ___ PROFESSIONAL JOURNAL ___ EMPLOYMENT AGENCY

___ COLLEGE COUNSELOR ___ RECRUITMENT PROGRAM ___ OTHER: PLEASE SPECIFY _____

WORK HOURS FULL TIME PART TIME DAYS EVENINGS NIGHTS WEEKENDS CALL

PREFERRED? Y N Y N Y N Y N Y N Y N Y N

AFTER EMPLOYMENT CAN YOU SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES
___ YES ___ NO IF HIRED, YOU WILL BE REQUIRED TO SHOW PROOF OF CITIZENSHIP

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR A MISDEMEANOR? ___ YES ___ NO IF YES,

EXPLAIN:

NOTE: A conviction is not an automatic bar to employment; each case will be considered on its own merit.

HAVE YOU REVIEWED A JOB DESCRIPTION FOR THE POSITION FOR WHICH YOU ARE APPLYING? ___ YES ___ NO
IF YES, ARE YOU ABLE TO PERFORM THE ESSENTIAL FUNCTION OF THE JOB, WITH OR WITHOUT

ACCOMODATIONS (S)? ___ YES ___ NO

YOU CAN ASSIST US BY DESCRIBING HOW YOU WOULD PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION
AND WITH WHAT REASONABLE ACCOMODATIONS WE CAN MAKE.

EDUCATION

NAME OF SCHOOL	LOCATION	COURSE OF STUDY	NO. OF YRS COMPLETED	DID YOU GRADUATE	DEGREE DIPLOMA
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HIGH SCHOOL

COLLEGE

GRADUATE

BUSINESS/TRADE/
TECHNICAL

EMPLOYMENT HISTORY
(MAY INCLUDE VOLUNTEER POSITIONS WHERE APPLICABLE)

COMPANY NAME	DATES EMPLOYED (MO/YR)
ADDRESS	FROM _____ TO _____ TELEPHONE: _____
CITY, STATE, ZIP	HOURLY PAY OR SALARY (CIRCLE ONE)
TITLE/POSITION	START _____ LAST _____ NAME AND TITLE OF SUPERVISOR
BRIEFLY DESCRIBE YOUR DUTIES	
PERSON(S) WE MAY CONTACT FOR REFERENCE	
REASON FOR LEAVING	

COMPANY NAME	DATES EMPLOYED (MO/YR)
ADDRESS	FROM _____ TO _____ TELEPHONE: _____
CITY, STATE, ZIP	HOURLY PAY OR SALARY (CIRCLE ONE)
TITLE/POSITION	START _____ LAST _____ NAME AND TITLE OF SUPERVISOR
BRIEFLY DESCRIBE YOUR DUTIES	
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COMPANY NAME	DATES EMPLOYED (MO/YR)
ADDRESS	FROM _____ TO _____ TELEPHONE: _____
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TITLE/POSITION	START _____ LAST _____ NAME AND TITLE OF SUPERVISOR
BRIEFLY DESCRIBE YOUR DUTIES	
PERSON(S) WE MAY CONTACT FOR REFERENCE	
REASON FOR LEAVING	

IF MORE INFORMATION PLEASE ATTACH A SEPARATE SHEET

PROFESSIONAL REGISTRATION
LICENSURE OR CERTIFICATION

STATE

ID NUMBER

EXPIRATION

OTHER STATES WHERE FORMERLY OR CURRENTLY REGISTERED? _____

IS YOUR PROFESSIONAL LICENSE OR REGISTRATION CURRENTLY SUSPENDED OR REVOKED IN ANY STATE? Y N

IF YES, EXPLAIN _____

HAVE YOU EVER HAD A PROFESSIONAL LICENSE OR REGISTRATION REVOKED IN ANY STATE? YES NO

IF YES, EXPLAIN _____

MILITARY

HAVE YOU EVER SERVED IN THE ARMED FORCES? YES NO

DESCRIBE THE TRAINING RECEIVED RELEVANT TO THE POSITION FOR WHICH YOU ARE APPLYING: _____

CERTIFICATION

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AGREE TO HAVE ANY OF THE ABOVE INFORMATION CHECKED BY SEASONS HOSPICE, INC. I AUTHORIZE THE USE OF ANY INFORMATION IN THIS APPLICATION TO VERIFY MY STATEMENTS AND I AUTHORIZE PAST EMPLOYERS, ALL REFERENCES, AND ANY OTHER PERSONS WHOM SEASONS HOSPICE, INC. CONTACTS TO ANSWER ALL QUESTIONS ASKED CONCERNING MY ABILITY, CHARACTER, REPUTATION, PREVIOUS EMPLOYMENT, EDUCATION, PUBLIC RECORDS, PROFESSIONAL CREDENTIALS, MOTOR VEHICLE RECORDS AND OTHER PERTINENT INFORMATION. I RELEASE ALL SUCH PERSONS FROM ANY LIABILITY OR DAMAGES ON ACCOUNT OF HAVING FURNISHED SUCH INFORMATION. I UNDERSTAND THAT ANY MISREPRESENTATION, FALSIFICATION, OR MATERIAL OMISSION OF INFORMATION ON THIS APPLICATION MAY RESULT IN MY FAILURE TO RECEIVE AN OFFER OF EMPLOYMENT OR, IF I AM HIRED, MY TERMINATION FROM EMPLOYMENT.

I UNDERSTAND THAT NOTHING CONTAINED IN THIS EMPLOYMENT APPLICATION OR IN THE GRANTING OF AN INTERVIEW IS INTENDED TO CREATE AN EMPLOYMENT CONTRACT BETWEEN SEASONS HOSPICE, INC. AND MYSELF FOR EITHER EMPLOYMENT OR FOR THE PROVIDING OF ANY BENEFIT. NO PROMISES REGARDING EMPLOYMENT HAVE BEEN MADE TO ME, AND I UNDERSTAND THAT NO SUCH PROMISES OR GUARANTEES ARE BINDING UPON SEASONS HOSPICE, INC. UNLESS MADE IN WRITING. IF AN EMPLOYMENT RELATIONSHIP IS ESTABLISHED, I UNDERSTAND THAT I HAVE THE RIGHT TO TERMINATE MY EMPLOYMENT AT ANY TIME AND THAT SEASONS HOSPICE, INC. RETAINS THE SAME RIGHT. I UNDERSTAND THAT NO EMPLOYEE OR REPRESENTATIVE OF SEASONS HOSPICE, INC. HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OR FOR EMPLOYMENT ON OTHER THAN AN AT-WILL BASIS. FURTHERMORE, THE AT-WILL NATURE OF EMPLOYMENT CANNOT BE ALTERED EXCEPT IN SIGNED WRITING BY THE PRESIDENT OR EXECUTIVE DIRECTOR.

I UNDERSTAND THAT IF I AM OFFERED EMPLOYMENT WITH SEASONS HOSPICE, INC. I MAY BE SUBJECT TO A CRIMINAL BACKGROUND CHECK, A DRUG AND/OR ALCOHOL SCREEN, USING URINE OR BLOOD TESTS, AND AN EMPLOYMENT EXAMINATION. IN THE EVENT I HAVE A DISABILITY WHICH WILL AFFECT MY ABILITY TO TAKE THE TEST, I WILL SO INFORM SEASONS HOSPICE, INC. PRIOR TO THE ADMINISTRATION OF THE TEST SO THAT A REASONABLE ACCOMODATION CAN BE MADE. REQUESTED ACCOMODATION MAY INCLUDE ACCESSIBLE TESTING SITES, MODIFIED TESTING CONDITIONS, AND ACCESSIBLE TESTING FORMATS. SEASONS HOSPICE, INC. RESERVES THE RIGHT TO REQUIRE MEDICAL DOCUMENTATION CONCERNING THE NEED FOR THE ACCOMODATION.

I ALSO UNDERSTAND THAT ALL OFFERS OF EMPLOYMENT ARE CONDITIONED ON THE PROVISION OF SATISFACTORY PROOF OF AN APPLICANT'S IDENTITY AND LEGAL AUTHORITY TO WORK IN THE UNITED STATES.

APPLICANTS SIGNATURE _____ DATE _____

THIS APPLICATION WILL REMAIN ACTIVE FOR A PERIOD OF 90 DAYS.
YOU MUST COMPLETE ANOTHER APPLICATION FORM SHOULD YOU WISH TO REMAIN ON FILE



RELEASE OF INFORMATION AGREEMENT

I hereby authorize Seasons Hospice, Inc. and/or its agents to make an independent investigation of my background for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualification for employment. This investigation may access records maintained by both public and private organizations. Information requested may include, but not limited to:

- Professional and Personal References
- Past and Current Employment
- Criminal and Police Reports
- Education
- Urine or Blood Tests to Determine Drug or Alcohol Use
- Credit History (Consumer Reports)
- Motor Vehicle Records
- Professional Credentials
- Public Records

I authorize any individual or entities contacted during this investigation to give you any and all pertinent information they may have, personal or otherwise, and release all parties from any and all liabilities, claims, or law suits in the regard to the information obtained.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge.

Signed: _____ Date: _____
 (Applicant)

PLEASE PRINT THE FOLLOWING INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
PRESENT ADDRESS	CITY, STATE	ZIP
PREVIOUS ADDRESS	CITY, STATE	ZIP
DRIVERS LICENSE #	STATE OF LICENSE	DATE OF BIRTH
SOCIAL SECURITY NUMBER	POSITION APPLYING FOR	

FOR OFFICIAL USE ONLY

The following information must be completed in order to process this request

Office Location _____ Phone Number _____

Requested By _____ Job Title _____

Please indicate the type of background check requested: Criminal MVA Workers Comp

If criminal, indicate County, City or State.

COUNTY _____ CITY _____ STATE _____