Health Services of the Pacific
Home Care – Medicare Certified & Joint Commission Accredited
Hospice
Diabetes Center

P. O. Box 8838
Tamuning, Guam 96931
Telephone (671) 647-5355/6
Fax (671) 647-5358

Application for Employment

PERSONAL INFORMATION

Name:_____ Social Security Number:_____

Mailing Address:_____

Home phone:_____ Alternate phone:_____ e-mail:_____

How did you learn of our agency: ___Advertisement ___TV ___Radio ___Personal referral

Other:_____

Classification: ___RN ___LPN/VN ___Cert. HHA ___PT ___OT Other:_____

Position applying for:_____ OR _____

What days will you be available to work? (please circle)

Mon Tues Wed Thurs Fri Sat Sun

Times available for days above: _____ _____ _____ _____ ____ ____ ____

Date available to start work:_____ Anticipated length of employment:_____

Have you ever been convicted of a felony? (A "yes" answer will not necessarily exclude you from consideration for employment.) Yes_____ No_____

Language:_____ Speak_____ Read_____ Write_____

Language:_____ Speak_____ Read_____ Write_____

EDUCATION/CERTIFICATIONS OR LICENSES

Name and Location of School **Did you graduate?** **Year** **Degree**

High School:

_____

College:

_____

Trade/Business or Tech School:

_____

Type of certification or license License # Expiration date State issued

_____

EMPLOYMENT HISTORY **Current/Most Recent Employer:**		
Address:		
Position Title:	Supervisor:	Phone:
Starting date:	Ending date:	
Job responsibilities:		
Starting salary:	Ending salary:	
Reason for leaving:		

Former Employer:		
Address:		
Position Title:	Supervisor:	Phone:
Starting date:	Ending date:	
Job responsibilities:		
Starting salary:	Ending salary:	
Reason for leaving:		

Former Employer:		
Address:		
Position Title:	Supervisor:	Phone:
Starting date:	Ending date:	
Job responsibilities:		
Starting salary:	Ending salary:	
Reason for leaving:		

Authorization

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and authorize the employers listed above to give you any and all information regarding my previous employment and any pertinent information they may have and release the company from all liability for any damage that may result from utilization of such information.

I understand that if considered for employment, I may be subject to pre-employment drug and/or alcohol testing.

Health Services of the Pacific is an Equal Opportunity Employer.

_____ _____

Signature of applicant Date

Filename: C:\Documents and Settings\Gurusamy Inc\HR\Forms\HSP employment application