

**ALSHAF HOME CARE AND SERVICES APPLICATION FORM**

**Availability: check all that you could work**

Mon\_\_\_\_ Tues\_\_\_\_ Weds\_\_\_\_ Thurs\_\_\_\_ Fri\_\_\_\_ Sat\_\_\_\_ Sun \_\_\_\_

Day hours\_\_\_\_ Evening hours (5-9 P) \_\_\_\_ nights (9 P-12 MN) \_\_\_\_ overnights\_\_\_\_ live-in\_\_\_\_

Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Available for Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position Applying For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Employment Desired: Per Diem Number of Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Part Time Number of Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Include any nicknames*: Full Time Number of Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Last Name First Name Middle Initial

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

Mailing Address City State Zip Code

(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number Cell Phone Number or Work Phone Number

Email address

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

Social Security Number Language skills other than English (written/spoken) Date of Birth

Have you ever been employed here before? Yes No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you legally eligible for employment in the US? Yes No

If not legal citizen:

Do you have a green card? Yes No

Do you have a social security card? Yes No

Has your visa expired? Yes No

**REFERRAL INFORMATION** How did you hear about us? (Please check)

Newspaper Ad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Internet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which newspaper? Which site?

Current Employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We’d like to thank them

**EMERGENCY CONTACT** **INFORMATION** - Please Print Clearly

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Helena Home care LLC is an equal opportunity employer. All applicants and employees are considered for employment, advancement, and development based upon their skills, performance and potential. No current or prospective employee will be discriminated against because of race, creed, color, gender, age, national origin, handicap or military status.

**AT LEAST 1 FULL YEAR- Employment History -** *Please begin with your most recent or current place of employment.*

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Final Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Experience:

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Final Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Experience:

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Final Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Experience:

**Education** Name & Location Course of Study Years Completed Date Graduated

High School:

College:

Other:

Other:

**Military Service:**

Branch of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Rank Achieved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently in a Reserve Unit? Yes / No

Special Schooling and/or Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Licenses and Certifications** (Provide copies of each

License or Certification ID Number Expiration Date State

**Applicant' Malpractice insurance Carrier (name and Address) --------------------------------------------------------------**

**------------------------------------------------------------------------------------------------------------**

**Applicant' Malpractice insurance policy number----------------------------------------**

1.

2.

3.

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**ALSHAF HOME CARE AND SERVICES LLC**

Health

Documents

2023

**Health Questionnaire – Medical History**

**ALSHAF HOME CARE AND SERVICES LLC**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate by checking any diseases or illnesses you have or have had:

\_\_\_\_\_\_\_ Asthma \_\_\_\_\_\_\_ Allergies \_\_\_\_\_\_\_ Arthritis \_\_\_\_\_\_\_ HBP

\_\_\_\_\_\_\_ Back Cond. \_\_\_\_\_\_\_ Fatigue \_\_\_\_\_\_\_ Joint Pain \_\_\_\_\_\_\_ LBP

\_\_\_\_\_\_\_ Bursitis \_\_\_\_\_\_\_ Ulcers \_\_\_\_\_\_\_ Heart Cond. \_\_\_\_\_\_\_ Sinus

\_\_\_\_\_\_\_ Hernia \_\_\_\_\_\_\_ Epilepsy \_\_\_\_\_\_\_ Eye Cond. \_\_\_\_\_\_\_ TB

\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_ Hearing \_\_\_\_\_\_\_ Anxiety \_\_\_\_\_\_\_ Vertigo

\_\_\_\_\_\_\_ Paralysis \_\_\_\_\_\_\_ Migraines \_\_\_\_\_\_\_ Depression \_\_\_\_\_\_\_ Thyroid

\_\_\_\_\_\_\_ Drug Use \_\_\_\_\_\_\_ Alcohol Use \_\_\_\_\_\_\_ Bronchitis \_\_\_\_\_\_\_ Pneumonia

\_\_\_\_\_\_\_ SOB \_\_\_\_\_\_\_ Skin Rashes \_\_\_\_\_\_\_ Hay fever \_\_\_\_\_\_\_ Weight Loss

\_\_\_\_\_\_\_ HIV \_\_\_\_\_\_\_ Hernia

Have you ever been hospitalized for any of the above or had surgery? Explain:

Have you ever had an industrial accident? Explain:

**Tuberculosis Screening Questionnaire**

**ALSHAF HOME CARE AND SERVICES LLC**

**Employee Information**

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date completing form\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Early Detection of Tuberculosis**: This questionnaire gives guidance in identifying individuals with  suspected or confirmed TB so that appropriate controls can be promptly initiated.  **AGENCY REP INSTRUCTIONS:**   * Circle each answer provided by the employee and add your comments as the evaluator. * Institute AMS exposure control measures outlined in AMS Exposure Control Plan,   Respiratory Protection and Medical Surveillance Program and refer the individual for further  evaluation if the individual has:  (1) A persistent cough lasting 3 or more weeks and two or more symptoms of active TB.  (2) Had a positive TB test on mucous that he/she coughed up.  (3) Been told that he/she had TB and was treated, but never finished the medication.   |  | | --- | | **TB HISTORY (Part 1)** |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **1.** | Have you ever had a positive TB skin test? YES NO Don’t Know | | | | | **2.** | Have you ever had an abnormal chest x-ray? YES NO Don’t Know | | | | |  | If yes, how long ago? | | | | | **3.** | Have you recently had the mucous you cough up tested for TB? YES NO Don’t Know | | | | |  | If yes, were you told it was positive? | | | | | **4.** | Have you ever been told you have Infectious Tuberculosis? YES NO Don’t Know | | | | |  | If yes, how long ago? | | | | | **5.** | Have you ever been treated with medication for Infectious TB? YES NO Don’t Know | | | | |  | If yes, how may medications? One Two Over Two | | | | | **6.** | Are you still taking TB medicine? YES NO | | | | |  | Did you take all the TB medicine until the health care professional told you that you were finished? | | | | |  | Yes | No |  |  | | **7.** | Do you live with or have you been in close contact with someone who was recently diagnosed with TB? (ie. shelter roommate, close friend, relative). YES NO Don’t Know | | | | | **CURRENT SYMPTOMS (Part Two)** | | | | | | **1.** | Do you have a cough that has lasted longer than three weeks? YES NO | | | | | **2.** | Do you cough up blood or mucous? YES NO | | | | | **3.** | Have you lost your appetite? Aren't hungry? YES NO | | | | | **4.** | Have you lost weight (more than 10 pounds) in the last two months? Without trying to? YES NO | | | | | **5.** | Do you have night sweats (need to change the sheets or your clothes because they are wet)? YES NO | | | | | Evaluator Comments: | | | | | | Referred for Further Evaluation? YES NO | | | | | | **Evaluator's Signature/Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **Date:\_\_\_\_\_\_\_\_\_\_\_** | |

**HEPATITIS B VACCINE** **ACCEPTANCE/DECLINATION**

I understand that due to my occupational exposure to blood or other potentially

infectious material, I may be at risk of acquiring the Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the vaccine, at no charge to me. The series consists of 3 doses: an initial IM dose, a 2nd dose 30 days after and a 3rd dose at 6 months.

*PLEASE CHECK* ***ONE*** *OF THE FOLLOWING:*

**I** **DECLINE HEPATITIS B SERIES:**

**I DECLINE THAT VACCINATION AT THIS TIME.**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me. OSHA [56 FR 64004, Dec. 06, 1991, as amended at 57 FR 12717, April 13, 1992; 57 FR 29206, July 1, 1992; 61 FR 5507, Feb. 13, 1996]

**I DECLINE as I have previously received the vaccine series on \_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Employee Signature Date**

**CONSENT TO HEPATITIS B VACCINE:**

I hereby consent to the administration of the Hepatitis B vaccine series and understand this will be at no charge to me. I know that I should not take this series if I am pregnant or nursing. I also understand that I should not take the vaccine if I have active infection present or have an allergy to the compound. I understand the risks and side effects of the injections and release the HCSF from any liability that may arise from the effects of the vaccine.

**BY SIGNING MY NAME BELOW, I AM STATING THAT I DO WISH TO HAVE THE**

**HEPATITIS B VACCINE. I UNDERSTAND THAT THIS IS THREE (3)**

**INJECTIONS AND THAT I MUST RECEIVE ALL INJECTIONS TO BE CONSIDERED VACCINATED AGAINST HBV INFECTION.**

**I AGREE TO FOLLOW THROUGH ON ALL 3 VACCINES.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee Signature** **Date**

**ALSHAF HOME CARE AND SERVICES LLC**

**EMPLOYEE HEALTH STATEMENT**

*Employee/Applicant*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Statement of Health**

*To be completed by Health Professional*

I have examined the individual named above and to the best of my knowledge; he/she is in good physical and mental health, free of any communicable diseases and is able to function in his/her profession at full capacity.

By signing below, I certify that the above information is true and correct.

Health Professional Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Office Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address:

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

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

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**ALSHAF HOME CARE AND SERVICES LLC**

**Criminal History**

Have you ever been convicted of violating any law? (Please omit minor traffic violations.)

🞎 Yes 🞎 No if yes, please list conviction(s), date(s) and location(s).

The presence of a criminal record is not an automatic rejection of your application. I attest that the above referenced information is true and accurate to the best of my knowledge. I further give the HCSF permission to call any of my cited previous employers or reference candidate for information regarding my character, employment history or work ethics and performs a criminal background check for the purpose of employment.

I ,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(applicant printed name) hereby authorize Helena Home Care to request and receive from all prior employers within one year of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.

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

Employee Candidate Signature Date



**ALSHAF HOME CARE AND SERVICES LLC**

**APPLICANTS CERTIFICATION AND AGREEMENT**

I hereby certify that the facts set forth in the above employment application are true and complete to the best of my knowledge and authorize ALSHAF HOME CARE AND SERVICES LLC to verify their accuracy and to obtain reference information on my work performance. I hereby release ALSHAF HOME CARE AND SERVICES LLC from any/all liability of whatever kind and nature which, at any time, could result from obtaining and having an employment decision based on such information.

I understand that, if employed, falsified statements of any kind or omissions of facts called for on this application shall be considered sufficient basis for dismissal.

I understand that should an employment offer be extended to me and accepted that I will fully adhere to the policies, rules and regulations of employment of the employer. However, I further understand that neither the policies, rules, regulations of employment or anything said during the interview process shall be deemed to constitute the terms of an implied employment contract. I understand that any employment offered is for an Indefinite duration and at will and that either I or the employer may terminate my employment at any time with or without notice or cause.

Signature of Applicant: Date: