Best Health Care Services, LLC.
9306-A Old Keene Mill Road, Burke, VA. 22015
Agency Phone: (703) 440-1131 Agency Fax: (703) 440-1132

JOB APPLICATION

Name: (last name) _____ (first name) _____

Social Security/EIN #_____Email address: _____

Services provided: ☐ CNA ☐ HHA ☐ PCA ☐ LPN ☐ RN ☐ Other: _____

Present Address: _____
Street City State Zip

Permanent Address: _____
Street City State Zip

Date of Birth: _____ Seeking ☐ Full time ☐ Part Time ☐ Temp ☐ Seasonal

Cellular Phone # _____ Home Phone # _____

EMERGENCY CONTACT: Name: _____ Phone: _____

His/her Address: _____

Relationship: _____ Email address: _____

Position desired _____ Date you can start_____ Desired rate_____

Are you employed now?_____ If so, may we inquire of your present Company? ☐Yes ☐No ☐ Self

Ever applied to this company before? ☐ Yes ☐ No Where_____ When_____

Will you travel if required? ☐Yes ☐ No Reason: _____

Will you relocate if job requires it? ☐Yes ☐ No. Will you work overtime if required? ☐Yes ☐ No

Are you able to meet the attendance requirements of this position? ☐Yes ☐No. Have you ever been bonded? ☐Yes ☐No.

Have you ever been convicted of a felony in the past 5 years ☐ Yes ☐ No Such conviction may be relevant if job related, but may not bar you from employment. If yes – explain: _____

_____

_____

Driver's license number: _____Expiration: _____ State _____

If you are under 18, can you furnish a work permit? ☐ Yes ☐ No

Education		Name and location of School	# of years Completed	Did you Graduate?	Subjects Studied
Academic	Currently Attending				
	Last Completed				

Trades of Business	Currently Attending				
	Last Completed				

Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with this company. _____

_____

WORK HISTORY:

Date Month and Year	Name and address of Company	Salary Rate	Job Title	Reason for Leaving
From_____ to_____				
Can we contact this Company? YES NO	Supervisor:			
	Contact #:			
From_____ to_____				
Can we contact this Company? YES NO	Supervisor:			
	Contact #:			
From_____ to_____				
Can we contact this Company? YES NO	Supervisor:			
	Contact #:			

References: Give the names of three persons not related to you, whom you have known for at least 1 year.

Name	Address	Phone	No. of years
	Email:	Ph. Fax:	
	Email:	Ph. Fax:	
	Email:	Ph. Fax:	

List any foreign language(s) and check the box that best describes your skill level.

Language	Read and write	Read and speak	Speak only

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Applicant Certifications and Authorizations

I certify that the information I have provided in my Job Application is true and accurate. I understand that any misrepresentation or falsification of information I provide to BHCS may be cause for consideration of my application to cease, or, if employed, for my immediate termination.

I hereby authorize BHCS to check my references as listed on my Job Application.

I agree that, if I am selected for employment with BHCS, BHCS may require me to undergo tuberculosis, blood and/or urinalysis testing, hepatitis vaccination, and other necessary tests and vaccinations as part of substance abuse program and disease prevention efforts of BHCS. I further agree that, at the time of any such examination, I will execute all consent forms and liability releases as usually and reasonably attendant to such testing or vaccination. Finally, I agree that I shall make the results of such examinations available to BHCS, its employees or agents.

I understand that, if I am employed by BHCS, my employment would be "at will" and I will abide by all its rules and regulations.

I certify that I have had no prior convictions for any offense described in Virginia Code §32.1-162.9:1 ("barrier crimes") that would potentially bar my employment with BHCS.

_____ _____

Signature Date

_____

Print Name

AGENCY MANAGEMENT NOTES: