

Personal Care Preferred Group

PERSONAL TOUCH HOME CARE SERVICES

13001 Main Street P.O. Box 305 Stony Creek, VA 23882 1.800.598.9854 434.246.3110 434.246.4213 fax

2903 Boulevard Suite B Colonial Heights, VA 23834 804.896.5548 804.526.9588 fax

107 Maifield Ave. Waverly, VA 23890 804.896.5553 804.834.1066 fax

115 West 2nd Ave Franklin, VA 23851 757.899.0446 757.562.7399 fax

MOORE HOME CARE SERVICES

410 S. Main St. P.O. Box 111 Emporia, VA 23847 434.348.8861 434.348.0661 fax

SOUTHERN TOUCH HEALTH CARE SERVICES

2903 Boulevard Suite B Colonial Heights, VA 23834 1.800.974.6959 804.733.9511 804.733.9577 fax

130 West Hicks St. Lawrenceville, VA 23868 1.800.974.6959 434.632.1809 434.848.2905 fax

Personal Care Preferred Group APPLICATION FOR EMPLOYMENT

(An Equal Opportunity Employer) A Drug-Free Environment

FOR OFFICE U	JSE ONLY
Hire date	
Certificate	
BkCheck	
Rate of Pay	

A Drug-Free Environment			Date:			
Full Legal Name:	LAST		FIRST		MI	
Address:	NUMBER		1101			
	NUMBER	STREET				
	CITY		STATE	Z	P	
Social Security No	umber:					
Home Phone: _		Cell Phor	ne:			
*Position Applied	For:		Fu	ll Time [] Pa	rt Time []	
Are you 18 years	or older? Birt	h date if under 1	.8 years of age:			
In an emergency	notify:		Relationshi	o:		
Emergency Conta	act #:		Work #•			
EDUCATION						
	Name and Location		Course of Study	Number of Years Completed	Diploma or Degree Received	
High School						
College						
Vocational or Trade School						
Graduate Work						
FOR PROFESS	IONAL APPLICANTS ONL	Y - Complete th	e section below:			
License or certific	cate number:					
Are you licensed	by Virginia?	Are you l	icensed by anoth	er state?		
If so, by which st	ate?	Last rene	wal date for licens	se?		
	I for a Virginia license?					
Professional mem	1 11					

^{*}Please note an application for nursing assistant positions must be accompanied by a copy of certificate of completion or state license to be considered for hire.

What date would you be available to begin v	work?
Are you legally eligible to be employed i (Proof of identity and eligibility will be requ	
	olation(s), not including moving traffic violations?
(A conviction will not necessarily result in the	e denial of employment.)
Have you ever worked for this Company	before? YES [] NO []
If yes, When? (Give dates)	Job Title:
Are you currently employed elsewhere?	YES [] NO []
Do you have any relatives or friends who	work for the Company? YES [] NO []
If yes, who and where do they work?	
Are you available to work: DAYS [] NI	GHTS[] WEEKENDS[] FULL TIME[]
If you cannot work full time, please explain:	
Days and Hours Available (If employed, I will no	otify my supervisor in writing, should my availability change.)
[] Sunday - From:	To:
[] Monday - From:	To:
[] Tuesday - From:	То:
[] Wednesday - From:	Τα:
[] Thursday - From:	To:
	To:
[] Saturday - From:	To:
References (Other than supervisors or relativ	res; list name, address, occupation, & phone #)
Please name all of the medical equipment th	at you are able to use:
r rease name an or the medical equipment th	at you are able to use.
Are you capable of lifting 10- 25 lbs? Y	ES [] NO []
	[] NO []
Have you ever used a lift machine? YES	[] 110 []
•	[] "0 []

EMPLOYMENT HISTORY (Please list m	nost recent employment first.)	
Name of Employer		Telephone Number
Full Address (Including Street, City, State & Zip)		Supervisor's Name and Title
Dates Employed: From (Month/Day/Year)	To (Month/Day/Year)	Rate of Pay: Beginning End
Reason for Leaving		
What was your position? Describe work performed:		
Name of Employer		Telephone Number
Full Address (Including Street, City, State & Zip)		Supervisor's Name and Title
Dates Employed: From (Month/Day/Year)	To (Month/Day/Year)	Rate of Pay: Beginning End
Reason for Leaving		
What was your position? Describe work performed:		
Name of Employer		Telephone Number
Full Address (Including Street, City, State & Zip)		Supervisor's Name and Title
Dates Employed: From (Month/Day/Year)	To (Month/Day/Year)	Rate of Pay: Beginning End
Reason for Leaving		
What was your position? Describe work performed:		
Preferred Group or its subsidiaries permission	are true and correct to the best of my knowledg to verify such answers. I understand that any false of an interview is intended to create an employm	statements or omission of facts on

Preferred Group or its subsidiaries permission to verify such answers. I understand that any false statements or omission of facts on this employment application in the granting of an interview is intended to create an employment contact between Personal Care Preferred Group and myself. If employed, I understand that I have the right to terminate my employment at any time and that Personal Care Preferred Group retains the same right. If employed I may be subject to random drug testing. I understand this application will be considered for thirty (30) days.

Signature of Applicant	 Date	



INSTRUCTIONS

Applicant: Complete Sections 1 and 2

Former Employer: Complete Section 3 and return to Personal Touch Home Care Services, Inc.

PERSONAL TOUCH HOME CARE SERVICES, INC.

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Personal Care Preferred Group Employment Verification

FOR OFFICE USE ONLY				
Telepho	ne Verification ,			
Faxed .				
Mailed				

SECTION 1 (COMPLETED BY APPLICANT)

Employment Verification for:			
Applicant (Please Print)	FIRST	MIDDLE	LACT
		MIDDLE	LAST
Social Security #		Date _	
Position Applied For:			
authorize you to verify my	ment with Personal Care Pre former employment and re 3 and return in a postage pai	lease you from any	y liability. Please supply the
Applicant's Signature:			
SECTION 2 (COMPLETED	BY APPLICANT)		
Former Employer (print)			
StreetAddress			
City/ State/Zip			
Attention:			
	End D		
SECTION 3 (COMPLETED	BY FORMER EMPLOYER)		
Please indicate employee's	job performance:		
. ,	ABOVE AVERAGE	AVERAGE	UNSATISFACTORY
Attendance			_
Attitude			_
Overall Ability			
Would you rehire? YES [1 NO []		
If no please explain:			
Signature			Date