File /Reference check to be used by FHS Only

	Driver's License		Probationary Period
	Social Security Card/Proof of Citizenship		Background Information
	Resume including 3 professional references		I-9 Form
	Copy of all Certifications/License (CNA, LPN, RN, PCA)		8850 Form
	Copy of CPR/First Aid (American Heart Association only)		Skills Checklist Form
	Criminal Background Check (Police Department)		Direct Deposit Form
	TB Test Results		Orientation Form
	TB Form		Orientation Instruction
	Handbook (Signed and date)		Orientation Curriculum
	Medical Questionnaire		Employee Ethics
	Hep B Vaccination Verification		Consent for Criminal Check
	W – 4 Form		Documentation of Training
	W – 11 Form		Reference Check & Work Verification

Professional Reference #1- Name:	Start Date:	End Date:	Rehire:
Professional Reference #2- Name:	Start Date:	End Date:	Rehire:
Professional Reference #3- Name:	Start Date:	End Date:	Rehire:
Personal Reference #1- Name:		Years Known:	
Personal Reference #2- Name:		Years Known:	
Personal Reference #3- Name:		Years Known:	

PCA/CNA Exam date: _____
CNA Certificate renewal date: _____
RN license renewal date: _____
LPN license renewal date: _____
First Aid/CPR renewal date: _____
TB test renewal date: _____
Chest X-ray renewal date (every 2 Yrs.): _____

To Be Completed by Favored Healthcare Services Representative Only

Special request/assignment preference:

Details	Comments
Completed Application: [ ] yes [ ] No	Satisfactory background check submitted: [ ] yes [ ] No
Satisfactory TB test Submitted: [ ] yes [ ] No	CPR and First Aid submitted: [ ] yes [ ] No
License checked: active license: [ ] yes [ ] No Any adverse findings: [ ] yes [ ] No	Reference checked: [ ] yes [ ] No
Pay Rate: $	

_____ _____

Favored Health Care Services Rep. Date

Favored Healthcare services
Employment Application

FHS is an Equal Opportunity Employer and EEO/Affirmative Action Employer committed to excellence through diversity. Employment offers are made on the basis of qualifications, and without regard to race, sex, religion, national or ethnic origin, disability, age, veteran status, or sexual orientation. Only completed and legible applications will be accepted. Attached resumes will not be replace this application.

APPLICANT INFORMATION												
Last Name		First		M.I.	Date							
Street Address					Apartment/Unit #							
City/State		Zip		DOB								
Phone		E-mail Address										
Date Available		Social Security No.		Desired Salary								
Position Applied for												
Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐	NO ☐							
Have you ever worked for this company?	YES ☐	NO ☐	If so, when?									
Have you ever been convicted of a felony?	YES ☐	NO ☐	If yes, explain									

EDUCATION												
High School				Address								
From		To		Did you graduate?	YES ☐	NO ☐	Degree					
College				Address								
From		To		Did you graduate?	YES ☐	NO ☐	Degree					
Other				Address								
From		To		Did you graduate?	YES ☐	NO ☐	Degree					
Any other education relative to the job(s) in which you are applying?												

REFERENCES			
Please list three professional references.			
Full Name		Relationship	
Company		Phone	
Address			
Full Name		Relationship	
Company		Phone	
Address			
Full Name		Relationship	
Company		Phone	
Address			

REFERENCES

Please list three personal references.			
Full Name		Relationship	
Years Acquainted?		Phone	
Address			
Full Name		Relationship	
Years Acquainted?		Phone	
Address			
Full Name		Relationship	
Years Acquainted?		Phone	
Address			
#1 Emergency Contact	Name ____ Telephone: ________________________________		
# 2 Emergency Contact	Name ____ Telephone: ________________________________		

PREVIOUS EMPLOYMENT

Company				Phone			
Address				Supervisor			
Job Title			Starting Salary	$	Ending Salary	$	
Responsibilities							
From		To		Reason for Leaving			
May we contact your previous supervisor for a reference?				YES ☐	NO ☐		
Company				Phone			
Address				Supervisor			
Job Title			Starting Salary	$	Ending Salary	$	
Responsibilities							
From		To		Reason for Leaving			
May we contact your previous supervisor for a reference?				YES ☐	NO ☐		
Company				Phone			
Address				Supervisor			
Job Title			Starting Salary	$	Ending Salary	$	
Responsibilities							
From		To		Reason for Leaving			
May we contact your previous supervisor for a reference?				YES ☐	NO ☐		

MILITARY SERVICE

Branch		From		To	
Rank at Discharge		Type of Discharge			
If other than honorable, explain					

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

IT IS THE POLICY OF **FHS** *TO AFFORD EQUAL OPPORTUNITY TO ALL EMPLOYEES AND APPLICANTS FOR EMPLOYMENT WITHOUT REGARD TO AGE, RACE, RELIGION, COLOR, SEX, NATIONAL ORIGIN, MARITAL STATUS, EXPUNGED JUVENILE RECORDS, OR PREGNANCY, AND TO AFFORD EQUAL OPPORTUNITIES TO DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND INDIVIDUALS WITH A DISABILITY, AND ANY AND ALL OTHER CHARACTERISTIC PROTECTED BY FEDERAL, STATE OR LOCAL LAW. I AUTHORIZE THE INVESTIGATION OF ALL STATEMENTS AND INFORMATION CONTAINED IN THIS APPLICATION. I RELEASE FROM ALL LIABILITY ANYONE SUPPLYING SUCH INFORMATION AND I ALSO RELEASE THE EMPLOYER FROM ALL LIABILITY THAT MIGHT RESULT FROM MAKING AN INVESTIGATION. IF HIRED, I AGREE TO ABIDE BY ALL* **FHS** *RULES AND REGULATIONS AND UNDERSTAND THAT, IF EMPLOYED, MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT THE OPTION OF* **FHS** *OR ME. I FURTHER UNDERSTAND THAT NO REPRESENTATION, WHETHER ORAL OR WRITTEN BY ANY REPRESENTATIVE OR AGENT OF* **FHS** *AT ANY TIME CAN CONSTITUTE A CONTRACT OF EMPLOYMENT. I UNDERSTAND THAT* **FHS** *AND ALL PLAN ADMINISTRATORS SHALL HAVE THE MAXIMUM DISCRETION PERMITTED BY LAW TO ADMINISTER, INTERPRET, MODIFY, DISCONTINUE, ENHANCE OR OTHERWISE CHANGE ALL POLICIES, PROCEDURES, BENEFITS OR OTHER TERMS OR CONDITIONS OF EMPLOYMENT. NO REPRESENTATIVE OR AGENT OF* **FHS** *HAS THE AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OF TIME OR TO MAKE ANY CHANGE IN POLICY, PROCEDURE, BENEFIT OR OTHER TERMS OR CONDITIONS OF EMPLOYMENT OTHER THAN IN A DOCUMENT SIGNED BY* **FHS** *PRESIDENT/CEO, ADMINISTRATOR, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING. I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS, AND HEREBY GRANT PERMISSION TO CONFIRM THE INFORMATION SUPPLIED ON THIS APPLICATION BY ME.*

Signature		Date	

EMPLOYEE ACKNOWLEDGEMENT OF PROBATIONARY PERIOD

I understand that I am on probation as an employee of Favored Health Care for the first ninety days of my employment, which started on _____ for the purpose of the applicable Unemployment Commission Law.

I acknowledge that I signed this form within seven (7) days of my employment date.

_____

Employee Signature Employee Soc. Sec. #. Date

Medical in Confidence

Baseline Health Questionnaire for Healthcare Workers

IT IS THE POLICY OF **Favored Healthcare Services, Inc** *TO AFFORD EQUAL OPPORTUNITY TO ALL EMPLOYEES AND APPLICANTS FOR EMPLOYMENT WITHOUT REGARD TO AGE, RACE, RELIGION, COLOR, SEX, NATIONAL ORIGIN, MARITAL STATUS, EXPUNGED JUVENILE RECORDS, OR PREGNANCY, AND TO AFFORD EQUAL OPPORTUNITIES TO DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND INDIVIDUALS WITH A DISABILITY, AND ANY AND ALL OTHER CHARACTERISTIC PROTECTED BY FEDERAL, STATE OR LOCAL LAW*

Section 1 – Personal Details *(please Print)*

Surname/Family Name _____ First Name _____

Title _____ Gender ____ M _____ F Maiden Name _____

D.O.B _____/_____/_____ Place of Birth _____

Present Address _____

Postal Address (if different) _____

Telephone _____ Have you worked for this organization before? _____ Y _____ N

If so please state in what capacity and when as _____ from _____ until _____

Data Protection Act 1998
Personal information generated by completion of this form provides a medical view of your fitness for the role or specific task. FHC may require further information about your health before coming to a view on your fitness. Your consent to further reports from your medical advisers will be sought in these circumstances. All such medical information will be kept in strict medical confidence by the FHC. Your consent will be sought for any other use of all or part of this confidential medical data.

Section 2 – Post Details *(Manager)*

Job hazards associated with this post

Direct Patient contact or contact with Specimens	☐	Work with Natural Latex products	☐	Work involving driving	☐
Work involving heavy lifting	☐	Shift work/Night work	☐	Work involving food handling	☐
Work using skin irritants	☐	Work can be stressful at times	☐	Other _____	☐

Section 3 – Job History

Is this your first employment following registration of your professional training? Yes ☐ No ☐

Job	Employer	From (date) / To (date)	Hazard
		/	
		/	
		/	

Please give details below of the previous employment and hazards you have been exposed to

	Yes	No	Details (give full information)
1. Do you consider yourself to be in good health?			
2. Have you required any modifications or additional or additional equipment in order to do your job for any reason?			
3. Have you been restricted from any particular type of work or had to give up a job for medical reasons?			
4. Have you been absent from work or study for any medical reason for more than 5 days in the last 12 months? *If so, please give cause and approximate dates*			
5. Are you currently taking any prescribed medication on a regular basis?			
6. Have you consulted your own doctor or any other health practitioner (including osteopath) during the past 3 months?			
7. Have you lived/worked abroad in the past 12 months?			
What is your approximate height and weight?	Height cm		Weight kg

Section 4 – Personal History

Section 5 – Smoking and Alcohol

	Yes	No
1. Do you Smoke?	☐	☐

If yes, quanity per day? _____ Cigarettes ☐ Pipe ☐ Cigars ☐

If ex-smoker, how many years since you stopped? 1 – 5 ☐ 5 – 10 ☐ 10+ ☐

2. Do you drink Alcohol? ☐ ☐

If ye, what is your average weekly intake? Pints _____ Shorts _____ Glass of wine _____

Section 6 – Medical History

	Yes	No	Details (give full information)
1. Are you allergic or sensitive to any substance?			
2. Do you have any allergic conditions e.g. asthma, hay fever, and rhinitis?			
3. Do you have, or have you had any skin trouble, e.g. eczema, dermatitis or psoriasis?			
4. Have you had problems with natural rubber such as that found in balloons or gloves? If so, when did you first notice it, and what problems did you first experience.			
5. Do you have any food allergies, particularly potatoes, peanut, egg, banana, almond, mango, milk, kiwi fruit?			
6. Do you have, or have you had any chest complaint or ailment, e.g. bronchitis, pleurisy, tuberculosis?			
7. Do you have a persistent cough, bring up phlegm or suffer from night sweats?			
8. Have you had persistent or recurrent back pain?			
9. Do you have any difficulty lifting weights, bending or climbing stairs?			
10. Have you had persistent or recurrent pain in your neck/shoulder/arms/hands?			
11. Do you suffer from any form of arthritis or rheumatism?			
12 .Have you suffered from depression, “nerves” or any psychiatric illness?			
13. Do you have deficiency of color vision?			
14. Do you have any other condition or disease affecting the eyes or your eyesight?			
15. Do you have any hearing problems or deficiency not corrected by a hearing appliance?			
16. Are you diabetic?			

17. Have you had any blackouts, seizures, or frequent fainting attacks?			
18. Do you suffer from frequent headaches or migraine?			
19. Have you been diagnosed as having high blood pressure?			
20. Have you had hepatitis or jaundice?			
21. Any other health problems that may interfere with your job performance?			

Section 7 – Immunization Status

	Yes	No	Details (give full information)
1. Have you had Measles, Mumps, Chickenpox or Shingles?			**Which?**
Have you had any of the following immunizations or injections?	**Yes**	**No**	**When?**
BCG for Tuberculosis			
Rubella (German Measles)			
Poliomyelitis			
Varicella (VZV)			
Initial course of Hepatitis B			
Booster dose of Hepatitis B			
Tetanus			
Diphtheria			
Other			
Have you had a skin test for tuberculosis?			

Females only: In order to ensure that an adequate risk assessment for pregnant employees can be carried out to protect both the employee and the baby, your manager should be informed in writing when you find out that you are pregnant. It is not compulsory to do so but may be necessary if modifications to your role are required for the sake of you or the baby's health. If you are pregnant at the time you commence in this post you should inform Favored Healthcare Services, Inc. when you start.

Section 8 – Declaration

I hereby declare that all medical information given by me to FHS, Inc. is true and accurate to the best of my belief and knowledge.

Signature of Employee_____ Date: _____

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REPORTING TUBERCULOSIS AND HEPATITIS EXPOSURE

IT IS THE EMPLOYEE'S OBLIGATION TO REPORT KNOWN EXPOSURE TO TUBERCULOSIS AND HEPATITIS
BY SIGNING I ACKNOWLEDGE THAT I HAVE READ THE ABOVE.

_____

Employee Name Date

_____

Employee Signature Date

EMPLOYEE DOCUMENTATION OF TB TEST TUBERCULOSIS

Employee Name: _____

Date of Hire: _____

Social Security#: _____

Test/Examination date: _____

Name of Clinic: _____

Type of TB Test: X-RAY [ ] SKIN [ ] OTHERS [ ] TB Test Results NEGATIVE [ ] POSITIVE [ ]

_____

Favored Health Care Services Rep. Date

_____

Employee Signature Date

Hepatitis B Vaccination Verification/Declination

I have recieved the Hepatitis B Vaccination series.
1st vaccination date _____/_____/_____
2nd vaccination date_____/_____/_____
3rd vaccination date_____/_____/_____
Titer _____ yes
Titer_____ no
Employee Signature:
_____Date:_____

The following statement of declination of the hepatitis B vaccine must be signed by an employee who:
Chooses not to accept the vaccine.
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 advice about the need for a hepatitis B vaccine. 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 should contact Favored Healthcare Services, Inc.
Employee Signature:
_____Date:_____

This statement is not a waiver.
An employer cannot require:
Employees to waive liability in order to receive the vaccine
Participation in pre-screening as a prerequisite for receiving the vaccine.

GENERAL CODE OF CONDUCT GUIDELINES FOR EMPLOYEES

PLEASE READ AND CHECK OFF

[ ] REPORT TO WORK 15 MINUTES BEFORE THE BEGINNING OF YOUR SHIFT
[ ] EMPLOYEE IS RESPONSIBLE FOR HIS/HER OWN TRANSPORTATION TO AND FROM WORK.
[ ] ALL SERVICES ARE TO BE PROVIDED IN ACCORDANCE WITH POLICY AND PROCEDURES OF FAVORED HEALTHCARE SERVICES
[ ] ALL INFORMATION ABOUT THE CLIENT IS TO BE KEPT CONFIDENTIAL, ANY NEGATIVE COMMENTS ABUT THE CLIENT SHOULD BE VOICED TO ONLY THE MANAGEMENT OF FAVORED HEALTHCARE SERVICES
[ ] YOU MUST CALL IN AT LEAST 24 HOURS PRIOR TO THE START OF YOUR SHIFT
[ ] GOOD PERSONAL HYGIENE IS REQUIRED
[ ] TWO ABSENCES WITHIN 30 DAY PERIOD THAT WAS NOT CLEARED BY FAVORED HEALTHCARE SERVICES WILL REQUIRE A WRITTEN EXCUSE OR DOCTOR'S EXCUSE DEPENDING UPON THE TYPE OF CALL IN.
[ ] AN EMPLOYEE IS REQUIRED TO MAINTAIN A PHONE OR PAGER AT ALL TIMES
[ ] AN EMPLOYEE IS REQUIRED TO WORK 1 DAY OUT OF EVERY 30 DAYS TO RETAIN ACTIVE STATUS
[ ] IT IS THE EMPLOYEE'S RESPONSIBILITY TO REPORT ALL WORK RELATED INJURIES TO FAVOR HEALTHCARE SERVICES PROMPTLY (WITHIN 24 HOURS). FAILURE TO REPORT MAY WAIVER THE RESPONSIBILITY OF FAVORED HEALTHCARE SERVICES, MAKING THE EMPLOYEE RESPONSIBLE FOR THE NEEDED CARE AND COST
[ ] A NO CALL/NO SHOW FOR A PREVIOUSLY CONFIRMED SHIFT WILL RESULT IN **TERMINATION**
[ ] FAILURE TO PROVIDE ALL REQUIRED DOCUMENTATION FOR YOU FILE (CPR, FIRST AID, TB SKIN TEST AND BACKGROUND CHECK) CAN AND WILL RESULT IN SUSPENSION UNTIL SUCH DOCUMENTS ARE OBTAINED BY FAVORED HEALTHCARE SERVICES
[ ] EXCESSIVE USE OF CELL PHONE OR BLUETOOTH OR CLIENT'S PHONE WHILE PROVIDING CARE FOR THE CLIENT CAN AND WILL RESULT IN SUSPENSION OR DISMISSAL
[ ] LEAVING WORK EARLY WITHOUT PERMISSION OR NOTIFYING FAVORED HEALTHCARE SERVICES WILL RESULT IN SUSPENSION

I, _____ (PRINT NAME) have read and understand the above policies and procedures set by Favored Healthcare Services and by signing I agree to uphold these policies and procedures.

_____ _____

EMPLOYEE SIGNATURE DATE

EMPLOYEE'S ETHICS FORM

Favored Health Care Services places more emphasis on the employee ethics, and Favored Health Care Services has established the following policies

Favored Health Care Services employees are not allowed to discuss political or religious beliefs or personal problems with the members in out center

Favored Health Care Services are not allow to accept gift or financial gratuities (tips) or personal problems with the member in our center

No employee shall engage in lending money or other items to the member: borrowing money or other items from the member

No employee shall be selling gifts, food, or other items to or other items to or for the member

No employee shall purchase any item for the member unless specified in the member care plan

Favored Health Care Services employees are not allow to bring visitors; friends, children, relatives, pets to the center.

Smoking in the center while members are in attendance is prohibited

Reporting for duty under the influence of alcoholic beverages or illegal substances is prohibited at Favored Health Care center.

Employee Signature _____ Date: _____

FHS Rep._____ Date: _____

EMPLOYMENT DRUG/ALCOHOL TESTING CONSENT AND RELEASE FORM

I hereby consent to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis, as shall be determined by (Favored Healthcare Services) _____ in order to meet with their policy regarding the selection of applicants for employment.

I further authorize and give full permission to have the Company and/or its authorized agents and physicians to send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company. I further agree to and hereby authorize the release of the results of said tests to the Company.

I understand that it is the current use of illegal drugs that would prohibit me from being employed at this Company.

I further agree to hold harmless the Company and its agents and physicians from any liability arising in whole or part, out of the collection of specimens, testing, and use of the information from said testing in connection with the Company's consideration of my application of employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone. I also understand that I am subject to random drug tests and post incident drug testing by Favored Healthcare Services, Inc. during the time of my employment.

APPLICANT:

Print Name: _____ S.S.#: _____

Signature: _____ Date: _____

WITNESS:

Print Name: _____ Signature: _____

BACKGROUND INFORMATION

Favored Healthcare Services requires that all employees must show proof of evidence of free of abuse and negligence and all employees must meet the following requirement.

Never have been shown by credible evidence (e.g. a court jury, a department investigation, or other reliable evidence) to have abused, neglected, sexually assaulted, exploited or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral or written statement to this effect obtained at the time of application;

_____ _____

Employee Full Name Date

_____ _____

Favored Health Care Services Rep. Date

EMPLOYEE ORIENTATION INSTRUCTION

Prior to working with client, all FHS employees shall be oriented in accordance with the rules and regulations of the Office of Regulatory Services, Health Care section. The orientation includes instructions in the following

FHS policies and procedures regarding its scope of services and the type clients it serves.
The employee's assigned duties and responsibilities.
Reporting client progress and problems to supervisory personnel and procedures for handling medical emergencies or other incidents that affect the delivery of services in accordance with the client's services plan.
The employee's obligations to report known exposure to tuberculosis and hepatitis to the employer.

_____ _____
Employee Name Date

_____ _____
Employee Signature Date

Employee Orientation Curriculum Form

Employee Name: _____

Date Hired: _____

Date of Orientation: _____

All FHS employees or contractors are required to receive orientation prior to performing any home care duties and this orientation is conducted by the agency administrator.
Once an employee/contractor is hired, he/she will receive orientation which includes an overview of Favored Healthcare Services program policies and procedures, as well as:

- Sensitivity training to the needs and rights of the elderly
- Client rights/responsibilities and handling of complaints and incidents
- Reporting of TB exposure
- Procedures for reporting client progress and problem to the supervisor
- Procedures for handling emergencies
- Procedures for reviewing employee job responsibilities
- Procedures for making entries in the client clinical record

Employee Signature: _____ Date: _____

Documentation of Training

Employee Name: _____
Date Hired: _____ Date of Training: _____
Name of Trainer: _____

Types of Training

1. Orientation to the Agency [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

2. FHC overview including program policies and procedures [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

3. Sensitivity to the needs/rights of the older individuals [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

4. Training in Techniques of first Aid/CPR [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

5. Member rights/elder abuse reporting Act/Advance Directives [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

6. Infection Control Procedures [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

7. Fire Safety and Accident prevention/safety [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

8. Confidentiality of member information [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

9. Medication Management [ ]
   Name of Trainer: _____
   Trainer's Credentials/Qualifications: _____
   Length of time/Duration of training: _____

10. Disaster Planning and Emergency Procedures [ ]
    Name of Trainer: _____
    Trainer's Credentials/Qualifications: _____
    Length of time/Duration of training: _____

11. Caring for client with Alzheimer's and related illnesses [ ]
    Name of Trainer: _____
    Trainer's Credentials/Qualifications: _____

Length of time/Duration of training: _____

Reference Check and Work Verification

The applicant named below has applied for a position of _____with Favored Healthcare Services, and has listed you as the previous employer. We would appreciate your assistance in verifying this applicant's employment and evaluating his/her job performance so that we can maintain our highest standard.

To be complete by the applicant

Full Name: _____

Date of Hire: _____

Your position: _____

Your hourly pay rate: $ _____

To be completed by former employer

1. Does this information above correspond with your record? Yes [ ] No [ ]

2. Would you rehire this applicant? Yes [ ] No [ ]

3. How long did the applicant work for your company? Please specify _____

4. Could you please evaluate this applicant job performance at your company?

_____

5. Could you please evaluate this applicant job performance at your company?

_____

FHS Rep. Date