

I understand that Barfield Health Care (BHC) requires certain information about me to evaluate my qualifications for employment and to conduct its business if I become an employee. Therefore, I authorize the company to investigate my past employment, conduct criminal history investigation, educational credentials and other employment-related activities. I agree to cooperate in such investigations, and release those parties supplying such information to BHC from all liability or responsibility with respect to information supplied.

I understand that any false answers or statements made by me on this application or any supplement thereto or in connection with the above mentioned investigations will be sufficient grounds for immediate discharge, if I am employed.

I agree that BHC may use the information it obtains concerning me in the conduct of its business. I understand that such use may include disclosure outside BHC in those cases where its agents and contractors need such information to perform their functions, where BHC's legal interests and/or obligations are involved, or where there is a medical emergency involving me. I hereby release BHC from any liability and agree to hold harmless any employee of BHC who furnishes such information.

I understand that employment could be subject to a drug test by a health care provider designated by BHC.

If I am employed and at any time suffer personal injuries for which I shall make a claim, I hereby agree to submit myself to examination by any doctor or doctors selected by BHC and as often as deemed necessary and requested. Any failure on my part to comply with this request shall result in my claim being considered waived and any legal action abated. I further agree that in case of injury, where insurance is carried under an employer's compensation law, to waive all actions for damages and accept said insurance as applicable with local, state and federal law.

If hired, I agree to abide by Company policies, rules and regulations.

I understand that employment is "at will". Employment is not for a fixed time and may be discontinued, with or without notice or cause, by myself or BHC. I understand that no employee, officer, representative or publication may obligate BHC to anything contrary to the above.

This application must be completed in full for consideration. It will be kept active for a period of 60 days after which you must resubmit it in order to continue to be considered for employment. Please attach any additional information you wish to present to BHC.

It is our policy to provide employment, training, compensation, promotion and other conditions of employment based on qualifications, without regard to race, religion, national origin, sex, age, veteran status, or physical or mental handicap unrelated to ability to the work required. We are an Equal Opportunity Employer.

Date _____ Applicant's Signature _____

Barfield Health Care, Inc.

(An Equal Opportunity Employer)

Application For Employment

To Applicant: We deeply appreciate your interest in Barfield Health Care and assure you that we are sincerely interested in your qualifications. Please answer all of the following questions accurately and completely.

Referral Source: Advertisement Walk-In Employee: _____
 Relative: _____ Government Employment Agency
 Private Employment Agency Other: _____

Position(s)/Department(s) Applied For: RN Nurse Aide Training Housekeeping
 LPN Dietary Laundry
 Certified Nurse Assistant Other: _____

Starting Salary Desired: _____ Today's Date: _____

Personal Information

Name _____ Social Security # _____
Last First Middle Initial

Present Address

P.O. Box/Street _____ City/State _____ Zip _____

Home Phone _____ Cell # _____ E-mail _____

How long at present address? _____ If you cannot be reached at the above number where may we contact you?

Name of Person/Company _____ Phone Number _____ Emergency Number _____

If your former employment references or Education records are under a name other than listed above, please indicate:

_____ Maiden _____ Additional Last Names _____

Have you been previously employed by Barfield Health Care? Yes No If yes, Position _____ Dates _____

Do you have any relative(s) or friend(s) currently employed here? Yes No

If yes, please note name and relationship: _____

Are you at least 16 years of age? (Need for work permits as applicable) Yes No

Are you legally eligible for employment in the United States? Yes No
(Proof of U.S. citizenship or immigration status will be required upon employment)

Date available for work _____ Will you work overtime if required? Yes No

Type of employment desired: Full-Time Part-Time Temporary PRN

If your working hours are restricted, please specify hours available for work _____

If required, will you undergo a pre-employment physical, which could include a drug test? Yes No

Excluding minor traffic violations, have you ever been convicted of a crime? Yes No

If yes, describe in full: _____
(A conviction will not necessarily disqualify you from consideration for employment)

Employment History

List your last four (4) employers, assignments or volunteer assignments, start with the most recent, including military experience. Explain gaps of employment in comment section below.

Company Name & Address:		Type of Business:		Phone #:		
From		Describe in detail the work you did (position, duties, type of work)	Starting hourly rate	Last hourly rate	Reason for Leaving	Name of Supervisor
Month	Year					
To						
Month	Year	May we contact your former employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name & Address:		Type of Business:		Phone #:		
From		Describe in detail the work you did (position, duties, type of work)	Starting hourly rate	Last hourly rate	Reason for Leaving	Name of Supervisor
Month	Year					
To						
Month	Year	May we contact your former employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name & Address:		Type of Business:		Phone #:		
From		Describe in detail the work you did (position, duties, type of work)	Starting hourly rate	Last hourly rate	Reason for Leaving	Name of Supervisor
Month	Year					
To						
Month	Year	May we contact your former employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name & Address:		Type of Business:		Phone #:		
From		Describe in detail the work you did (position, duties, type of work)	Starting hourly rate	Last hourly rate	Reason for Leaving	Name of Supervisor
Month	Year					
To						
Month	Year	May we contact your former employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Comments (explain gaps in employment): _____

Record Of Education

School	Name of School & Location	Course of Study	Did You Graduate?	List Diploma or Degree
High School			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> GED	
College			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (Specify)			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Professional Licenses and Certifications:

Type of License	State Issued	Date Issued	License Number

Personal References

Please list three (3) personal references you have known at least one year (not former employers or relatives.)

Name and Occupation	Address	Phone Number

List professional, trade, business or civic associations and any offices held. (Exclude memberships which would reveal sex, race, religion, national origin, age, ancestry, handicap or other protected status.)

Organization	Offices Held

List special accomplishments, publications, awards. (Exclude information which would reveal sex, race, religion, national origin, age, ancestry, handicap or other protected status.)

List any additional information you would like us to consider, including skills and qualifications acquired from employment or other experiences that may qualify you for work with our Nursing Facility.

Do you meet the qualifications and have the ability to perform the essential job functions in which you are applying?

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