



ANGEL HEALTHCARE



5828 Balcones Dr., #105 – Austin, TX 78731 *  115 E. Travis St., #445 – San Antonio, TX 78205 **

(512) 453-6449 – Austin-Main phone ♦ (512) 453-6490 – FAX ♦ e-mail - info@angelhealthcare.com
(210) 225-8016–San Antonio♦ (512) 930-4135-Georgetown♦ (512) 352-6449-Taylor♦ (512) 847-1266-Wimberley
(254) 881-1907–Waco ♦(817) 877-1332–Ft. Worth ♦(214) 522-1332-Dallas ♦(713) 622-4115–Houston

(date hired ___/___/___) *-for office use only*

APPLICATION

for office use only- (Wage \$____.____ / hr.)

Date ___/___/___ Name _____ Maiden Name _____
(Last) (First & Middle)

Address: _____ City _____ ST ___ Zip _____

Social Security # _____ - _____ - _____ TX Drivers License # _____ e-mail: _____

Phone # where we may call you (Day) _____ (Evening) _____ (cell/other) _____

Are you a U.S. citizen? Yes _____ No _____ (If No, List Work Permit # _____ and Visa # _____)

In which states are you currently (or have been) licensed/certified? _____

Have you ever been denied a license/certification? Yes _____ No _____ Has it ever been revoked or suspended? Yes _____ No _____

Have you ever been convicted of, or are you presently being charged or under indictment for a Felony Crime in any state? Yes _____ No _____

Have you ever been convicted of, or are you presently being charged with or under indictment for a Misdemeanor in any state? Yes _____ No _____

Has there ever been a complaint registered against you with any state licensing or certification board or agency? Yes _____ No _____

Have you ever received worker’s compensation or payment for an on-the-job injury? Yes _____ No _____ Have you ever been, or are you currently a party to any lawsuit involving negligence or personal injury? Yes _____ No _____

If Yes to any question(s) above, please explain _____

Do you have your own transportation? Yes _____ No _____ (If no, explain how you will get to work) _____

Auto Insurance Carrier _____ Policy # _____ Expiration _____

In case of emergency, who would we notify? Name(s) _____

Relationship _____ Phone(s) _____

Address _____

The law requires Angel HealthCare to conduct a criminal history investigation, and to check the Nurse Aide Registry and Employee Misconduct Registry maintained by DADS. I understand that as an applicant I will be subject to Senate Bill 332 (H.B. 1466) which mandates that persons convicted of certain crimes may not be employed; and I further understand that failure to disclose any relevant background information may result in rejection or termination. An employee cannot be employed if listed in the misconduct registry. _____ (applicant’s initials)

Angel HealthCare routinely contacts an applicant’s current and former employers for reference checks and in addition verifies licensure/certification status. Would this pose any difficulties for you? Yes _____ No _____ (If yes, please explain) _____

In compliance with Federal and State equal opportunity laws, qualified applicants are considered for all positions without regard to age, race, gender, religion, sexual orientation, marital status, or the presence of non-job related medical condition or handicap.

If faxing your application, send to (512) 453-6490, if e-mailing send to: mollie@angelhealthcare.com



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EMPLOYMENT RECORD

Current or last employer _____ Type of Business _____

Supervisor's Name _____ Supervisor's Title/Dep't _____

Address _____ Telephone # _____

Job Title _____ Start Date _____ Salary \$ _____ End Date _____ End Salary \$ _____

Brief Description of Your Duties _____

Reason For Seeking Change _____

Previous employer _____ Type of Business _____

Supervisor's Name _____ Supervisor's Title/Dep't _____

Address _____ Telephone # _____

Job Title _____ Start Date _____ Salary \$ _____ End Date _____ End Salary \$ _____

Brief Description of Your Duties _____

Reason For Seeking Change _____

Previous employer _____ Type of Business _____

Supervisor's Name _____ Supervisor's Title/Dep't _____

Address _____ Telephone # _____

Job Title _____ Start Date _____ Salary \$ _____ End Date _____ End Salary \$ _____

Brief Description of Your Duties _____

Reason For Seeking Change _____

Previous employer _____ Type of Business _____

Supervisor's Name _____ Supervisor's Title/Dep't _____

Address _____ Telephone # _____

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Brief Description of Your Duties _____

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EDUCATION/TRAINING

Name of School	City/State	Dates Attended	Course of Study	Diploma or Degree
High School(s)				
Trade School(s)				
College(s)				
Other (Specify)				

Extracurricular Activities in School: _____

Professional Organization Memberships, Honors Received, Volunteer or Community Service or other Qualifications you have which you feel are related to the position for which you are applying: _____

MILITARY RECORD

Military Service: Branch _____ Location _____ Dates of Service _____
Entry Rank _____ Separation Rank _____ Occupational Specialty _____

Reserve Duty: Branch _____ Location _____ Dates of Service _____

Are there any required reserve duties that limit your availability to work? Yes _____ No _____ (If yes, please explain)

PROFESSIONAL LICENSES / CERTIFICATIONS

Type _____ Issued by _____ Date Issued _____ Number _____ Exp Date _____

Type _____ Issued by _____ Date Issued _____ Number _____ Exp Date _____

(For Interviewer's Use Only): Credentials Verified by _____ Date _____

Texas Prof. License (type and #) _____ Exp. Date _____

Nurse Aide Registry: C.N.A. Cert # _____ Name on Cert. _____

Exp Date _____ Listed but not employable as CNA _____ Not Listed _____

Employee Misconduct Registry Check: Not Listed _____ Listed (reason) _____



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BUSINESS SKILLS

Do you have language/translation skills, spoken or written, that could help us communicate with non-English speaking patients?

Yes _____ No _____

Languages (other than English) Spoken _____ Written _____

SCHEDULE FLEXIBILITY

Day	From:	To:
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Are you available to work: Weekends _____ Holidays _____ Rotating Shifts _____ On-Call _____

I understand that emergency conditions may require me to temporarily work shifts other than the one(s) for which I am applying, and I agree to such scheduling changes as directed by department heads. If my availability status changes, I understand it is my responsibility to notify the department head. _____ (applicant's initials)

Angel HealthCare does not discriminate in hiring or any other decision on the basis of race, religion, color, sex or sexual orientation, citizenship, national origin, ancestry, Vietnam era veteran status, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I understand that my employment or contractual relationship is at will, and that either party is free to terminate the employment or contractual relationship at any time without cause. I also understand that my employment/contractual relationship may be terminated for any misstatement or omission of fact appearing on this application form. I also understand all documents I sign or verbally agree to in the cause of my employment are the exclusive property of Angel Healthcare and I will not receive a copy of said documents

I voluntarily give Angel HealthCare the right to make a thorough investigation on my past employment and credit history and activities, agree to cooperate in such investigations and release from liability or responsibility all persons, companies, or corporations supplying such information. To expedite such investigation, I furnish the following list of other names I have been known by at any time (List names or put "none" if not applicable) _____.

I agree to take the physical examination and/or answer medical examination questionnaire, and such future physical examinations (including drug tests) as may be required by agency, which relate to the essential duties I would be required to perform. I will be required to complete an Employment Verification Form (I-9) and show satisfactory evidence of identity and eligibility for employment.

I understand that this is part time work on an as needed basis, not a permanent position. There are no guaranteed minimum hours or days of work promised. I understand that my pay rate may vary depending on the client that I am assigned to. _____

Angel Healthcare, LP / FCHN LLP has elected not to obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. Contact the Division of Workers' Health & Safety at 1-800-452-9595. Notice 5 (Rev. 07/00) TEXAS WORKERS' COMPENSATION COMMISSION Rule 110.101

Applicant's Signature _____

Date _____

DPS 10/08

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