

| JOB/EMPLOYMENT APPLICATION | |
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| Personal Information | |
| Name | First _____ Middle Initial _____ Last: _____ |
| Address | Street: _____ Apt/FI/Ste: _____ City: _____ State: _____ Zip: _____ |
| Phone | Home: _____ Cell: _____ Other: _____ |
| Electronic | Email Address: _____ |
| Date of Birth | Month: _____ Day: _____ Year: _____ |
| SSN | Social Security Number: _____ |
| Gender | Male: _____ Female: _____ |
| Language | What languages do you speak? _____ _____ |
| Emergency Contact | Name & Phone Number of Person to contact in the event of an emergency: Local: _____ Out-of-Area: _____ |
| Position | |
| Type of Position(s) Preferred | <p><u>Circle all that apply. Complete other application sections with corresponding number for the company you're applying.</u></p> <p>1. Larock Home Health: HHA/STNA LPN RN PT OT ST SW</p> <p>2. Larock Home Care: HHA/STNA LPN RN PT OT ST SW Caregiver</p> <p>3. Larock Healthcare Academy: Program Coordinator Primary Instructor Clinical Instructor</p> <p>4. Other: Billing Office Marketing</p> |
| Education - (1, 2, 3 & 4) | |
| Formal | Diploma: _____ Certificate: _____ Degree: _____ License: _____ Other: _____ |

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|---|---|-----------------------------|-----------------------------|---------------|------------|--------------------------|---------------|----------------------------|-------------|-------------------------|--|----------------|-------------------------|---|--|
| Informal | Do you have current First Aid Certification: _____ Expiry Date: _____ Do you have current CPR? _____ Expiry Date: _____ Have you taken a Food Safety course? _____ Other: _____ <i>(Specify)</i> Other: _____ <i>(Specify)</i> | | | | | | | | | | | | | | |
| Restrictions - (1 & 2) | | | | | | | | | | | | | | | |
| Work Limitations | List any work limitations that you may have and briefly describe: Hearing: ___ Yes ___ No _____ Speech: ___ Yes ___ No _____ Lifting: ___ Yes ___ No _____ Health: ___ Yes ___ No _____ Physical: ___ Yes ___ No _____ Emotional: ___ Yes ___ No _____ Other: ___ Yes ___ No _____ | | | | | | | | | | | | | | |
| Availability for Work - (1, 2, 3 & 4) | | | | | | | | | | | | | | | |
| Hours & Days Available for Work | _____ Full-time _____ Part-time/PRN _____ Short-notice _____ Split Shift Indicate Days and List Hours Available for Work: _____ Sunday: From: _____ To: _____ _____ Monday: From: _____ To: _____ _____ Tuesday: From: _____ To: _____ _____ Wednesday: From: _____ To: _____ _____ Thursday: From: _____ To: _____ _____ Friday: From: _____ To: _____ _____ Saturday: From: _____ To: _____ What is the minimum number of hours you will work in one day? _____ What is the maximum number of hours you will work in one day? _____ | | | | | | | | | | | | | | |
| Client Types and Work Duties - (1 & 2) | | | | | | | | | | | | | | | |
| Clients <u>Not</u> Willing/Able to Work With | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">_____ Dementias/Alzheimer's</td> <td style="width: 50%;">_____ Physical Disabilities</td> </tr> <tr> <td>_____ Smokers</td> <td>_____ Pets</td> </tr> <tr> <td>_____ Mental Retardation</td> <td>_____ Females</td> </tr> <tr> <td>_____ Behavioral Disorders</td> <td>_____ Males</td> </tr> <tr> <td>_____ Elderly (over 65)</td> <td>_____ Client use of marijuana for medicinal purposes</td> </tr> <tr> <td>_____ Children</td> <td>_____ HIV Positive/AIDS</td> </tr> <tr> <td colspan="2">_____ Other: _____ <i>(Specify)</i></td> </tr> </table> | _____ Dementias/Alzheimer's | _____ Physical Disabilities | _____ Smokers | _____ Pets | _____ Mental Retardation | _____ Females | _____ Behavioral Disorders | _____ Males | _____ Elderly (over 65) | _____ Client use of marijuana for medicinal purposes | _____ Children | _____ HIV Positive/AIDS | _____ Other: _____ <i>(Specify)</i> | |
| _____ Dementias/Alzheimer's | _____ Physical Disabilities | | | | | | | | | | | | | | |
| _____ Smokers | _____ Pets | | | | | | | | | | | | | | |
| _____ Mental Retardation | _____ Females | | | | | | | | | | | | | | |
| _____ Behavioral Disorders | _____ Males | | | | | | | | | | | | | | |
| _____ Elderly (over 65) | _____ Client use of marijuana for medicinal purposes | | | | | | | | | | | | | | |
| _____ Children | _____ HIV Positive/AIDS | | | | | | | | | | | | | | |
| _____ Other: _____ <i>(Specify)</i> | | | | | | | | | | | | | | | |
| Assignment Location | Are you restricted in the geographical location you are willing/able to work? ___ Yes ___ No Explain: _____ | | | | | | | | | | | | | | |
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| Transportation – (1 & 2) | |
| Type | <input type="checkbox"/> Private Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Bike <input type="checkbox"/> Other: _____ <i>(Specify)</i> |
| License / Insurance | Do you have a valid Driver's License? _____ DL Number: _____ Do you have a valid auto insurance policy? _____ Provider: _____ |
| Transporting Clients | Are you willing to transport clients in your private vehicle? _____ Are you willing to drive a client's vehicle? _____ Are you willing to escort a client in their own vehicle? _____ Are you willing to escort a client on public transportation? _____ Comments: _____ |
| Criminal Conviction – (1, 2, 3 & 4) | |
| Convictions | Have you ever had a criminal conviction, including a misdemeanor or felony, or had a civil judgment rendered against you? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain: _____ _____ |
| Reference Information – (1, 2, 3 & 4) | |
| Work Related #1 (Last Position) | Company Name _____ Address: _____ Telephone No. & Email Address: _____ Supervisor's Name _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____ |
| Work Related #2 (2nd Last Position) | Company Name _____ Address: _____ Telephone No. & Email Address: _____ Supervisor's Name _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____ |
| Work Related #3 (3rd Last Position) | Company Name _____ Address: _____ Telephone No. & Email Address: _____ Supervisor's Name _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____ |
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|----------------------------|--|
| Personal #1 | Name _____ Address: _____ Telephone No. & Email Address: _____ Relationship: <i>(friend, co-worker, family etc.)</i> _____ <i>(Other than relative.)</i> |
| Personal #2 | Name _____ Address: _____ Telephone No. & Email Address: _____ Relationship: <i>(friend, co-worker, family etc.)</i> _____ <i>(Other than relative.)</i> |

I certify that, to the best of my knowledge, the answers given are true and complete and that purposeful misrepresentation may result in rejection of my application. I authorize investigation of all statements contained in this application, as required. Additionally, I authorize former employers, references and any other individual/organizations to provide information to **Larock, LLC**, DBA Larock Home Care LLC, Larock Home Health LLC, Larock Healthcare Academy LLC and I hereby release and discharge any of the above and **Larock, LLC**, DBA Larock Home Care LLC, Larock Home Health LLC, Larock Healthcare Academy LLC from any liability of any kind or nature. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary

I agree to a physical examination, if requested, and understand that failure to meet any medical and/or health requirements for the position may prevent my employment with the Agency. I also understand that employment, for certain positions, and may be conditional upon successful completion of a substance abuse screening test, if part of the Agency's pre-employment policy.

I understand that, if hired, I may be required to provide proof that I am a citizen of the United States or proof that I am currently authorized to work in the United States.

Applicant's Signature

Date

PLEASE RETURN THE COMPLETED DOCUMENT TO ONE OR MORE OF THE FOLLOWING:

Email: careers@larockllc.com
Mail: PO Box 4384 Copley, OH 44321 or PO Box 164293 Columbus, OH 43216
Fax: (614) 675-2552