9521 Business Center Drive Suite 9-101
Rancho Cucamonga, CA 91730
Tel.(909)945-9899 Fax(909)945-9799

Employee Application Form

Today's Date: ________________ Social Security Number: ______________________

Name: ____
(last) (first) (middle)

Address: ____

Birth Date: ________________________ Driver's License No.: ______________________

Citizenship: _______________________ Legal Resident Card No.: __________________

Tel. No.: (______)___________________ Cell No.: (______)___________________________

Fax No.: (______)___________________ Email: __________________________________

Language Spoken: ____

Emergency Contact Person: _________________________ Relation: ________________

Address: ____________________________________ Contact No.: (______)___________

Are you legally permitted to work in the United States? ☐ Yes ☐ No
Have you used name other than your present name? ☐ Yes ☐ No
Have you ever been convicted of a felony or misdemeanor? ☐ Yes ☐ No
If yes, please explain:____
Have you previously been employed by this agency? ☐ Yes ☐ No
How did you learn about the company? ☐ Friend ☐ Ads ☐ Internet

PROFESSIONAL LICENSE / CERTIFICATION:

Type	Number	State Issued	Date Issued	Expires on	Verified by

EDUCATIONAL HISTORY:

High school: ______________________________________ Year Graduated: ________
(School name) (Location)

College: ____ Year Graduated: ________
(School name) (Location)

Other Courses: _____________________________________ Year Graduated: ________
(School name) (Location)

Have you been in the U.S. Armed forces? ☐ Yes ☐ No

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JOB INTEREST:

Position Applied: ______________Date Available: _________ Desired Salary: ___________
Preferred Area of visit: ____
Hours & Shift Available:

☐ Full time ☐Part time ☐On call ☐Days ☐Nights ☐Weekends

EMPLOYMENT HISTORY:

Company Name: _____________________________________ Date Employed:______________
Address: ____ Position: _____________________
Tel. No.: (_____)____________ Fax No.: (_____)____________ End Salary: $_______________
Reason for leaving: ____

Company Name: _____________________________________ Date Employed:______________
Address: ____ Position: _____________________
Tel. No.: (_____)____________ Fax No.: (_____)____________ End Salary: $_______________
Reason for leaving: ____

Company Name: _____________________________________ Date Employed:______________
Address: ____ Position: _____________________
Tel. No.: (_____)____________ Fax No.: (_____)____________ End Salary: $_______________
Reason for leaving: ____

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and I agree to have any of the statement checked by Allstar Health Providers, Inc. unless I have indicated to the contrary. I authorized the reference listed to provide Allstar Health Providers, Inc. any and all information concerning my previous employment and any pertinent information that they may need. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to Allstar Health Providers, Inc. as well as the use of disclosure of such information by Allstar Health Providers, Inc. or any of its agents, employees or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or if I am hired, in my dismissal from employment.

In consideration of my employment, I agree to the rules and standards of Allstar Health Providers, Inc. and agree that my employment and compensation may be terminated, with or without cause, and with or without notice at any time, either at my option or at the option of Allstar Health Providers, Inc. I understand that no employee or representative of the agency other than the Director of Human Resources and the Administrator has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing. Further, Allstar Health Providers, Inc. may not alter the at-will nature of the employment relationship unless it does so specifically in writing. I also understand that all offers of employment are conditioned on the provision of satisfactory proof of the applicant's identity and legal right to work in the U.S.

I understand that any offer of employment with Allstar Health Providers, Inc. may be conditioned completing a pre-employment medical examination. Purpose of medical examination is to determine whether I am able to perform the essential function of the job I am offered with or without reasonable accommodation, to identify any reasonable accommodation if such is warranted, and to ensure that my performance of the essential functions of the job does not present a direct threat to my health and safety of others. I agree to undergo such pre-employment medical examination. If hired by Allstar Health Providers, Inc., I further agree to undergo any periodic medical examinations, which are permitted or required by law.

Allstar Health Providers, Inc. complies with the Federal and State Laws, which prohibits discrimination on the basis of race, color, age, sex, religion, national origin, ancestry, disability or handicap, veteran status, medical condition (as defined by California law), sexual orientation and marital status.

____
Applicant Signature over Printed Name Date

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VERIFICATION OF EMPLOYMENT

Name of Applicant: ______________________________________ SSN: ________________
Employer's Name: ____
Address: ____
City: _________________________ State: _____________ Zip Code: ________________
Tel. No.: (____)____________Fax No.: (____)_____________Contact name: ___________
Employed From: ________ to _________ Position Held: __________________________
Reason for Leaving: ____
____
____

I hereby authorize the above-mentioned company to release information pertaining to my previous / current employment.

____

Signature of Applicant Date

The person whose signature appears above has applied for a position with Allstar Health Providers, Inc. Please verify the information given. Thank you for your prompt attention.

☐ Some information listed above is not in accordance with our record. The correct information is listed below under the remarks.

☐ I verify that the above information is true and correct to the best of my knowledge.

Verified by:

Signature: __________________________

Name: ______________________________

Position: ____________________________

Date: _______________________________

Remarks: ____
____
____

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REFERENCE VERIFICATION

Name of Applicant: ____ SSN: __________________
Address: ____
City: ______________________________ State: ________________ Zip Code: __________________
Tel. No.: (_____)______________Fax No.: (____)________________ Email: ___________________

I hereby authorize the persons below whom I named as my references to release/ give information pertaining to myself.

____
Applicant Signature   Date

(1) REFERENCE

Name: ____
Address: ____
City: ______________________________ State: ________________ Zip Code: __________________
Tel. No.: (_____)________________ Relationship to Applicant: ______________________________

Verified by: _______________________________________ Date: ________________________________
Comment: ____
____
____

(2) REFERENCE

Name: ____
Address: ____
City: ______________________________ State: ________________ Zip Code: __________________
Tel. No.: (_____)________________ Relationship to Applicant: ______________________________

Verified by: _______________________________________ Date: ________________________________
Comment: ____
____
____

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AUTHORIZATION TO OBTAIN EDUCATIONAL AND CLINICAL BACKGROUND INFORMATION

Applicant's Name: ___________________________________ SSN: ________________________

Name of Institution: ____

Address: ____

Tel. No.: (_______)_________________________ Fax No.: (________)_________________________

Year Attended: From ____________________________ To __________________________________

I, the above named applicant have applied for employment with Allstar Health Providers, Inc. In order to ensure that my qualifications are consistent with the job requirements, I authorized Allstar Health Providers, Inc. and/or any entity directed by Allstar Health Providers, Inc. to obtain all information relating to my education or any other information pertinent to my employment from educational institutions, present or past employer, supervisor, hospital or medical facility. I understand that this report will include my training, performance, and experience obtained through written verification and/or personal interview with associates who have knowledge concerning such information. I authorize all employers, educational institutions and/or any other persons or entities having information about my education and training to provide the information to Allstar Health Providers, Inc.
I further fully release Allstar Health Providers, Inc. and it's employees, officers, directors, agents and assigned parties involved in this background investigation from any claims or actions and liabilities whatsoever related to the process or results of the background investigation.

____
Signature   Date

Verifying Institution Representative: ____

Title: ____ Date: ___________________________________

Comments: ____

____

____