NEW CARE HEALTH PARTNERS LLC
EMPLOYMENT APPLICATION

Employer: NEW CARE HEALTH PARTNERS LLC
Address: 7 GLENWOOD AVE 414D
City/State/ZIP: EAST ORANGE, NEW JERSEY 07017
Telephone: 862-233-6274 Fax: 862-438-8451 Email: newcarehp@gmail.com

It is the policy of NEW CARE HEALTH PARTNERS LLC to provide equal employment opportunities to all applicants and employees without regard to any legally protected status such as race, color, religion, gender, national origin, age, disability or veteran status.

1.) **Applicant Information**

Applicant Full Name: ____

Home Address: ____

City/State/ZIP: ____

Number of years at this address: _________

Daytime phone: ____________________ Evening phone: ____________________

Mobile phone: ____________________

Social Security Number: ___________________________ Date of Birth_______________

Driver's License (State/Number): ___________________________

2.) **Emergency Contact**

Who should be contacted if you are involved in an emergency?

Contact Name: ____

Relationship to you: ____

Address: ____

City/State/ZIP:____

Daytime phone: ____________________ Evening phone: ____________________

3.) Who referred you to the company? ____

Do you have any friends or relatives who work here? If yes, please list here:

____

4.) Have you applied to our company previously? ______ Yes ______ No

If yes, when?_________________________

5.) Are you at least 18 years old? ______ Yes ______ No

6.) Have you ever been convicted of a felony or misdemeanor? ________YES _______NO

If yes, I was convicted of___________________________________(date) _____________

(city)_______________________ (state)_______________________

7.) Are you willing to undergo a state / federal criminal background check? ___YES ___NO

8.) If you are offered employment, when would you be available to begin work?

____

9.) If hired, are you able to submit proof that you are legally eligible for

employment in the United States? _____ Yes _____ No

Please submit / attach a copy of your social security card

10.) **Applicant Employment History**

List your current or most recent employment first. Please list all jobs (including self-employment and military service) which you have held, beginning with the most recent, and list and explain any gaps in employment.

Employer Name: ____

Supervisor Name:____

Address:____

City/State/ZIP:____

Job Duties:____

Reason for Leaving:____

Dates of Employment (Month/Year): ______________________________

Employer Name: ____

Supervisor Name:____

Address:____

City/State/ZIP:____

Job Duties:____

Reason for Leaving:____

Dates of Employment (Month/Year): ______________________________

Employer Name: ____

Supervisor Name: ____

Address: ____

City/State/ZIP: ____

Job Duties: ____

Reason for Leaving: ____

Dates of Employment (Month/Year): ______________________________

11.) **Applicant's Education and Training**

College/University Name and Address

____

Did you receive a degree?______ Yes _____ No If yes, degree(s) received:___________

High School/GED Name and Address

____

Did you receive a diploma?______ Yes _____ No

Other Training (graduate, technical, vocational):

____

Please indicate any current professional licenses or certifications that you hold:

____

12.) **References**

List two professional references who would be willing to provide a reference for you.

Name: ____________________________________

Address:____________________________________

City/State/ZIP:____________________________________

Telephone:________________________

Name:____________________________________

Address:____________________________________

City/State/ZIP:____________________________________

Telephone:________________________

CERTIFICATION

I certify that the information provided on this application is truthful and accurate. I understand that providing false or misleading information will be the basis for rejection of my application, or if employment commences, immediate termination.

I authorize NEW CARE HEALTH PARTNERS LLC to contact former employers and educational organizations regarding my employment and education. I authorize my former employers and educational organizations to fully and freely communicate information regarding my previous employment, attendance, and grades. I authorize those persons designated as references to fully and freely communicate information regarding my previous employment and education.

If an employment relationship is created, I understand that unless I am offered a specific written contract of employment signed on behalf of the organization by its Director, the employment relationship will be "at-will." In other words, the relationship will be entirely voluntary in nature, and either I or my employer will be able to terminate the employment relationship at any time and without cause. With appropriate notice, I will have the full and complete discretion to end the employment relationship when I choose and for reasons of my choice. Similarly, my employer will have the right. Moreover, no agent, representative, or employee of NEW CARE HEALTH PARTNERS LLC, except in a specific written contract of employment signed on behalf of the organization by its director, has the power to alter or vary the voluntary nature of the employment relationship.

I HAVE CAREFULLY READ THE ABOVE CERTIFICATION AND I UNDERSTAND AND AGREE TO ITS TERMS.

________________________________ ________________

APPLICANT SIGNATURE **DATE**