

# Application for Employment

Honeyflower Holdings, LLC dba Arlington Gardens Care Center is an Equal Opportunity Employer. All employment decisions are made without regard to unlawful considerations of race, sex, sexual orientation, gender, gender identity, gender expression, religion, national origin, ancestry, age, mental or physical disability, medical condition, genetic information, military or veteran status, or any other status protected under federal, state or local laws or regulations. Reasonable accommodations are available to qualified disabled individuals, upon request.

## Personal Information

Date \_\_\_\_\_ Name \_\_\_\_\_

Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Are you at least 18 years of age?  Yes  No If no, can you furnish a valid work permit?  Yes  No

Position applied for: \_\_\_\_\_

Type of employment desired:  Full-Time  Part-Time  Temporary  On Call

Are there any hours, shifts, or days you cannot or will not work? \_\_\_\_\_

Please indicate specific days and/or hours

Are you willing to work overtime as required?  Yes  No

Have you ever been employed with Honeyflower Holdings, LLC dba Arlington Gardens Care Center in the past?  Yes  No

Are you related to anyone employed at Honeyflower Holdings, LLC dba Arlington Gardens Care Center?  Yes  No If so, whom? \_\_\_\_\_

After being offered employment with Honeyflower Holdings, LLC dba Arlington Gardens Care Center, will you be able to provide documentation of your legal right to work in the United States?  Yes  No (As a condition of employment, successful candidates must provide written documentation to prove either citizenship or proper authorization to work in the United States. Specific instructions will be provided prior to your first day of employment regarding legally required documentation.)

## Licensure/Certification

Do you currently hold a valid professional license or certification?  Yes  No

If yes, note type(s):  Registered Nurse  LVN  CNA  PT  ST  OT

State: \_\_\_\_\_ Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

## Education, Training and Experience

School	Name, City, State, Country	How many years completed (select box)	Major	Diploma/Degree
High School		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		<input type="checkbox"/> Diploma or GED Certificate
College/University		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+		<input type="checkbox"/> Degree
Graduate School, Technical Trade School, other		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+		<input type="checkbox"/> Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Degree

## Driver Information – for drivers only

Please complete this section only if you will be driving a company-owned vehicle, or will be driving frequently on company business (excluding your regular commute to and from work) using a personally owned vehicle or rental car.

Drivers License #:		State of Issuance:	
Name on License:		Class of License (circle one):	A   B   C   D   E
Expiration Date:			

Have you ever been denied a license or permit to operate a motor vehicle?  Yes  No

Has your drivers' license ever been suspended or revoked?  Yes  No

**Employment History**

List present and past employment, including military experience, starting with most recent employer. Account for all periods of unemployment. You must complete this section even if submitting a resume.

<b>Most Recent Employer</b>		Address	Telephone
Name of Supervisor	Positions Held	Reasons for Leaving	
Date Started	Date Left		
<b>Previous Employer</b>		Address	Telephone
Name of Supervisor	Positions Held	Reasons for Leaving	
Date Started	Date Left		
<b>Previous Employer</b>		Address	Telephone
Name of Supervisor	Positions Held	Reasons for Leaving	
Date Started	Date Left		

**References**

List three persons not related to you who have knowledge of your work performance within the past three years.

Name	Telephone Number	Occupation	# of Years Acquainted
1.			
2.			
3.			

**Applicant's Certification and Agreement**

I understand and agree that nothing contained in this application packet or in the hiring process is intended to create an employment contract. I understand that no representation, whether oral or written, by any representative or agent of Honeyflower Holdings, LLC dba Arlington Gardens Care Center, at any time, can constitute an implied or express contract of employment. If I am offered and accept employment, I agree to abide by the Facility's policies and procedures and employee handbook. IF HIRED, I UNDERSTAND AND AGREE THAT MY EMPLOYMENT WILL BE AT-WILL AND MAY BE TERMINATED AT THE OPTION OF EITHER Honeyflower Holdings, LLC dba Arlington Gardens Care Center OR MYSELF, AT ANY TIME, WITH OR WITHOUT CAUSE OR ADVANCE NOTICE. In connection with this at-will policy, I understand that Honeyflower Holdings, LLC dba Arlington Gardens Care Center reserves the right to alter my position and to impose any form of discipline it determines is appropriate, at any time, at its sole discretion. I further understand that the at-will employment relationship cannot be altered unless it is done specifically, in writing, and signed by the President of the Company.

I understand and agree that I must meet all the physical standards established by Honeyflower Holdings, LLC dba Arlington Gardens Care Center to perform the essential functions of any job for which I am offered employment. I understand that if offered employment I am required to complete a Post-offer, Pre-employment Health Questionnaire and physical examination. I also understand that during employment I might from time to time be subjected to physical examinations and/or physical ability tests to demonstrate that I can perform the essential functions of my job.

Honeyflower Holdings, LLC dba Arlington Gardens Care Center reserves the right to conduct searches on Honeyflower Holdings, LLC dba Arlington Gardens Care Center property or of Honeyflower Holdings, LLC dba Arlington Gardens Care Center's property, vehicles and/or equipment at any time. I further understand that if I refuse to submit to Honeyflower Holdings, LLC dba Arlington Gardens Care Center's search I may be terminated.

By signing below, I hereby certify that all of the foregoing information I have supplied in this application is correct and complete. I understand that any falsification of information will constitute grounds for immediate dismissal upon discovery thereof. I give Honeyflower Holdings, LLC dba Arlington Gardens Care Center permission to contact any or all of my previous employers and references for full information and hereby release it from any and all liability for doing so:

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Legal Name

\_\_\_\_\_  
Date

# Equal Employment Opportunity Data

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## SECTION A: To Be Completed by Applicant

Completion of the following information is voluntary, and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodation, please check where applicable.

Name: \_\_\_\_\_

Gender:  Male  Female

Race/Ethnicity: (Please choose only one. For detail descriptions, see reverse.)

- American Indian or Alaskan Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Hispanic or Latino
- Two or more races

Government contractors must take affirmative action to employ and advance certain qualified individuals subject to the Rehabilitation Act of 1973 and the Vietnam Era Veterans Readjustment Act of 1974. Completion of the following information is voluntary, and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodation, please check where applicable.

- Vietnam Era Veteran
- Disabled Veteran
- Individual with a Disability

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## SECTION B: To Be Completed by Employer

(Please choose only one. For detailed descriptions, see reverse.)

EE0-1 Category:

- |   |   |
|---|---|
| <input type="checkbox"/> 1a. Officials and managers-Exec & Senior Level |   |
| <input type="checkbox"/> 1b. Officials and managers-First/Mid=Level     |   |
| <input type="checkbox"/> 2. Professionals                               | <input type="checkbox"/> 6. Crafts          |
| <input type="checkbox"/> 3. Technicians                                 | <input type="checkbox"/> 7. Operatives      |
| <input type="checkbox"/> 4. Sales                                       | <input type="checkbox"/> 8. Laborers        |
| <input type="checkbox"/> 5. Office and clerical                         | <input type="checkbox"/> 9. Service workers |

Employer Information completed by:

\_\_\_\_\_  
Name (must be legible)

\_\_\_\_\_  
Date

USE TO COMPLETE SECTION A

American Indian or Alaskan Native. A person having origins in any of the original peoples of North American and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, and Vietnam.

Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Black or African American. A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American".

White. A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

Two or more races. A person of two or more races who does not identify with one race in particular.

#### USE TO COMPLETE SECTION B

##### **1. Official and Managers**

1a. Administrator, Business Office Manager, Director of Nursing, Facility Rehab Director, Marketing Director

1b. Admissions Director, Activity Director, Asst FRD, DSD, Dietary Services Supervisor or Manager, Housekeeping Supervisor, Laundry Supervisor, Maintenance Director, Medical Records Director, Social Services Director, Sub-Acute Clinical Manager

##### **2. Professionals**

Asst. Director of Nursing (ADON), Dietitian, MDS Coordinator, Nurse Practitioner, Registered Nurses, Licensed Social Worker, Therapists (including PT, OT, Speech)

##### **3. Technicians**

Case Manager, COTA, Licensed Practical or Vocational Nurses, Phlebotomist, PT Asst, Respiratory Therapists

##### **4. Sales**

None

##### **5. Office and Clerical**

Admissions Asst, AP/Payroll, Business Office Asst, Central Supply, Concierge, DSD Asst, MDS Asst, Receptionist, Social Service Asst., Staffing Coordinator, Ward Clerk, other Admin Asst

##### **6. Crafts**

Maintenance Asst

##### **7. Operatives**

None

##### **8. Laborers**

None

##### **9. Service Workers**

Activities Asst, Certified Nursing Assistant, Cook, Dietary Aide, Dishwasher, Housekeeper, Janitor, Laundry Aide, Patient Sitter, Transportation Specialist, Rehab Tech, RNA

## Voluntary Self-Identification of Disability

Form CC-305  
OMB Control Number 1250-0005  
Expires 1/31/2017  
Page 1 of 2

### Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.<sup>1</sup> To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

### How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Autism
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Deafness
- Cerebral palsy
- Major depression
- Obsessive compulsive disorder
- Cancer
- HIV/AIDS
- Multiple sclerosis (MS)
- Impairments requiring the use of a wheelchair
- Diabetes
- Schizophrenia
- Missing limbs or partially missing limbs
- Intellectual disability (previously called mental retardation)
- Epilepsy
- Muscular dystrophy

**Please check one of the boxes below:**

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

\_\_\_\_\_  
Your Name

\_\_\_\_\_  
Today's Date

## Voluntary Self-Identification of Disability

Form CC-305  
OMB Control Number 1250-0005  
Expires 1/31/2017  
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### Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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<sup>i</sup> Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

**PUBLIC BURDEN STATEMENT:** According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

# **“PRE-OFFER” INVITATION – PROTECTED VETERANS AS REQUIRED BY 41 CFR 60-300.42(a).**

THE DEFINITIONS OF THE SEPARATE CLASSIFICATIONS OF PROTECTED VETERANS SET FORTH IN PARAGRAPH 1 MUST ACCOMPANY THIS SELF-IDENTIFICATION REQUEST. DEFINITIONS OF PROTECTED VETERANS ARE ATTACHED.

If you believe you belong to any of the categories of protected veterans listed on the attached sheet, please indicate by checking the appropriate box below.

As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS  
OF PROTECTED VETERANS LISTED ON THE ATTACHED FORM.

I AM NOT A PROTECTED VETERAN

We have a long-standing policy of Equal Opportunity in employment. Our practice is to fill positions by selecting applicants who can perform the work in a competent and professional manner. Qualified applicants are considered for employment, and employees are treated during employment, without regard to race, color, religion, sex, national origin, status as protected veteran or disability.

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NAME

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SIGNATURE

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DATE

## **DEFINITIONS OF VETERANS TO BE INCLUDED WITH SELF-ID INVITATIONS**

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

**A "disabled veteran"** is one of the following: a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; **or** a person who was discharged or released from active duty because of a service-connected disability.

**A "recently separated veteran"** means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

**An "active duty wartime or campaign badge veteran"** means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

**An "Armed forces service medal veteran"** means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA - the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at **1-866-4-USA-DOL**.



## Affirmative Action Data

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Government agencies require reports on the status of applicants. This data is for analysis and affirmative action only. Failure to supply this information will not jeopardize or adversely affect any consideration you may receive for employment or later advancement in employment. Please complete the information below to assist us in complying with Equal Opportunity Affirmative Action recordkeeping and reporting requirements. This Information Form will be kept in a separate, confidential file and will be used only for safety and government reporting purposes.

*Qualified applicants are considered for employment, and employees are treated during employment, without regard to race, color, religion, sex, national origin, genetic information, age, marital status, medical condition or disability.*

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Position applied for: \_\_\_\_\_

Gender:  Male  Female

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### Race/Ethnic Groups

- White
  - Black
  - Hispanic
  - Asian/Pacific Islander
  - American Indian/Alaskan Native
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Please identify where you learned about an employment opportunity with this organization.

- Newspaper ad
  - Employee referral
  - Walk In
  - Recruiter
  - Tech school/college
  - Temporary service
  - Internet Applicant
  - State Employment Service
  - Other
-