

Daybreak Adult Medical Day Services

Application for Employment

Daybreak Adult Medical Day Services is an Equal Opportunity Educational Institution and EEO/Affirmative Action Employer committed to excellence through diversity. Employment offers are made on the basis of qualifications and without regard to race, sex, religion, national or ethnic origin, disability, age, veteran status, or sexual orientation.

PLEASE TYPE OR PRINT. Complete the entire application. You may attach a resume, but you must still complete all questions; or your application will be deemed incomplete and may not be considered. Please fill out each box (don't just indicate "See Resume.") Applications with missing or invalid job numbers will not be considered for any position.

Position Applying For:	Name (Last, First, Middle):	Other names under which you have attended school or been employed:	
Street Address:		City, State & Zip:	
Social Security Number:	Home Phone:	Work Phone:	Other Phone:
Are you eligible to work in the United States?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you 18 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, what is your current age?	
Are you currently employed at Daybreak Adult Medical Day Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what is your current job title & department?	
Have you ever been employed by Daybreak Adult Medical Day Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, dates of employment & reason for leaving:	
Are you related to any current Daybreak Adult Medical Day Services or related Corporation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, their name & their relationship to you?	
If required for position, do you have a valid driver's license?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, State of issuance, license #, and expiration date:	
Are you able to perform the job with or without reasonable accommodations?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
How did you learn about this employment opportunity? Check all that apply:		<input type="checkbox"/> Ad in newspaper <input type="checkbox"/> Ad in magazine <input type="checkbox"/> Other:	
<input type="checkbox"/> Job Bulletin (Posting) /Walk-in <input type="checkbox"/> Referral by _____		<input type="checkbox"/> Dept. of Labor	

EDUCATION

Name of School	City/State	Did you graduate?	If No, # of years left to graduate	If Yes, date of Graduation	Degree received	Major
High School:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
GED:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other School:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
College:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
College:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
College:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other credentials/ licenses/ professional affiliations, etc., which are relevant to the job(s) for which you are applying.						

SKILLS: Please list technical skills, clerical skills, trade skills, etc., relevant to this position. Include relevant computer systems and software packages of which you have a working knowledge, and note your level of proficiency (basic, intermediate, expert)

WORK EXPERIENCE-Please detail your entire work history. Begin with your current or most recent employer. If you held multiple positions with the same organization, detail each position separately. Attach additional sheets if necessary. Omission of prior employment may be considered falsification of information. Please explain any gaps in employment. Include full-time military or volunteer commitments. **PLEASE DO NOT** complete this information with the notation “See Resume.”

PLEASE NOTE: Daybreak Adult Medical Day Services reserves the right to contact all current and former employers for reference information.

Dates Employed (most recent position) From: To:	<input type="checkbox"/> Full time <input type="checkbox"/> Part-time If part-time, # hrs./wk: <input type="checkbox"/>	Title:
Starting Salary:	Organization Name and Address:	
Final Salary:		
Supervisor’s Name, Title and Phone #:	Other Reference Name, Title and Phone #:	Contact my current references: <input type="checkbox"/> At any time <input type="checkbox"/> Only if I am a finalist candidate
Primary duties:		Reason for Leaving:

Dates Employed (most recent position) From: To:	<input type="checkbox"/> Full time <input type="checkbox"/> Part-time If part-time, # hrs./wk: <input type="checkbox"/>	Title:
Starting Salary:	Organization Name and Address:	
Final Salary:		
Supervisor's Name, Title and Phone #:	Other Reference Name, Title and Phone #:	Contact my current references: <input type="checkbox"/> At any time <input type="checkbox"/> Only if I am a finalist candidate
Primary duties:		Reason for Leaving:

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Primary duties:		Reason for Leaving:

MISCELLANEOUS

Have you ever been convicted of a crime? Yes No If yes, state the crime and the date of conviction. You may omit information regarding convictions which have been expunged.

FOR NURSES ASSISTANTS ONLY:

Do you hold a Maryland Geriatric Assistant Certificate? Yes No

If yes, where did you do your clinical work? _____

EMERGENCY CONTACT:

In case of emergency notify:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PLEASE READ CAREFULLY AND SIGN THAT YOU UNDERSTAND AND ACCEPT THIS INFORMATION.

I certify that the information on this application and its supporting documents is accurate and complete. I understand and agree that failure to fully complete the form, or misrepresentation or omission of facts, represents grounds for elimination from consideration for employment, or termination after employment if discovered at a later date. I authorize Daybreak Adult Medical Day Services to investigate, without liability, all statements contained in this application and supporting materials. I authorize references and former employers, without liability, to make full response to any inquiries in connection with this application for employment. If requested, I agree to submit to a physical exam, criminal background investigation, and/or screening for illegal substances upon conditional offer of employment. I understand that this document is NOT an offer of employment, and that an offer of employment, if tendered, does NOT constitute a contract for continued guaranteed employment. I understand that staff employees of Daybreak Adult Medical Day Services serve at-will, and the employment relationship may be terminated at any time by either party, or any or no reason, other than a reason prohibited by law. If employed, I will be required to furnish proof of eligibility to work in the United States, to file a State security questionnaire and State loyalty oath, and to comply with company and departmental regulations. I understand that if employed on a temporary basis, I would be paid for hours worked only, and would be ineligible for benefits including paid time off. If employed on a regular, benefits-eligible basis, I understand that I would be required to make mandatory contributions to the Daybreak Adult Medical Day Services Retirement System or to an optional retirement program, if applicable. I understand that any benefits I receive may be subject to change or discontinuation at any time without prior notice. I also authorize Daybreak Adult Medical Day Services to deduct from my wages any amounts which may be due it as result of an overpayment of wages, loss or destruction of its property or any other amounts which I may lawfully owe Daybreak Adult Medical Day Services, or for which I have received full consideration. In the event that I become an employee of Daybreak Adult Medical Day Services, I agree to comply with all the rules and regulations and understand that the rules and regulations may be changed, interpreted, withdrawn or added to by Daybreak Adult Medical Day Services at any time at its sole option and without any prior notice and that I may be terminated or disciplined for any violations.

Applicant Signature: _____ Date: _____

UNDER MARYLAND LAW AN EMPLOYER MAY NOT REQUIRE OR DEMAND ANY APPLICANT FOR EMPLOYMENT FOR PROSPECTIVE EMPLOYMENT OR ANY EMPLOYEE TO SUBMIT TO OR TAKE A POLYGRAPH, LIE DETECTOR OR SIMILAR TEST OR EXAMINATION AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT. ANY EMPLOYEE WHO VIOLATES THIS PROVISION IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT TO EXCEED \$100.00

Applicant Signature: _____ Date: _____

Verification of Previous Employment/Reference Check

Confidential Reference Request

Applicant Name: _____

Date: _____

Position Applied for: _____

Last

First

M.I.

I authorize Daybreak Adult Medical Day Services to investigate my personal background, qualifications and references, including contacting previous employers. I hereby release from liability all representatives of Daybreak Adult Medical Day Services for their acts performed in good faith and without malice in connection with investigation and evaluating my references. I further release from any liability all individuals and organizations that provide information to Daybreak Adult Medical Day Services in good faith and without malice concerning my qualifications and previous work record.

Previous Employer: _____

Name: _____

Phone #: _____

Employer Name: _____

Social Security #: _____

Dates Employed – From: _____

To: _____

Job Title: _____

Reason for Leaving: _____

Applicant Signature: _____

Date: _____

TO BE COMPLETED BY EMPLOYER ONLY:

THE PERSON NAMED ABOVE HAS APPLIED FOR A POSITION ON OUR STAFF. WE WOULD APPRECIATE YOUR FRANK EVALUATION OF THE APPLICANT’S PERFORMANCE. AS SHOWN ABOVE, THE APPLICANT HAS SIGNED A FULL RELEASE FOR THIS INFORMATION, IF FOR ANY REASON YOU WOULD PREFER TO RESPOND BY FAX, PLEASE SEND TO 410-298-5206. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT ME AT 410-298-9800 x233.

Program Director _____

Is the above information correct? Yes No

If no, please provide correct information: _____

Eligible for Rehire? Yes No Why? _____

Reason for Leaving? Laid Off Resigned Discharged

Would you recommend this applicant to us? Yes No

Why? _____

Comments: _____

Completed By:

Print Name and Title _____ Date: _____

Signature _____

Verification of Previous Employment/Reference Check

Confidential Reference Request

Applicant Name:

Date:

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M.I.

Position Applied for:

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Program Director _____

Is the above information correct? Yes No

If no, please provide correct information: _____

Eligible for Rehire? Yes No Why? _____

Reason for Leaving? Laid Off Resigned Discharged

Would you recommend this applicant to us? Yes No

Why? _____

Comments: _____

Completed By:

Print Name and Title _____ Date: _____

Signature _____

KROLL

DISCLOSURE AND AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize **KROLL BACKGROUND AMERICA, INC.** ("Kroll") to procure a consumer report and/or investigative consumer report on me. I understand that this authorization shall be valid for subsequent consumer and/or investigative consumer reports during my period of employment with **DAYBREAK ADULT MEDICAL DAY SERVICES** for investment purposes. In addition to Kroll and Company, I hereby authorize any and all other third party investors as determined by Company to also view the aforementioned consumer reports and/or investigative consumer reports on me.

Such reports may include, but are not limited to, information as to my character, general reputation, personal characteristics, and mode of living; discerned through employment and education verifications; personal references and interviews; my personal credit history based on reports from any credit bureau; my driving history, including any traffic citations; workers' compensation records after a conditional job offer has been extended and to the extent permitted by law; a social security number trace; present and former addresses; criminal and civil history/records; and any other public record. I authorize any person, business entity or governmental agency that may have information relevant to the above to disclose the same to Company and Kroll, including, but not limited to, any and all courts, public agencies, law enforcement agencies and credit bureaus.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any consumer report of which I am the subject upon my written request to Kroll. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681 et. seq. I certify that the information contained on this Authorization form is true and correct and that my application or employment may be terminated based on any false, omitted or fraudulent information.

Signature: _____ Date: _____

IDENTIFYING INFORMATION FOR CONSUMER REPORTING AGENCY

Last Name: _____ First Name: _____ Middle: _____

Other Names Used _____ Years Used _____

Current Address: _____
Street /P. O. Box City State Zip Code County Dates

Former Address: _____
Street /P. O. Box City State Zip Code County Dates

Social Security Number: _____ Daytime Phone Number: _____

E-mail Address: _____ Driver's License Number: _____ State of Issuance: _____

Date of Birth: _____ *Gender _____

*Providing gender is strictly voluntary. This information will enable us to properly identify you in the event we find adverse information during the course of a background search.

Please note that nothing herein shall be construed as legal advice.

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