Date Received: _____

Quality Care
Health Services Inc.

Application for Employment

Personal Information

Last Name:	First Name:	Middle:	Date:
Street Address	Mailing Address		Home Telephone (with area code)
City: / State:	Zip:	County:	Secondary Telephone (with area code)
Email address:			Social Security Number
From whom or where did you learn of our agency and this vacant position?			Are you legally eligible to work in the United States? ☐ Yes ☐ No

Are you related to anybody now working for QCHS Inc? ☐ Yes ☐ No

If yes, whom: Relationship:

Have you ever applied for employment with us? ☐ Yes ☐ No

If yes, date of employment

When are you available to begin work?

Positions(s) Desired:

Salary Expectations: $ per ☐ Hour ☐ Week ☐ Monthly ☐ Year

Check the types of work you will accept:

☐Permanent Full-time ☐Temporary Full-time ☐Shift of Split Shift Work ☐Any of the previous

☐Permanent Part-time ☐Temporary Part-time ☐Work Involving Travel

Notice:

Typical work activities may include changes in work location, position, duties assigned and work schedules, which best fit current needs. No condition of employment is guaranteed, but is subject to change as to best fit the needs of the agency and the customers served. At some point in your "at will" employment you may be directly involved in this type of activity.

Applicant's Signature: _____

Attention: Human Resources Department
1016 Broad Street, Durham, NC 27705
Office: 919-286-6766 / Fax: 919-286-1016

Date Received: _____

Education (Please include copy of transcripts and diploma, originals will be required upon employment)

Circle highest grade *Completed*	1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 Grad. School 1 2 3 4			
School	**Name and Location**	**Dates Attended From To**	**Graduate Y or N Type of Degree Received**	**Course of Study**
High School			☐ Yes ☐ No	
College or University			☐ Yes ☐ No	
Graduate or Professional			☐ Yes ☐ No	
Other educational, vocational, etc.			☐ Yes ☐ No	

Skills and Trainings (Please include copies of licenses, registrations and certification)

Please circle the following skills and experience in which you have: ☐Word ☐Excel ☐Database ☐Desktop Publishing ☐Windows ☐Other
Special training programs and seminars you have completed:
Licenses and Certifications (list dates and sources of issuance):
Any additional information pertaining to skills, trainings and certifications:

1. **Describe your three best attributes. What do you like about yourself?**

   a.

   b.

   c.

2. **Describe your three weaknesses. What do you like to improve on?**

   a.

   b.

   c.

3. **What would your last employer tell us about you?**

4. **What is your personal history or background that is a source of pride to you?**

5. **What would be the perfect job for you?**

6. **Where do you see yourself (as a profession/career) in five years?**

Date Received: _____

Have you ever been convicted of an offense against the law other than a minor traffic violation? (A conviction does not mean you cannot be hired. The offense and how recently you were convicted will be evaluated in relation to the job for which you are applying.) ☐ Yes ☐ No (If YES, explain fully on additional sheet)

Military Service

Have you served honorably in the Armed Forces of the United States on active duty for reasons other than training?	☐ Yes ☐ No
If YES, were you discharged honorably?	☐ Yes ☐ No
If YES, do you wish to declare a service-connected disability?	☐ Yes ☐ No
If YES, are you a Vietnam, a Desert Storm/Shield, or other veteran? Is so, please specify:	
Are you a member of the Military Reserves?	☐ Yes ☐ No
If YES, please provide your Branch: and Rank:	

Employment History

Please give accurate information of complete full-time and part-time employment. Start with your present or most recent employer; submitting RESUME ONLY is not acceptable.)

**** BE SPECIFIC OF THE POPULATION YOU HAVE WORKED WITH ****

(CHILD or ADULT, Mental Health, Developmentally Disabled, or Substance Abuse)

Current or Last Employer	Job Title
Address	Starting Salary: $ Per Hour Ending Salary: $ Per Hour
Supervisor Name/Title Telephone Number	May we contact employer before offer? ☐ Yes ☐ No
Full-time: From To Part-time: From To Hours/Week:	If supervisor responsibility, the number of employees supervised by you?
Major Duties: (Please be specific)	
Reason for Leaving	
Previous Employer	Job Title
Address	Starting Salary: $ Per Hour Ending Salary: $ Per Hour
Supervisor Name/Title Telephone Number	May we contact employer before offer? ☐ Yes ☐ No
Full-time: From To Part-time: From To Hours/Week:	If supervisor responsibility, the number of employees supervised by you?
Major Duties: (Please be specific)	
Reason for Leaving	

Date Received: ____________________

Previous Employer	Job Title
Address	Starting Salary: $ Per Hour Ending Salary: $ Per Hour
Supervisor Name/Title Telephone Number	May we contact employer before offer? ☐ Yes ☐ No
Full-time: From To Part-time: From To Hours/Week:	If supervisor responsibility, the number of employees supervised by you?
Major Duties: (Please be specific)	
Reason for Leaving	
Previous Employer	Job Title
Address	Starting Salary: $ Per Hour Ending Salary: $ Per Hour
Supervisor Name/Title Telephone Number	May we contact employer before offer? ☐ Yes ☐ No
Full-time: From To Part-time: From To Hours/Week:	If supervisor responsibility, the number of employees supervised by you?
Major Duties: (Please be specific)	
Reason for Leaving	
Previous Employer	Job Title
Address	Starting Salary: $ Per Hour Ending Salary: $ Per Hour
Supervisor Name/Title Telephone Number	May we contact employer before offer? ☐ Yes ☐ No
Full-time: From To Part-time: From To Hours/Week:	If supervisor responsibility, the number of employees supervised by you?
Major Duties: (Please be specific)	
Reason for Leaving	

Date Received: _____

Quality Care Health Services Inc.

PRE-EMPLOYMENT INQUIRIES RELEASE AND CONSENT

In connection with my application n for employment (including contract for services) with Quality Care Health Services, Inc., I undersigned, understand and consent that a consumer report, which may contain public record information, will be requested. This report may include the following types of information: name and dates of previous employers, reasons for termination of employment, work experience, accidents, etc. I further understand that such a report may contain public information concerning my driving record, workers compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state, and other agencies which maintain such records.

I authorize without reservation, any party or agency contacted by this employer to furnish the above mentioned information. A facsimile or other copy of this release/consent bearing my signature is as valid as the original. For purposes of gathering this information, I agree to supply the following information

(Please print the following information)

Last Name	First Name	Middle	Maiden
Current Address		Social Security Number	
City/State/Zip		County	
Previous Address, If above address is less than three (3) years			
City/State/Zip		County	
Driver's License #	State of Issue	Date Issued	

I hereby fully release and discharge above name employer, their respective affiliates, subsidiaries, officers, employees, agents, and attorneys thereof, and each of them, and an individual, organization, entity, agency, or other source providing information to above name employer, from all claims and damages arising out of or relation to any investigation of my background for employment purposes. I have the right to make a request, upon proper identification of all of the information obtained from the consumer report agency.

Signature of Applicant: _____ Date: _____

Equal Opportunity Employment Information (This information is ***voluntary***):
Quality Care Health Services, Inc. policy prohibits discrimination based on race, sex, color, national origin, age or handicap. Sex, age or absence of handicap is a bona fide occupational in a small number of jobs. The information requested below will in no way affect you as an applicant. Its sole use will be to see how well our recruitment efforts are reaching all segments of the population.

Date of Birth *mm/dd/yyyy)*: Gender: Male ☐ Female ☐

☐ ***White*** (non-Hispanic; includes Arabians) ☐ ***Black*** (non-Hispanic; includes Jamaicans, Bahamians and other Caribbean peoples of African but not Hispanic or Arabian descent) ☐ ***Hispanic*** (included persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish origin/culture) ☐ ***Asian*** (includes Pacific Islanders, Pakistanis and Indians) ☐ ***American Indian*** (includes Alaskan natives) ☐ ***Other*** (if you feel you do not fit into one of the above categories please elaborate)
_____

I certify that I have given true, accurate and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize education institutions, associations, registration and licensing boards, and others to furnish whatever detail is viable concerning my qualifications. I authorize investigation of all statements made in this application and understand that false information or documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action or dismissal if I am employed and (or) criminal action. I further understand that dismissal upon employment shall be mandatory if fraudulent disclosures are given to position qualifications. (Authority: G.S/ 126-30, G.S. 1401221)

Signature of Applicant: _____ Date: _____
(unsigned application will not be processed)

Attention: Human Resources Department
1016 Broad Street, Durham, NC 27705
Office: 919-286-6766 / Fax: 919-286-1016

Date Received: _____

Quality Care Health Services Inc.

EMPLOYEE STAFF MEMBER REFERENCES

Name: _____ **Years Known** _____

Relationship: _____

Job Title _____

Company _____

Telephone Number _____

Email Address _____

Name: _____ **Years Known** _____

Relationship: _____

Job Title _____

Company _____

Telephone Number _____

Email Address _____

Name: _____ **Years Known** _____

Relationship: _____

Job Title _____

Company _____

Telephone Number _____

Email Address _____

Comments/Notes

_____

_____

_____

_____

Date Received: _____

Quality Care Health Services Inc.

Background Check Authorization

Last Name	First Name	Middle	Maiden
Former Names(s) and Dates Used			
Current Address			
City/State/Zip		Since (Mo/Yr)	
Previous Address			
City/State/Zip		Since (Mo/Yr)	
Previous Address			
City/State/Zip		Since (Mo/Yr)	
Social Security Number		Telephone Number	
Driver's License Number / State Issued			

The information contained in this application is correct to the best of my knowledge.

I hereby authorize **Quality Care Health Services, Inc**. and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to **Quality Care Health Services, Inc.** or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Quality Care Health Services, Inc. and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicant's personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: _____ Date: _____

Date Received: _____

AUTHORITY FOR RELEASE OF INFORMATION
State Access Only
Name Check Access

I authorize the North Carolina Department of Public Safety through the State Bureau of Investigation to perform a North Carolina name-based criminal history record information check in connection with my application for employment, my employment or volunteer services with QUALITY CARE SOLUTIONS pursuant to HEALTH CARE PROVIDER – STATE ONLY – NCGS 114-19-3

(Type or print clearly)

Last Name	First Name	Middle	Maiden
Social Security Number (Optional*)	Date of Birth	Sex	Race

I understand that the North Carolina State Bureau of Investigation, officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the above named agency cannot provide a HARD COPY of the results of this criminal history record check to me.

*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.

Applicant's/Employee's/Volunteer's Signature

_____

Date

_____

This form must be maintained on the file with the above named agency for one year. UPON COMPLETION OF THIS FORM, MAIL A PHOTOCPY TO THE ADDRESS INDICATED BELOW

State Bureau of Investigation
Criminal Information and Identification Section
Attn: Applicant Unit
Post Office Box 29500
Raleigh, North Carolina 27626-0500

ORI # HCP0001116 – QUALITY CARE

Date Received: _____

Quality Care
Health Services Inc.

MEMORANDUM

DATE:

TO: Applicants

FROM: Luanne Fanelli
Director, Human Resources

RE: NC Division of Motor Vehicles

The following form requires the following information:

1. Your full name as it appears on your driver's license
2. Your signature
3. Your driver's license number, SSN, and date of birth. (ALL THREE ITEMS MUST APPEAR)
4. Date

If you should have any additional questions or concerns, please feel free to contact my office.

Thanks for your time and consideration.

Attention: Human Resources Department
1016 Broad Street, Durham, NC 27705
Office: 919-286-6766 / Fax: 919-286-1016

Date Received: _____

NORTH CAROLINA
DIVISION OF MOTOR VEHICLES
DRIVER LICENCE SECTION

Driver Privacy Protection Act Authorization
To Disclose Personal Information Form DL-DPPA-2

I understand that personal information contained in my Motor Vehicle Record is protected by the federal Driver Privacy Protection Act and N.C. General Statue 20-43.1. I hereby authorize the release of my personal information to the person named below.

_____ _____
Print your full name as it appears on your driver license Your signature (MUST BE SIGNED)

_____ _____
Your N.C. driver license number, SSN or ITIN & date of birth Date signed

Person to receive information: **LUANNE FANELELLI, Director – Human Resources (919) 790-2446**

Mailing address: **Quality Care Health Services, Inc. 1016 Broad Street, Durham, NC 27705**

Fees: Certified Complete History - $14.00 Uncertified Complete History -$10.00 Uncertified Limited History - $10.00

Circle one of the above to indicate the type of MVR to be released. Make checks payable to "NCDMV".

Mail this form and fees to: NCDMV, Driver License Records, 3113 Mail Service Center, Raleigh, NC 27697-3113, ***please allow 10 business days processing time***, *this does not include US Postal service delivery time to or from the DMV*.

Form DL-DPPA-2, Revised May 2018
Previous editions are obsolete, DO NOT USE