EASTON HEALTHCARE AGENCY, INC
2021 E. DUBLIN GRANVILLE RD. SUITE 290
COLUMBUS, OHIO 43229.
Phone; (614) - 880.9402
Fax: (614) - 880-9401.

APPLICATION FOR EMPLOYMENT

Personal Information: (Please Print) **Today's Date:** ____________________

Name:

____

Last First Middle Initial

Address:____
Street

____(_______)________________

City State Zip Code Telephone Number

Date of Birth: ________/_______/_______ **Social Security Number:**______-______-______

Please Indicate address where you have resided in the past five years:

From Date	To Date	Address Street City State Zip

How did you hear about this company?_______________________________________

Who referred you?____

Have you ever applied to this company before? ______________**Yes** ________________**No**

How Far can you Drive . ___________________________

EDUCATIONAL BACKGROUND

School Name and Address	Course of Study	Did you Graduate?	Degree or Diploma

WORK HISTORY (List most recent employer first)

Date Month & Year	Employer's Name, Address, Supervisor's Name, Phone Number	Job Title and Duties	Salary Start/End	Reason for Leaving
From: To:				
From: To:				
From: To:				
From: To:				

Are you legally permitted to work in the U.S.? ____________Yes ________________No

If yes, can you show proof of employment eligibility? ______________Yes ________________No

Emergency Contact: Name of contact.______________________________.

Phone Number: _(________)__________ **Alternative Number.**_(________)________________.

Address. ____.

City. ____________________ **State.**______________ **Zip Code**__________________.

I hereby certify that all responses on this employment application are true and complete.
I hereby authorize Easton Healthcare Agency, Inc. to contact former employers and obtain any information pertaining to this employment application.
I understand and agree that any falsification, misrepresentation or omission, either on this application or during the interview process may disqualify me from further consideration for employment. If employed by Easton Healthcare Agency, Inc. the discovery of any falsification, misrepresentation or omission may make me subject to dismissal.

I understand and agree that if I am employed by Easton Healthcare Agency, Inc. my employment is at-will, so that I can terminate my employment at any time and for any reason, after at least a week notice.
Likewise, Easton Healthcare Agency, Inc. can terminate my employment at any time with or without notice and for any reason.

If employed, I hereby authorize deductions from wages due me for any amount I owe Easton Healthcare Agency, Inc. or for charges I have incurred including but not limited to unreturned Easton Healthcare Agency, Inc.'s property, telephone call charges, damages to property or equipment, failure to follow Easton Healthcare Agency, Inc. 's policies which results in cash or inventory shortages.

AN EQUAL OPPORTUNITY EMPLOYER.

______________________________. Alternative Phone # _(________)______________.
Applicants Name

______________________________.
Applicants Signature

______/________/__________.
Date.

Easton Healthcare Agency, Inc.
2021 E. Dublin Granville Rd
Suite#290
Columbus, Ohio 43229
614.880.9402
614.880.9401 Fax

EMPLOYER REFERENCE CHECK

(Attach Copy of Applicant Authorization Check)

TO: ______________________________ Date Mailed or Faxed

______________________________ ____________

____

Applicant Name ______________________ SS # _____ _____ _____

Please furnish us with an evaluation of the named applicant's work record. Any information will be held in strict confidence. Thank you for your cooperation.

Length of Employment: From: ______ To: ______ Position: ____________

Date of Termination or Separation: ____________________

EVALUATION:	Excellent	Good	Fair	Poor	N/A
Quality of Work:	_____	_____	_____	_____	_____
Attendance/Punctuality:	_____	_____	_____	_____	_____

Would you Rehire this person? __________

How would you evaluate the overall job performance of the applicant?

Excellent _____ Good ______ Fair _____ Poor ______

General Remarks: ____

Completed By: ____________________ Title ____________ Date ________