



MERIDIAN CARE
OF ALICE

Thank you for taking the time to apply for employment at Meridian Care of Alice. We ask that you please fill out the attached form completely and accurately. Please bring the completed application to our facility, along with your COVID Vaccine Card, social security card, driver's license, photo ID, or passport.

MERIDIAN CARE OF ALICE

EMPLOYMENT APPLICATION

PLEASE PRINT

POSITION APPLYING FOR _____ DATE: ____/____/____

NAME: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP CODE

TELEPHONE #: _____ SOCIAL SECURITY #: _____ EMAIL: _____

EMPLOYMENT INFORMATION

POSITION DESIRED: _____ SALARY: _____

DATE AVAILABLE FOR WORK: ____/____/____ SHIFT: _____

ARE YOU ABLE TO MEET ATTENDENCE REQUIREMENTS OF THE JOB?.....YES NO

HAVE YOU EVER APPLIED OR BEEN EMPLOYED HERE?.....YES NO IF YES, WHEN? _____

ARE YOU CURRENTLY EMPLOYED?.....YES NO MAY WE CONTACT EMPLOYER?.....YES NO

SKILLS AND QUALIFICATIONS

(Summarize special skills and qualifications acquired from employment or other experiences that may qualify you for work with our Company.)

GENERAL INFORMATION

IF YOU ARE UNDER 18, CAN YOU FURNISH A WORK PERMIT?..... YES NO

ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THIS COUNTRY?..... YES NO

HAVE YOU BEEN CONVICTED OF A FELONY IN THE LAST 7 YEARS?..... YES NO

IF YES, PLEASE EXPLAIN: _____

IN CASE OF EMERGENCY, NOTIFY: _____ TELEPHONE: _____

EDUCATIONAL BACKGROUND

SCHOOL NAME/ LOCATION	YEARS COMPLETED	DID YOU GRADUATE?	COURSES OF STUDY
HIGH SCHOOL		YES <input type="checkbox"/> NO <input type="checkbox"/>	
COLLEGE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
TRADE/TECHNICAL SCHOOL		YES <input type="checkbox"/> NO <input type="checkbox"/>	

EMPLOYMENT HISTORY

List your last three (3) employers, assignments, or voluntary activities (at least 5 years), starting with the most recent, including military experience.

FROM	TO	EMPLOYER	PHONE
JOB TITLE		ADDRESS	
SUPERVISOR/TITLE		NATURE OF WORK/JOB RESPONSIBILITIES	
HOURLY RATE/ SALARY START \$ _____ PER _____ FINISH \$ _____ PER _____		REASON FOR LEAVING	
FROM	TO	EMPLOYER	PHONE
JOB TITLE		ADDRESS	
SUPERVISOR/TITLE		NATURE OF WORK/JOB RESPONSIBILITIES	
HOURLY RATE/ SALARY START \$ _____ PER _____ FINISH \$ _____ PER _____		REASON FOR LEAVING	
FROM	TO	EMPLOYER	PHONE
JOB TITLE		ADDRESS	
SUPERVISOR/TITLE		NATURE OF WORK/JOB RESPONSIBILITIES	
HOURLY RATE/ SALARY START \$ _____ PER _____ FINISH \$ _____ PER _____		REASON FOR LEAVING	

It is understood and agreed upon that any misconception by me in this application will be sufficient cause for cancellation of this application and/or separation from the Employer's service if I have been employed.

I give the Employer the right to investigate all references and to secure additional information about me, if job related. I hereby release from liability the Employer and its representatives for seeking such information, and all other persons, corporations or organizations for furnishing such information.

The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state, or federal law.

This application is current for only 60 days. At the conclusion of this time, if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

I understand that just as I am free to resign at any time, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

By completing and submitting the application for employees, I understand and agree that **The Meridian** ("the Company"), has a Dispute Resolution Plan, which is incorporated by reference in this application. This Plan is the required and exclusive way for applicants, Employees and the Company to resolve any and all disputes. I agree to resolve any dispute between the Company and me arising out of this application or, if the Company hires me, out of my employment, through the Dispute Resolution Plan, which includes binding arbitration as a final step.

SIGNATURE OF APPLICANT

DATE

SIGNATURE

DATE

PRINTED NAME OF PARENT/LEGAL GUARDIAN

RELATIONSHIP

MERIDIAN CARE OF ALICE

CRIMINAL HISTORY CHECKS ON EMPLOYEES SERVING THE ELDERLY

Senate Bill 322 amends the Human Resource Code by adding provisions that allow for criminal history checks of employees in certain facilities serving the elderly or disabled. Under the new legislation the Department of Public Safety may provide the Texas Department of Human Services (TDHS), Texas Department of Health (TDH) or the facility with privileged criminal records related to specific misdemeanors, felonies, robberies and burglaries. Facilities must inform applicants for employment if offered. Exceptions to the criminal check procedures are provided for persons licensed under other laws, such as nursing home administrators and nurses. However, Meridian Care of Alice will request a criminal history check on those exempt persons. **Temporary employment may be offered pending the results of a criminal conviction check.** Conviction of listed offenses, with some exceptions, will bar or terminate a person's employment.

RELEASE & AUTHORIZATION

In order to determine whether a candidate is suitable for a position, it is necessary to thoroughly review your complete employment background and references. All current and past employers will be contacted once the offer of employment has been accepted. Many employers and references will not provide a candid response unless there is an authorization and release of liability statement. Please carefully review the following paragraph and sign and date the form below.

I, _____, hereby authorize any employer, law enforcement agency, state agency, institution or private information bureau that has any record or knowledge of my worker's compensation claims, motor vehicle operation history or criminal history to provide Meridian Care of Alice any such information.

The authorization is included, but not limited to criminal, credit, driving and education. This authorization shall be valid for one (1) year from the date signed and a photographic copy of the authorization shall be as valid as the original. Permission is granted for information to be released by any state agency.

I waive any provision impeding the release of this information and agree to provide any information necessary for the release of this information above and beyond that provided on the employment application.

If employed, I further authorize periodic checks of all the above referenced sources as may be deemed necessary by the employer.

Full Name, Including Maiden (Please Print)

Social Security Number

Address

Driver's License Number & State

City/State/Zip

Date of Birth

Signature

Date

Social Security Number Verified By: _____
(800)772-6270

Date: _____

THE MERIDIAN

RELEASE OF EMPLOYMENT RECORDS

I, _____ (Applicant), do hereby authorize **Meridian Care of Alice.** (Company) or those authorized by them, to investigate all facts contained in my application for employment with said company. I also authorize the release of any and all by my present and past employers, wherever located, which may be required for a reference check and which may be obtained in a pre-offer of employment inquiry under the Americans with Disabilities Act of 1990 (ADA). I further authorize all of my current employer and all previous employers to give any and all information concerning my employment and any other information which said employers may have, personal or otherwise, and which may be obtained in a pre-offer of employment inquiry under the ADA. I also release all parties from all liabilities for any damages which may result from the furnishing of said information.

A copy of this release shall be as valid as the original.

APPLICANT

SIGNATURE

PRINTED NAME

DATE

WITNESS

SIGNATURE

PRINTED NAME

DATE

THE MERIDIAN

CONDITIONAL OFFER OF EMPLOYMENT RELEASE OF MEDICAL RECORDS

I, _____ (Conditional Employee), do hereby authorize and give permission to all healthcare providers who have rendered medical care or related services to me, to give to **Meridian Care of Alice**. (Conditional Employer), or any person duly acting on their behalf with written authorization of the same, complete access to all of my medical records pertaining to any diagnosis or treatment or any injury, disease, illness or medical condition. Permission is also given to said healthcare providers to fully discuss my diagnosis, treatment, condition and prognosis with my employer or others acting on their behalf. The undersigned has received a conditional offer of employment from the employer. This release is given for the purpose of facilitating the evaluation and processing of such conditional offer of employment at the Company.

A copy of this release shall be as valid as the original.

CONDITIONAL EMPLOYEE

SIGNATURE

PRINTED NAME

DATE

WITNESS

SIGNATURE

PRINTED NAME

DATE

THE MERIDIAN

DISPUTE RESOLUTION PLAN NOTICE OF EMPLOYMENT APPLICATION

By completing and submitting this application for employment with **Meridian Care of Alice**, I understand and agree that:

Meridian Care of Alice (the "Company"), has a Dispute Resolution Plan, which is incorporated by reference in this application. This Plan is the required and exclusive way for applicants, Employees and the Company to resolve any and all disputes. I agree to resolve any dispute between the Company and me arising out of this application or, if the Company hires me, out of my employment, through the Dispute Resolution Plan, which includes binding arbitration as a final step.

APPLICANT

SIGNATURE OF APPLICANT

DATE

PARENT/LEGAL GUARDIAN (IF UNDER 18 AND UNMARRIED)

SIGNATURE OF PARENT/LEGAL GUARDIAN (IF UNDER 18 & UNMARRIED)

PRINTED NAME OF PARENT/LEGAL GUARDIAN

DATE

RELATIONSHIP

MERIDIAN CARE OF ALICE

CONDITIONAL JOB OFFER

CONDITIONAL EMPLOYER: _____ **MERIDIAN CARE OF ALICE**

(Hereinafter called "Employer")

Based on the information and qualifications submitted on your application for employment and/or job interview you are hereby offered employment with our organization.

In compliance with the Americans With Disabilities Act of 1990 (ADA), this offer is conditional upon your signing all Company employment forms, agreeing to all Company policies, and your ability to fulfill the functions of the job. Your response to the questions on this form and, if required, the results of a medical examination will help determine that ability. False or intentionally misleading answers on your application and/or job interview are grounds for rescinding this offer and/or terminating your employment. Any medical history information requested is required of all applicants who apply for the job category for which you have applied. The answers to any medical history questions and/or any medical examination results will be kept confidential and in separate personnel files.

CONDITIONAL EMPLOYEE: _____
(Hereinafter called "Employee") LAST FIRST Middle Initial

EMPLOYEE'S ADDRESS: _____
STREET CITY STATE ZIP

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

DRIVER'S LICENSE #: _____ STATE: _____

HAVE YOU EVER USED OR BEEN EMPLOYED UNDER ANY OTHER NAME?.....YES NO

IF "YES," INDICATE OTHER NAME: _____

DO YOU HAVE A LEGAL RIGHT TO WORK IN THE UNITED STATES?.....YES NO

HAVE YOU BEEN CONVICTED OF A CRIME?.....YES NO

IF "YES," EXPLAIN FULLY: _____

ARE YOU USING, OR HAVE YOU USED IN THE PAST 60 DAYS, ILLEGAL DRUGS?.....YES NO

CONDITIONAL EMPLOYEE'S SIGNATURE _____ DATE _____

HIRING SUPERVISOR'S SIGNATURE _____ DATE _____

<u>FOR EMPLOYER'S USE ONLY</u>		
<input type="checkbox"/> Drug Screen Only	<input type="checkbox"/> Basic Physical Only	<input type="checkbox"/> Basic Physical & Drug Screen

DPS Computerized Criminal History (CCH) Verification (AGENCY COPY)

I, _____, acknowledge that a Computerized Criminal
APPLICANT OR EMPLOYEE NAME (Please Print)

History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. (This is not a consent form, but serves as information for the applicant.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at [www.dps.texas.gov/Crime Records Information/Review of Personal Criminal History](http://www.dps.texas.gov/Crime_Records_Information/Review_of_Personal_Criminal_History) or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of \$25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

Signature of Applicant or Employee

Date

Agency Name (Please Print)

Agency Representative Name (Please Print)

Signature of Agency Representative

Date

Please: Check and Initial each Application Space	
CCH Report Printed:	
YES <input type="checkbox"/>	NO <input type="checkbox"/> _____ initial
Purpose of CCH: _____	
Empl <input type="checkbox"/>	Vol/Contractor <input type="checkbox"/> _____ initial
Date Printed: _____	_____ initial
Destroyed Date: _____	_____ initial
Retain in your files	

FOR OFFICE USE ONLY

MERIDIAN CARE OF ALICE

APPLICANT EVALUATION SHEET

(To Be Completed by Everyone Who Interviews the Applicant)

APPLICANT'S NAME: _____

INTERVIEWER'S NAME: _____

INTERVIEW DATE: _____

COMMENTS: _____

(Include Notes on Neatness, Ability, Communication Skills, Complaints about previous job, etc.)

REFERENCES & PRIOR EMPLOYMENT VERIFICATION

INDIVIDUAL CONTACTED	AFFILIATION/APPLICANT	RESULTS

PROFESSIONAL LICENSE/CERTIFICATION VERIFICATION

INDIVIDUAL CONTACTED	LICENSE/CERTIFICATION	RESULTS

Equal Employment Opportunity Form

Meridian Care of Alice

Applicant Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Home Phone: () _____ Social Security Number: _____

Position Applied for: _____

Voluntary Information

This information is being requested in accordance with federal regulations. The information is voluntary and will not be used when considering you for employment with our company.

Racial or Ethnic Group

- | | | |
|--------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> American Indian/Alaskan | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Other |

Gender

- | | |
|---------------------------------|-------------------------------|
| <input type="checkbox"/> Female | <input type="checkbox"/> Male |
|---------------------------------|-------------------------------|

Military Service

- | | |
|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Pre-Vietnam Era | <input type="checkbox"/> Vietnam Era |
| <input type="checkbox"/> Post-Vietnam Era | <input type="checkbox"/> Disabled Veteran |

How did you hear about this position?

- | | | |
|--------------------------------------|-------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Company Employee | <input type="checkbox"/> Professional Publication |
| <input type="checkbox"/> Job Fair | <input type="checkbox"/> Placement Office | <input type="checkbox"/> Web Site |
| <input type="checkbox"/> Other _____ | | |