Unified Care Services, Inc.
525 Route 73 N, Suite 104
Marlton, NJ 08053
Tel: 856-200-8005
Fax: 609-450-8800
info@unifiedcareservices.com

EMPLOYMENT APPLICATION

PERSONAL DATA			
LAST NAME, FIRST NAME M.I.		DATE	HOME PHONE
CURRENT ADDRESS (STREET, CITY, STATE, ZIP CODE)		CELL PHONE	
		EMAIL ADDRESS	
MALE / FEMALE ☐ ☐	DRIVER'S LICENSE NUMBER	STATE ISSUED	DATE OF BIRTH

EMERGENCY CONTACT		
NAME	ADDRESS	TELEPHONE

LICENSING INFORMATION			
TYPE	LICENSE NUMBER	STATE ISSUED	EXPIRATION DATE

ADDITIONAL CERTIFICATIONS/TRAINING (Please provide copies)	
TYPE	DATE COMPLETED

EDUCATIONAL BACKGROUND				
NAME OF SCHOOL	ADDRESS (CITY, STATE)	SUBJECT	DEGREE	YEARS

REFERENCES			
NAME	RELATIONSHIP	TELEPHONE	YEARS
NAME	RELATIONSHIP	TELEPHONE	YEARS
NAME	RELATIONSHIP	TELEPHONE	YEARS

EMPLOYMENT HISTORY (PAST 3 YEARS)		
PRESENT/LAST EMPLOYER	**TELEPHONE**	**SUPERVISOR'S NAME** **MAY WE CONTACT? YES ☐ NO ☐**
ADDRESS	**POSITION TITLE**	**CURRENT OR END SALARY/WAGE**
SUMMARY OF DUTIES	**DATES EMPLOYED** **TO**	**REASON FOR LEAVING**
FIRST PREVIOUS EMPLOYER	**TELEPHONE**	**SUPERVISOR'S NAME** **MAY WE CONTACT? YES ☐ NO ☐**
ADDRESS	**POSITION TITLE**	**CURRENT OR END SALARY/WAGE**
SUMMARY OF DUTIES	**DATES EMPLOYED** **TO**	**REASON FOR LEAVING**
NEXT PREVIOUS EMPLOYER	**TELEPHONE**	**SUPERVISOR'S NAME** **MAY WE CONTACT? YES ☐ NO ☐**
ADDRESS	**POSITION TITLE**	**CURRENT OR END SALARY/WAGE**
SUMMARY OF DUTIES	**DATES EMPLOYED** **TO**	**REASON FOR LEAVING**

HEALTH HISTORY					
HAVE YOU HAD:	**YES**	**NO**	**HAVE YOU HAD:**	**YES**	**NO**
Any illness or injury in the last 5 years	☐	☐	**Nervous or psychiatric disorders**	☐	☐
Head/brain injuries, disorders or illnesses	☐	☐	**Loss of, or altered, consciousness**	☐	☐
Seizures, epilepsy	☐	☐	**Stroke or paralysis**	☐	☐
Eye disorders or use corrective lenses	☐	☐	**Spinal injury or disease**	☐	☐
Ear disorders, loss of hearing or balance	☐	☐	**Chronic back pain**	☐	☐
Heart problems, heart surgery	☐	☐	**Regular, frequent alcohol use**	☐	☐
High blood pressure	☐	☐	**Narcotic or habit forming drug use**	☐	☐
Muscular disease	☐	☐	**Hepatitis**	☐	☐
Shortness of breath	☐	☐	**Tuberculosis (TB)**	☐	☐
Fainting, dizziness	☐	☐	**Tuberculosis test within the last 3 years**	☐	☐
Kidney disease, dialysis	☐	☐	**Jaundice**	☐	☐
Liver disease	☐	☐	**Chickenpox**	☐	☐
Lung disease (asthma, emphysema, chronic bronchitis)	☐	☐	**Diabetes or elevated blood sugar controlled by:** **☐ diet ☐ pills ☐ insulin**	☐	☐
Digestive (stomach) problems	☐	☐	**Measles or Mumps**	☐	☐
Any other infectious diseases? If YES, please list them:				☐	☐
Do you have any allergies? If YES, please list them:				☐	☐
List all medications used regularly or recently, including over the counter medications:					
List any current medical conditions (e.g., pregnancy, recent surgeries, etc.):					
For any YES answers, indicate onset date, diagnosis, threating physician's name and address, and any current limitation:					

HAVE YOU EVER BEEN CONVICTED OF A CRIME (FELONY OR MISDEMEANOR)?	**YES / NO** ☐ ☐	**IF YES, PLEASE EXPLAIN THE CRIME AND DATE CONVICTED**
DO YOU HAVE A CLEAN DRIVING RECORD?	**YES / NO** ☐ ☐	**IF NO, PLEASE EXPLAIN**

By signing this application, I certify all information to be true and correct. I agree to allow Unified Care Services, Inc. to perform a criminal history background check and to check my references. I understand that any false information provided could result in termination of employment with Unified Care Services, Inc.

I also agree not to seek or accept any arrangement privately from any of Unified Care Service, Inc.'s clients. Additionally, I understand that Unified Care Services, Inc. shall be entitled to compensation of no less than $2500.00 for loss of revenue and breach of this contract.

SIGNATURE **DATE**

Please fax this completed form to **609-450-8800** or email it to **info@unifiedcareservices.com.**

Alternatively, you can mail this form to:

Unified Care Services, Inc.
Attn: Human Resources Department
525 Route 73 N, Suite 104
Marlton, NJ 08053