



## Employment Application

### MUSTARDSEED HEALTHCARE SERVICES LLC

Please print or type clearly in ink and return application  
To MustardSeed Healthcare Services LLC address below

Mustardseed Healthcare Services LLC  
Office of Human Resource  
198 Thomas Johnson Dr, Ste 205  
Frederick, Maryland 21702

#### Personal

Last Name		First	Middle	Social Security Number			
Permanent Address-Number and Street			City	State	Zip Code		
Do you have the legal right to work in USA? (If Yes, verification will be required)		Are you over 18?		Residence Phone Number		Emergency Phone Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Sex		<input type="checkbox"/> Male <input type="checkbox"/> Female		Referred by:			
				Date of Application			

#### **EMAIL ADDRESS:**

#### **Birth Date:**

#### Job Interest

Position Desired		Company or Division Preferred (if any)			
Are you seeking Time Position		Date Available		Salary Desired	
<input type="checkbox"/> Full-Time Position <input type="checkbox"/> Part-Time Position <input type="checkbox"/> PRN					
Hours Desired		Shift Available		Days Available	
<input type="checkbox"/> 40/Wk <input type="checkbox"/> < 40/Wk <input type="checkbox"/> Other _____ <input type="checkbox"/> Any		<input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Nights <input type="checkbox"/> Any		<input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	
Preferred Locations/Site (Hospitals, Nursing Home, Clinics, Homes, etc) of interest to work, Make a list. (City, State)					




Will you consider split shift?  Yes  No Will you relocate?  Yes  No Are you willing to travel?  Yes  No

Is this your first time applying for employment with us?  Yes  No

Have you ever been employed with us?  Yes  No

If yes, give Division Name and Location -----

Dates employed ----- Position -----

**Miscellaneous**

Have you ever been convicted of a felony?  Yes  No

If yes, explain (convictions are not an automatic bar to employment): \_\_\_\_\_

Have you ever been excluded from the Medicaid program for conduct that would constitute a misdemeanor, gross misdemeanor or a felony under the law?  Yes  No

If yes, explain (convictions are not an automatic bar to employment): \_\_\_\_\_

Have you ever been disciplined by professional of state ethic or licensing board?  Yes  No

If yes, explain (convictions are not an automatic bar to employment): \_\_\_\_\_

Do you have a working knowledge of the fundamental job duties (essential function) of the position for which you are applying?

Yes  No

If yes, can you perform the essential functions of the job with reasonable accommodation?

Are you related to anyone employed by Mustardseed Healthcare Services LLC?  
(To be used for assignment purposes)

Yes  No

Name(s)

Division/Department

Location

The policy of this agency is to provide every individual a fair and equal opportunity to seek employment and advancement at the agency without regard to race, color, religion, sex age, national origin, citizenship status, veteran status, disability or factors protected by state or local laws. "An Equal opportunity Employment Act".

**All Applicants**

**Please read carefully before signing**

I certify that any information I give during the course of applying for employment is true and complete. I understand that any false, incorrect or misleading information or the omission of any pertinent information including that given at the time my application may be considered as sufficient reason for my discharge, if hired. I further understand that this application is not intended to be a contract of employment and that, if I am hired, my employment is at will and can be terminated by either me or the agency, with or without notice, for any or no reason. No supervisor or manager has authority to make an agreement to the contrary changing employment at will. This application will be in effect for 90 days from the date indicated below and, if employment is not offered within the 90-day period, I understand that I must reapply to be considered for future employment. I also understand that this application for employment in no way obligates the agency to employ me.



I hereby authorize Mustardseed Healthcare Services LLC to investigate my former employment and other references and to make any further investigations deemed necessary in connection with my application for employment and I do hereby release Mustardseed Healthcare Services LLC and all informants of all liability whatsoever resulting from such investigations.

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 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Supplement to employment application**

I understand that an offer of employment I may receive is subject to my subsequent completion, satisfactory to the agency, of all pre-employment procedures, including a drug and alcohol screen test, and submission of documents establishing my rights to work in the USA.

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 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

EDUCATION							
TYPE OF SCHOOL	SCHOOL NAME AND ADDRESS	TYPE OF DEGREE EARNED	MAJOR	NUMBER OF YEARS COMPLETED	GRADUATED		GRADE POINT AVG.
					YES	NO	
High School							
Business Trade, Technical or Vocational							
College or University							
College or University							
Further Education Planned:							

SKILLS	
List office equipment you can operate:	
Typing (WPM):	Shorthand (WPM):
Computer hardware:	Computer software:
What official language do you speak? (Respond if you believe this information is relevant to the position applied for):	
Do you have any commitment to another employer or business which might affect your employment with us? If Yes, Explain:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	



<b>Professional Licensure / Certification</b>			
TYPE	NUMBER	EXPIRATION	CURRENT STATE

**Work History**

List names and address of all former employers, beginning with the most recent. (Attach additional sheet if necessary)

EMPLOYERS NAME AND ADDRESS	NATURE OF BUSINESS	DATES OF EMPLOYMENT FROM/TO	POSITION/TITLE	RATE OF PAY STARTING/LAST	REASON FOR LEAVING	SUPERVISOR'S NAME, TITLE AND TELEPHONE

Please indicate by number which employer you do not wish us to contact (prior to employment):

List any additional skills, knowledge, experience or other relevant qualifications that might benefit the Foundation:

**References**

**Business and Personal (Do not include relatives). Provide at least three references**

NAME	POSITION OR OCCUPATION	RELATIONSHIP	ADDRESS	YEARS KNOWN	TELEPHONE



<b>Driver's License</b>					
Driver License No.	Date of Expiration	Province Issued	Type or Class of License:	Class -----	
			<input type="checkbox"/> Operator <input type="checkbox"/> Commercial <input type="checkbox"/> Chauffeur <input type="checkbox"/> Other-----		
Have you ever been denied a license, permit or privilege to operate a motor vehicle?		Has any license, permit or privilege ever been suspended, denied or revoked?		If the answer to either of these questions is yes, attach a statement giving details.	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			

**Traffic Record**

**Attach sheet if more space is needed.**

DATES (BEGIN WITH MOST RECENT)	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES

**Traffic convictions and forfeitures (other than parking violations) for the past 3 years and any convictions or forfeitures involving possession, sale, manufacturing, transportation, or use of drugs.**

LOCATION	DATE	CHARGE	PENALTY

**What Racial/Ethnic Category Do You Consider Yourself**

American Indian or Alaskan Native    All persons having origins in any of the original people of North American.  
 Asian or Pacific Islander    All Persons having origins in any of the original people of East, Southeast Asia, the Pacific Island or Indian Subcontinent. This area includes for example China, Japan, The Philippines Island, and Samoa  
 Black    Not of Hispanic Origin. All persons having origins in any of the Black racial groups.  
 Hispanic    All Persons of Mexican, Puerto Rican, Cuban, Central or south America, or other Spanish Culture of origin

**Vietnam Veteran**

Did you serve active duty in the armed services (For a period of more than 180days) Between August 5, 1964 and May 7, 1975?  
 Yes     No

**Disabled Veteran**

Are you entitled to disability compensation under laws administered by the Veterans Administration for disability rates at 30% or more, or are you a person whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty  
 Yes     No

**Handicapped**

Do you (1) have a physical or mental impairment which substantially limits one or more major life activities, (2) have a secure record of such impairment, (3) regarded as having such impairment, or (4) have experienced difficulty, retaining or advancement in employment because of your handicapped?  
 Yes     No

I understand that the information on this application will be used and that prior employers will be contacted for the purpose of investigation.