2212 Encompass Drive, Suite 160 • Chattanooga, Tennessee 37421

Office: 423-702-5134 / 5240 • Fax:423-702-5269

Email: eucabeth@perfectcaresolutions.com

Website: www.perfectcaresolutions.com

Perfect Care Solutions, Inc
"SERVING LIVES OF THE DEVELOPMENTALLY DISABLED"

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Perfect Care Solutions Inc. Application

PLEASE READ THE FOLLOWING BEFORE FILLING OUT AN APPLICATION:

After completion of the Prefect Care Solutions Inc. application, we will ask you to provide the following:

- Drivers License in good standing
- Proof of Automobile Liability Insurance
- An up-to-date Social Security Card or Passport

The following credentials are required for any position with Perfect Care Solutions Inc. If you already have proof of these trainings, please be prepared to offer a copy of them at the window after your application is completed. If you do not possess any of these trainings, it will not necessarily disqualify you for a position, but only helps us make decisions regarding the amount of training we may need to do with you.

- CPR
- Red Cross approved First Aid course
- Medication Administration course
- TB Test *(administered within the last 6 months)*
- "F" Drivers License endorsement *(required within 30 days of hire)*

Additionally any current copies of applicable training from prior employers is always appreciated so that duplicate training will not be necessary.

Thank you for your interested with Perfect Care Solutions Inc.

The Management of Perfect Care Solutions Inc.

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Perfect Care Solutions Inc. Application

PLEASE READ THE FOLLOWING BEFORE FILLING OUT AN APPLICATION:

PLEASE READ THE FOLLOWING PRIOR TO TURNING IN YOUR APPLICATION:

Prefect Care Solutions receives several phone calls daily from applicants wanting to check on the status of their application. Due to the volume of calls, we do not make return phone calls. The best way to check on your application is to make note of the date that you completed your application. The application is in our active files for 30 days and is reviewed every time we have an opening. We ask that you do not call to follow up on your application. It is being reviewed and if there is an opening for which it is felt that you make a good fit, you will receive a call for an interview. After 30 days, you may complete a new application.

Thank you.

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PLEASE COMPLETE THE ENTIRE APPLICATION IN BLACK OR BLUE INK.

Date: _____ Email Address: _____

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

Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Valid Driver's License: _____ DL # _____ State of Issue: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relation: _____ Phone: _____

Address: _____ City/State/Zip: _____

Positions applied for: 1. _____ 2. _____ 3. _____

Category Preferred: ○ Full-Time ○ Part-Time ○ Temporary

Circle ALL Shifts you are available: ○ 1st ○ 2nd ○ 3rd ○ 12hr Rotational ○ Shifts Weekends Only

Minimum Pay You Are Seeking: *(Will not accept application without an amount specified)* $ _____

How did you hear about us?

○ Employee ○ Advertisement ○ Employment Agency ○ Walk-in Job ○ Fair Internet

Have you lived in Tennessee for at least one (1) year? ○ YES ○ NO Where? _____

Have you ever applied with us before? ○ YES ○ NO If Yes, how long ago? _____

Have you ever been employed by Perfect Care Solutions, Inc.? ○ YES ○ NO If yes, Dates: _____

Have you ever worked for another Department of Intellectual Disability/Mental Retardation Agency?

○ YES ○ NO If Yes, what agency? _____

Select or write in highest grade completed in each category:

High School: _____ ○ GED College: _____ Grad School: _____

Degree Held: ○ BS Degree ○ BA Degree ○ Masters Degree What Major/Minor: _____

List registration, certification, or license you hold or have held: _____

Type: _____ Expiration Date: _____ Number: _____ State: _____

Type: _____ Expiration Date: _____ Number: _____ State: _____

****Application for employment active for thirty (30) days only.****

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EMPLOYMENT HISTORY

FIVE (5) YEAR OF CONTINUOUS WORK HISTORY IS REQUIRED

YOU ARE REQUIRED TO COMPLETE THIS ENTIRE SECTION, EVEN IF YOU SUBMIT A RESUME. We will make every effort to contact previous employers/ The correct telephone numbers of previous employers are critical.

1. Current or Most Recent Employer Telephone Number: _____

_____ _____
Company Address City State Zip

From _____ To _____ _____ _____

_____
Your Duties and Responsibilities

_____ Per _____ _____
Salary Hour, Week, Month, Year Reason for Leaving

2. Current or Most Recent Employer Telephone Number: _____

_____ _____
Company Address City State Zip

From _____ To _____ _____ _____

_____
Your Duties and Responsibilities

_____ Per _____ _____
Salary Hour, Week, Month, Year Reason for Leaving

3. Current or Most Recent Employer Telephone Number: _____

_____ _____
Company Address City State Zip

From _____ To _____ _____ _____

_____
Your Duties and Responsibilities

_____ Per _____ _____
Salary Hour, Week, Month, Year Reason for Leaving

GAPS IN WORK HISTORY

List any significant gaps in employment history, if the above history does not total 5 years continuous activity: *(ie., caring for ill relative, stay at home mom, volunteer work, school etc)*. There must be at least 5 years of continuous work history or activities listed:

From _____ To _____ _____
Date of Gap Date of Gap Reason for Gap

From _____ To _____ _____
Date of Gap Date of Gap Reason for Gap

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FIVE (5) YEAR OF CONTINUOUS WORK HISTORY IS REQUIRED

YOU ARE REQUIRED TO COMPLETE THIS ENTIRE SECTION, EVEN IF YOU SUBMIT A RESUME. We will make every effort to contact previous employers/ The correct telephone numbers of previous employers are critical.

4. Current or Most Recent Employer Telephone Number: _____

_____ _____
Company Address City State Zip

From _____ To _____ _____ _____

_____
Your Duties and Responsibilities

_____ Per _____ _____
Salary Hour, Week, Month, Year Reason for Leaving

5. Current or Most Recent Employer Telephone Number: _____

_____ _____
Company Address City State Zip

From _____ To _____ _____ _____

_____
Your Duties and Responsibilities

_____ Per _____ _____
Salary Hour, Week, Month, Year Reason for Leaving

6. Current or Most Recent Employer Telephone Number: _____

_____ _____
Company Address City State Zip

From _____ To _____ _____ _____

_____
Your Duties and Responsibilities

_____ Per _____ _____
Salary Hour, Week, Month, Year Reason for Leaving

GAPS IN WORK HISTORY

List any significant gaps in employment history, if the above history does not total 5 years continuous activity: *(ie., caring for ill relative, stay at home mom, volunteer work, school etc)*. There must be at least 5 years of continuous work history or activities listed:

From _____ To _____ _____
Date of Gap Date of Gap Reason for Gap

From _____ To _____ _____
Date of Gap Date of Gap Reason for Gap

REFERENCES

Do not include relatives or previous employers. Include only individuals familiar with your work ability and character.
Each MUST have known you **for at least 5 years**.

Reference Name	Phone Number	Years Known Must be 5yrs or more	Occupation/Job Title/Relationship

○Yes ○No Are you legally eligible for employment in the United States?

○Yes ○No Have you had any moving traffic violations? If yes, please list: _____

○Yes ○No Have you ever been licensed or practiced professionally under a different name?
If so, What Names: _____

○Yes ○No Have you ever had a nursing license, or other professional license, in any jurisdiction limited, suspended,revoked or relinquished?

○Yes ○No Have you ever been sanctioned or fined for misconduct by a professional or trade organization or agency?

○Yes ○No Have you ever served in the U.S. Armed Forces? If yes, what branch: _____

○Yes ○No Have you ever held a position of trust handling money or confidential material?

○Yes ○No Have you been convicted of or served time for a felony? ***(List below)***

○Yes ○No Have you been convicted of a misdemeanor involving physical harm to a person including but not limited to neglect or abuse or a misdemeanor involving financial harm/exploitation to a person including but not limited to theft, misappropriation of funds, fraud or breach or fiduciary duty?

○Yes ○No Have you been convicted of a misdemeanor involving illicit drugs, drug/alcohol misuse or sexual misbehavior *(e.g. indecent exposure, voyeurism)*?

○Yes ○No Have you been charged with child abuse?

○Yes ○No Has a child in your custody or control ever been declared neglected? If yes to any of the above, please list below.

Incident & Date	City & State	Charge

Please initial the applicable blanks in this statement I, the undersigned applicant, certify and affirm that, to the best of my knowledge and belief; _____
I have or_____ I have not bad a case of abuse, neglect, mistreatment, or exploitation substantiated against me. AS a condition of submitting this application and in order to verify this affirmation, I further release and authorize Perfect Care Solutions, Inc., and the Tennessee Department of Intellectual and Development Disabilities to have full and complete access to any and all current or prior personnel or investigative records, from any party, person, business, or agency, as pertains to any allegations against me of abuse, neglect or mistreatment and to consider this information as may be deemed appropriate.

I hereby certify that I have read this application and the answers given by me to the questions and statements are complete and true. I understand that any false information, omissions, or misrepresentations of facts called for in this application may result in rejection of my application or discharge at any time during my employment. I authorize Perfect Care Solutions, Inc., and/or its agents, including consumer-reporting bureaus, to verify any of this information. I authorize all former employers, schools, companies and law enforcement authorities to release any information concerning my background and hereby release any said employers, schools, companies, and Jaw enforcement authorities from any liability for any damage whatsoever for issuing this information.

_____ _____
Application Signature Date

PERFECT CARE SOLUTIONS, INC. is an EQUAL OPPORTUNITY EMPLOYER. Federal and state Jaws, and our own company policy, prohibit discrimination in employment on the basis of age, sex, race, national origin, religion, or disability. Persons denied employment based on conditions may file a complaint with our firm and/or with state or federal authorities.

The following information is optional only and used for Equal Opportunity Employment tracking purposes

Last Name: _____ First Name: _____ Middle Name: _____

Gender: ○Male ○Female Date of Birth: _____ Race or Nationality: _____ *(Optional)*

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I certify that the information contained in this application is correct to the best of my knowledge and understand that falsification of this information or deliberate omission of a material fact in my app1ication is grounds for refusal to hire, or if hired, dismissal.

It is my understanding that Perfect Care Solutions, Inc., may make a thorough investigation of my entire work and personal history *(including police records)* and may verify all data given in my application for employment, related papers, or oral interview. I hereby consent to the Chattanooga Police Department, the Hamilton County Sheriffs Department, or any other jurisdiction of any and all arrest and/or convictions or other police records to release information about me to the Human Resources Department or other agents of Perfect Care Solutions for use only in connection with my application for employment with said organization.

I hereby release the city of Chattanooga and the County of Hamilton, as well as Perfect Care Solutions and their officers, agents, employees, successors, and assigns from any and all claims, actions, or suits, for damages or injuries of whatever nature which may result from release of my police records upon this consent. I specifically authorize any of the persons or organizations referenced in this application to give you any and all information they might have, personal or otherwise, with regard to any subjects covered by this application and release all such parties from all liability for any damage that may result from furnishing such information to you. I authorize you to request and receive such information.

I also understand that **(1)** Perfect Care Solutions has a Drug and Alcohol Policy that provides for pre-employment testing, as well as testing after employment; **(2)** consent to and compliance with such policy is a condition of my employment; and **(3)** continued employment is based upon the successful passing of testing under such Policy. I understand that the samples of bodily fluids *(blood, urine)* that may be requested during the course of the preemployment process may be tested for a number of physical conditions, including, but not limited to use of drugs and alcohol I agree to allow the testing.

I further understand that two **(2)** original sets of my fingerprints may be required because I will have direct contact with or responsibility for people with developmental disabilities. Should the agency use fingerprinting as its source of verification, I agree to allow the fingerprinting and comply with any/all criminal background verification.

I understand that a *Motor Vehicle Record* is required for most positions at Perfect Care Solutions. Because I may be hired or later transfer to a position that requires driving, I agree to provide a current, valid *Motor Vehicle Record* as part of the employment process.

I understand that this is an application for employment and that no employment contract is being offered or implied. In addition, if I am employed, it is also understood that Perfect Care Solutions, should it be warranted and at its sole discretion may change wages, benefits, and policies and procedures. I also understand that the conditions of my employment at any time and the employment with this organization may be terminated any time by either employer or employee at will.

I understand that this application will remain active for 30 days from the date it was made. On the 31st day, the application will be placed in the inactive file.

Signature of Applicant _____ Date _____

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STATEMENT AUTHORIZING RELEASE OF INFORMATION

Date: _____

Name of Agency & Region: PERFECT CARE SOLUTIONS, INC.

Full Name of Applicant/Employee: _____

Previously used names *(nicknames, maiden name, etc.)*

SS#: _____

DL#: _____

State of DL: _____

I _____ certify and affirm that, to the best of my knowledge and belief, I _____ HAVE/ _____ HAVE NOT had a case of abuse, neglect, mistreatment or exploitation substantiated against me. In order to verify this affirmation, I release and authorize Perfect Care Solutions Inc., and the Tennessee Department of Intellectual and Developmental Disabilities *(DIDO)* to have full and complete access to any and all current or prior personnel or investigative records, from any party, person, business, entity or agency, whether governmental or non-governmental, as pertains to any allegations against me of abuse, neglect, mistreatment or exploitation and to consider this information as may be deemed appropriate. This authorization extends to providing any applicable information in personnel or investigative reports concerning my employment with this employer to my future employers who may be providers of services under contract with DIDO

Signature of Applicant/Employee: _____

Date: _____

Witness: _____

Date: _____

Fair Credit Reporting Act Disclosure Regarding Consumer Reports

_____, as a condition of your employment *(post-offer/pre-employment)*, when deciding whether to continue your employment *(if you are hired)*, and when making other employment related decisions directly affecting you, may wish to obtain and use a *"consumer report"* from a *"consumer reporting agency."* These terms are defined in the Fair Credit Reporting Act *("FCRA")*. As an applicant for employment or employee of **Perfect Care Solutions, Inc**, you are a *"consumer"* with rights under the FCRA.

A *"consumer reporting agency"* is a person or business which, for monetary fees, dues or on a cooperative nonprofit basis, regularly assembles or evaluates consumer credit information or other information on consumers for the purpose of furnishing *"consumer reports"* to others, such as **Perfect Care Solutions, Inc**.

A *"consumer report"* is any written, oral or other communication of any information by a *"consumer reporting agency"* bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or collected for the purpose of serving as a factor in establishing the consumer's eligibility or continued eligibility for employment purposes.

If **Perfect Care Solutions, Inc**, obtains a *"consumer report"* about you, and if **Perfect Care Solutions, Inc**, considers any information in such report when making an employment related decision that directly and adversely affects you, you will be provided with a copy of the *"consumer report"* before the decision is finalized. You also may contact the Federal Trade Commission about your rights under the FCRA as a *"consumer"* with regard to *"consumer reports"* and *"consumer reporting agencies."*

Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the information requested. Such disclosure will be made to you within 5 days of the date on which we receive the request from you or within 5 days of the time the report was first requested, whichever is later.

Applicant's Name (Please Print)	Social Security Number
Applicant's Signature	Date

pcs

SECURITY WALLS llc
Impenetrable Protection & Investigative Services

I, _____ authorize Security Walls, LLC to make whatever inquiries it deems necessary in connection . with my application for employment or in the course of review of any employment. I authorize all persons, schools, companies, corporations, credit bureaus, department of motor vehicles and law enforcement agencies to supply information concerning my background. I release Security Walls, LLC, TransUnion, and all persons who provide information concerning me harmless from all liability or any damages resulting from the inquiry and the furnishing of said information.

A photocopy of this authorization shall be deemed an original and shall be accepted as such by every person. I understand that I have the right to request a copy of any report by writing to Security Walls, LLC within 60 days. The fee for this report will be paid at my expense to Security Walls, LLC. As per the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained from a consumer reporting agency such as Security Walls, UC.

_____ _____

Signature Date | Date of Birth

_____ _____

Other names used | Social Security Number

_____ _____

Name as It appears on driver's license | D.L. Number | State

_____ _____

Address | City/State | Zip

_____

Phone Number *(Must Be Provided Before Processing)*

Requested By: Perfect Care Solutions, Inc.

Please print or type all information

All forms should be emailed or faxed to Security Walls 865-546-2932