Dear Applicant,

Thank you for applying for a position at A.C.T. Home Care, Inc. Please fill out all the necessary information requested in this Application for Employment packet. Once you have completed the packet, you may attach a resume and/or other documents (certifications, licenses, etc.) and submit all materials to the A.C.T. Home Care, Inc. front desk. You may also fax the application packet to fax# 706-559-4498, or mail to: A.C.T. Home Care, Inc. 1075 Gaines School Rd. Athens, GA 30605.

All applications are reviewed – and subsequent staffing needs are determined – according to our current and / or projected client demand, and on an as-needed-basis. When application reviews occur, A.C.T. Home Care, Inc. will respond directly to those applicants whose experience, credentials, and applicable employment history meet the standards and requirements necessary to be employed at A.C.T. Home Care, Inc. As applying for a position does not automatically qualify you for an interview, it is the policy of A.C.T. Home Care, Inc. to seek highly qualified, responsible, and professional personnel to work with "A Caring Touch" for our clients. We will contact applicants for an interview that we feel are best suited to fulfill this most important goal of A.C.T. Home Care, Inc.

Thank you for your interest in employment at A.C.T. Home Care, Inc.

Sincerely,

Helen Springs, RN, President

Paula Sartain, RN, BSN, Administrator

A.C.T. Home Care, Inc. "A Caring Touch" 1075 Gaines School Road, Athens, GA 30605
Phone: (706) 559-4432 • Fax: (706) 559-4498 • TOLL FREE: 1-866-559-4432• ACTHomeCare.com
acthomecarecorp@bellsouth.net

Application for Employment

Equal Opportunity Employer

Date: _____

Personal Information

Name:	Social Security Number:			Date of Birth:
Street Address:	City:	State:	Zip Code:	Referred By:
Home Phone:	Cell Phone:			Alternate Phone:

Employment Desired

Position:	Date available to start work:
Are you employed? Y_____ N_____	If employed, may we contact your employer? Y_____ N_____
Have you ever applied/worked for A.C.T. before? Y_____ N_____	If previously employed at A.C.T., dates of employment:

Previous Employment (MUST PROVIDE 5 YEARS OF WORK HISTORY. LIST LAST EMPLOYER FIRST. IF NOT EMPLOYED, PROVIDE LAST 5 YEARS OF LOCATION AND ACTIVITY.)

Name/Address of Employer	Dates of Employment	Position	Reason for Leaving

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Education History

Name/Location of School	Years Attended	Did you Graduate? / Degree

Please list days and hours you are available for work:

_____

_____

In what areas/locations are you interested in working?

_____

_____

List References:

NAME **PHONE NUMBER** **PERSONAL OR PROFESSIONAL**

_____

_____

_____

_____

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Authorization:

I Certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be considered grounds for dismissal. I authorize investigation of all statements contained herein and the references and employees listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability and damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative. This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the American with Disabilities Act (ADA) and other relevant federal and state laws.

Signature _____Date _____

Understanding:

I understand that A.C.T. Home Care, Inc. does not guarantee a full time position. All positions with A.C.T. Home Care, Inc. are PRN (as needed) positions. I further understand that I must agree to work every other weekend, as needed.

Signature _____Date _____

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GCIC Consent Form

I hereby authorize A.C.T. Home Care, Inc. to receive any Georgia criminal history record information pertaining to me, which may be in the files of any state or local criminal justice agency in Georgia.

_____

FULL NAME INCLUDING MAIDEN (please print)

_____

Address

_____	_____	_____	_____
Sex	Race	Date of Birth	Social Security #

_____ _____

Signature Date

Special employment provisions (check the following if applicable)

_____Employment with mentally disabled (Purpose code 'M')

_____Employment with elder care (Purpose code 'N')

_____Employment with children (Purpose code 'W')

Check the following:

_____I_____ give consent to the above named to perform periodic criminal history background checks for the duration of my employment with A.C.T. Home Care, Inc.

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Employment Drug Screen Consent Form

I, _____, hereby understand that, as a condition of my employment, I may be subject to drug testing for any of the following reasons:

- Pre-employment
- Post-hire
- Post-accident
- For cause or suspicion
- Promotion and/or job transition
- Random

I understand that when I am requested to produce a specimen for drug testing, I must comply immediately. I also understand that a positive drug test or refusal to produce a specimen upon request can be cause for termination. I further understand that the illegal use, sale, possession, or distribution of drugs, as well as any illegally obtained prescription medication, is a violation of company policy and is cause for immediate termination.

I understand and accept the terms of this agreement as a condition of my employment.

_____
Signature

_____
Date

Motor Vehicle Report Consent Form

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acthomecarecorp@bellsouth.net

I hereby authorize A.C.T. Home Care, Inc. to receive any Georgia motor vehicle report histories pertaining to me, which may be in the files of any state or local development of motor vehicle agencies in Georgia.

_____	_____
Signature	Date
_____	_____
Witness	Date

Please complete sections (1) and (4) with your signature and date of attached MVR request form.

I_____ give consent to the above named to perform periodic vehicle report histories for the duration of my employment with A.C.T. Home Care, Inc.

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acthomecarecorp@bellsouth.net

Georgia Department of Driver Services
Customer Service, Licensing and Records Division
P.O. Box 80447
Conyers, Georgia 30013

REQUEST FOR MOTOR VEHICLE REPORT (MVR)

☐ **I am requesting my own Georgia MVR. (Complete Sections 1, 3, and 4)**

☐ **I am requesting a Georgia MVR of another individual. (Complete Sections 1, 2, 3, and 4)**

PLEASE PRINT LEGIBLY

SECTION 1 – DRIVER INFORMATION (must exactly match driving record)			
Full Name (First, Middle, Last)			
Driver Date of Birth (MM/DD/YY)		**Driver's License Number**	

SECTION 2 – THIRD PARTY REQUESTOR INFORMATION	
Full Name (First, Middle, Last)	
Firm Name (if applicable)	
Address	
FOR DEPARTMENTAL USE ONLY	

SECTION 3 – TERM OF REQUEST

Please choose one of the following options:
☐ **Three (3) year Georgia MVR ($6.00 fee)** ☐ **Seven (7) year Georgia MVR ($8.00 fee)**

If you are requesting a Georgia MVR by mail, please include a business sized self-addressed stamped envelope along with this request and the required payment amount. By mail, we accept personal checks, cashier's checks, money orders, and company checks.

SECTION 4 – AUTHORIZATION TO RELEASE RECORD OF DRIVER

Under penalty of law, I hereby (please check one)

☐ **request release of my driving record; OR**
☐ **consent to release of my driving record to the person and/or entity named in Section 2, in accordance with O.C.G.A. §40-5-2.**

Signature of Driver		**Date (MM-DD-YY)**	