PROFESSIONAL HISTORY

(LIST LAS EMPLOYER FIRST)

	DATES OF EMPLOYMENT	EMPLOYER'S NAME	TELEPHONE NUMBER	STARTING SALARY	ENDING SALARY	TITLE & DUTIES
	MONTH/YEAR					
FROM						
TO						

	DATES OF EMPLOYMENT	EMPLOYER'S NAME	TELEPHONE NUMBER	STARTING SALARY	ENDING SALARY	TITLE & DUTIES
	MONTH/YEAR					
FROM						
TO						

	DATES OF EMPLOYMENT	EMPLOYER'S NAME	TELEPHONE NUMBER	STARTING SALARY	ENDING SALARY	TITLE & DUTIES
	MONTH/YEAR					
FROM						
TO						

MAY WE COMMUNICATE WITH YOUR EMPLOYER? PAST _YES _ NO PRESENT __ YES __NO

Information provided in response to these questions will not bar employment. If answer to any of the following question "YES", please give full details on separate sheet.

1. Has your clinical license to practice in any jurisdiction ever been limited, suspended, or revoked? __ YES __ NO
2. Have your clinical privileges ever been suspended, diminished, revoked, or not renewed? __ YES __ NO
3. Do you have any physical or mental limitations that may interfere with your function in your profession? __ YES __ NO
4. Have you been convicted of any felony within the past five years? If so state the offense and findings? __ YES __ NO
5. Have you had a physical examination within the past twelve months? __ YES __ NO
6. Have you ever received Workman's Compensation for injuries? __ YES __ NO

PLEASE READ CAREFULLY
APPLICATION CERTIFICATE AGREEMENT

I certify that the statements on this application are true and correct to the best of my knowledge and belief and hereby grant Assurance ElderCare Services, permission to verify such answers. I understand that any false statement on this application may be considered as sufficient cause for rejection of this application or for dismissal if such false statement is discovered subsequent to my employment. I authorize written access to any records concerning my education or employment background. I understand that if any inquiry is made. All information as to it nature and scope will be supplied upon written request.

Signature Date