

APPLICATION FOR AT-WILL EMPLOYMENT

CareLinc Medical Equipment & Supply Co., L.L.C.

This Company is an equal opportunity employer and will not discriminate against any applicant on the basis of any characteristic that is protected by state or federal law. Michigan law requires that a person with a disability or handicap requiring accommodation to perform the essential duties of the job must notify the employer in writing within 182 days of the date that the need is known or should have been known.

Position Applied For: _____ Date of Application: _____

Date You Can Start: _____ *Please note that this application will only remain active for 3 months, after which the applicant would need to re-apply.

Name: _____ Social Security #: _____
Last First Middle

Present Address: _____
Street City State Zip

Permanent Address: _____
Street City State Zip

Telephone #: Home (____) _____ Work (____) _____

Are you 18 years or older? _____ Yes _____ No

Are there any hours or days of the week you cannot work? _____ If so, when? _____

Salary Desired _____ Type of Employment: _____ Full-time _____ Part-time

Are you employed now? _____ May we contact your present employer? _____

Did you ever apply to this Company before? _____ Where? _____

Under what name? _____ When? _____

CURRENT AND FORMER EMPLOYERS: (Most Recent One First)

DATE MONTH/YEAR	NAME, ADDRESS AND TELEPHONE NO. OF EMPLOYER	SALARY: STARTING/ENDING	LAST POSITION HELD/RESPONSIBILITIES	REASON FOR LEAVING
FROM: TO:				
FROM: TO:				
FROM: TO:				
FROM: TO:				
FROM: TO:				

May We Contact The Employers Listed? _____ Yes _____ No
If not, which one(s)? _____

Please read the following statement carefully before signing to indicate your understanding:

I understand that prior to being offered employment, I may be requested to take an employment examination. In the event that I have a disability that will affect my ability to take the test, I will so inform the Company reserves the right to require medical documentation regarding the need for accommodation.

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 may result in termination.

I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated with or without cause, at any time, with or without notice.

I authorize investigation of all statements contained in this application for any employment-related purpose. I release the listed references and all employers, except those specifically accepted, * to provide you with any and all applicable information they may have. I hereby release these references and former employers from all liability for any information they may give to you.

_____ Date _____ Signature

*Employers specifically accepted: _____

For Employer Use Only

Interviewed By: _____ Date: _____ Hired: _____ Yes _____ No

Starting Date: _____ Position: _____ Wage: _____

AUTHORIZATION TO OBTAIN DRIVING RECORDS

Job Applicant / Employee Name: _____

Street Address: _____

City, State, Zip _____

Date _____

CareLinc Medical
89 54TH Street S.W.
Grand Rapids, MI 49548

Dear CareLinc,

Consumer reports may be obtained as part of CareLinc’s evaluation of my job application/employment. The reports may include my driving record, an assessment of my insurability under CareLinc’s insurance coverage’s or other consumer reports. By signing this disclosure, I hereby authorize CareLinc to produce such reports and additional reports about me from time to time as deemed appropriate to evaluate my insurability or for other permissible purposes.

Sincerely,

Signature of Job Applicant: _____

Typed or Printed Name of Job Applicant: _____