Sherwood
HEALTHCARE CENTER

APPLICATION FOR EMPLOYMENT

EMPLOYEE INFORMATION:			
Name: Last First M.I.	**Telephone**	**Social Security #**	
ADDRESS: Number Street	**City**	**State**	**Zip**
POSITION APPLYING FOR:			
Shift desired in order of Preference: **Days Evenings Nights**	**Special Training, Skills and [or Foreign Language Spoken Fluently**		
Name of Schools	**Major Fields**	**Diploma Received**	
Current Professional Registration, License of Certification: **Type State Number Expiration Date**			
If not a U.S. Citizen, do you have the right to remain permanently and work in the USA? **[ ] YES** **[ ] NO If yes Alien Reg. No.**			

REFERENCES:			
Name	**Address**	**Phone**	**Years Known**

Other skills:

EMPLOYMENT HISTORY:

Employer:_____Telephone: _____Supervisor:_____ May we contact? [Y] [N]

From: _____ To: _____ Position: _____

Address: _____

Reason for Leaving: _____ Hours per week:_____

Describe your Duties:

Employer: _____Telephone: _____Supervisor: _____ May we contact? [Y] [N]

From: _____To: _____Position: _____

Address:_____

Reason for Leaving: _____ Hours per week:_____

Describe your Duties:

Employer: _____Telephone: _____Supervisor:_____ May we contact? [Y] [N]

From: _____ To: _____ Position: _____

Address: _____

Reason for Leaving: _____ Hours per week:_____

Describe your Duties:

EMPLOYMENT UNDERSTANDING (Please read and sign) I hear-by certify that the information contained in this application form is true and correct. I authorize ***Maltique, LLC dba Sherwood Healthcare Center*** to contact any of my schools, former employers or other references for the purpose of collecting information. I agree to hold any or all of them blameless and free of any liability for releasing any such information. I understand that if I am employed, any deletion, misrepresentation or misstatement of the facts as stated or implied is sufficient cause for dismissal. I understand that this application does not bind the employer or me for any specific period regarding employment.

I understand that I will be required as a condition of employment, to successfully complete a physical examination before employment. I understand that all offers of employment are conditional on the provision of satisfactory proof-of any applicant's identity and legal authority to work in the United States. I agree to observe all rules regulations and policies of ***Maltique, LLC dba Sherwood Healthcare Center:***

SIGNATURE: **DATE:**

Sherwood
HEALTHCARE CENTER

AGREEMENT, AUTHORIZATION AND CONSENT FOR RELEASE OF BACKGROUND INFORMATION:

I, _____

Last Name *First Name* *Middle Name*

understand that in conjunction with my application for employment, work to be performed under contract, promotion, volunteer position, reassignment, and/or retention ("Work"), ***Maltique, LLC dba Sherwood Healthcare Center*** use the services of an outside agency to research and verify the information I have provided on my application for employment, including my personal background, character, professional work history and qualifications, This agency will provide a written report of its findings to ***Maltique, LLC dba Sherwood Healthcare Center*** uses ENZIO, a consumer-reporting agency, as an agent to perform its Employment related background investigations.

ENZIO will various sources of information, It deems appropriate including but not limited to: criminal conviction records, current and former employers, department of motor vehicle records, military records, credit reporting agencies, education records, professional and personal references and compensation records including any and all injuries in compliance with the Americans with Disabilities Act. agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to ***Maltique, LLC dba Sherwood Healthcare Center***, and ENZIO.

I agree, authorize and consent to the procurement of a Consumer Report and/or an Investigative Consumer Report and understand that it may contain information about my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living, this authorization in original or copy form shall be valid for my term of Work from the date indicated next to my signature. According to the Fair Credit Reporting Act, I be notified ***Maltique, LLC dba Sherwood Healthcare Center*** if Work is denied because of information obtained from a Consumer Reporting Agency, Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to ***Maltique, LLC dba Sherwood Healthcare Center*** I further understand that I may request a copy of the report, and that when doing so, proper identification will be required, and I should direct my request to: ENZIO. I understand that residents all states will automatically receive a copy of the report if an adverse action is taken regarding the employment application, or upon request as outlined herein,

[ ] CHECK THIS BOX: **IF** are applying for work with a California, Minnesota or Oklahoma based employer and you would like a copy of your Consumer Report if one is prepared in the investigation of your background. CA Codes 1785.20.5 & 1785 & 1786.18(a)(5)(b)(1), MN Code 13C Subdivision 2, OK Code 24 0.S, 148

LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES FOR POSITIVE IDENTIFICATION PURPOSES REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS, IT IS CONFIDENTIAL AND WILL NOT EIE USED FOR ANY OTHER PURPOSES, PLEASE PRINT CLEARLY.

SIGNED: _____ TODAY'S DATE: _____

NAME as it appears on your Driver's License: _____ POSITION APPLIED FOR: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

DRIVERS LICENSE NUMBER: _____ STATE: _____

OTHER NAMES THAT YOU HAVE USED, OR ALSO KNOWN AS, INCLUDING MAIDEN NAME, NAME CHANGES AND ANY ALIASES: _____ _____

Corporate Office: Cypress HealthCare Group
2266 Lava Ridge Ct. #105 Roseville, CA 95661