



1025 Westchester Ave, Suite 200  
 White Plains, NY 10604  
 Phone 914-682-1484  
 Fax 914-682-9425  
 E-mail info@hospiceofwestchester.com

**Employment Application**

Date: \_\_\_\_\_

\_\_\_\_\_  
 Position Applying For

**PERSONAL DATA**

NAME: \_\_\_\_\_  
 Last, First, MI

SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Are you at least 18 years of age? \_\_\_\_\_

YES NO

- Have you previously applied to Hospice of Westchester?
- Were you previously employed by Hospice of Westchester?
- Are you legally eligible for employment in this country? (Proof will be required)
- Do you have a current Driver's License?
- Do you have a car available for work?

Date available for employment: \_\_\_\_\_

How did you learn of this position? \_\_\_\_\_

What other languages do you speak/and or write fluently? \_\_\_\_\_

**EDUCATION: (Most Recent First)**

School Name & Address	Dates of Attendance	Major	Degree & Date

**EMPLOYMENT HISTORY: (Most Recent First)**

Company & Address	Name of Supervisor	Position Held	Dates

**CERTIFICATION: PLEASE READ AND SIGN**

I certify that the statements contained herein are true to the best of my knowledge and belief. I understand that any false or misleading statements or omissions made on this application or during the course of any employment, interview, may result in a refusal of employment or, if employed, discipline up to and including immediate termination.

I understand that jobs require pre-employment exams and immunizations, as well as a criminal background check and review of the Child Registry, and that any employment will be made contingent upon satisfactory results. If hired, I agree to abide by all Hospice of Westchester policies, rules and regulations.

Applicant Signature: \_\_\_\_\_



**REFERENCE REQUEST**

Please list three (3) references who you have worked for or are familiar with your work:

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

3. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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By signing below, I accept this as authorization to release personnel information regarding my occupation, qualifications and job performance to Hospice & Palliative Care of Westchester.

I understand that your reply will be held in confidence and without liability to you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_