2103 E Cone Blvd Suite 119, Room 5

Greensboro, NC 27405

 Phone: 336-541-6937 | Fax: 866-491-0389

Email: divinemeasures@dmhc-llc.com

Greetings,

Thank you for considering DMHHC, LLC as your employment source for private non-emergency (NEMT) driver.

DMHHC is licensed by the state of NC to provide Non-Emergency Transportation Services (NEMT) as a private driver(s) or bus/van. We hire commercial as well as private drivers.

DMHHC places divers on trips as they are accepted only and on a part-time basis. We do not guarantee hours or staffing under any circumstances. All driving staff are called and asked to accept or decline open assignments. NC DMV records for the last three (3) years are also required prior to employment and applicants are subject to random illegal drug screenings.

* **Initial here:** **that you understand this policy.**

**Have you ever been convicted of a crime? Yes** **[ ]  No** **[ ]**

If yes, explain number of conviction(s), nature of offence(s), how recently such offence(s) was/were committed, sentence(s), imposed, and type(s) of rehabilitation.

**As you complete your application, be sure it’s accurate and truthful.**

**Thank You!**

|  |  |  |
| --- | --- | --- |
| PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE | **NEMT DRIVER eMPLOYMENT aPPLICATION** | Divine Measures Home Healthcare, LLC |
|  |
| **APPLICANTS WILL BE TESTED FOR ILLEGAL DRUGS** |
|  |
| PLEASE COMPLETE ENTIRE APPLICATION | DATE:       |
| Name       |
|  **Last First Middle Maiden** |
| **Address**  |
|  **Number Street City State Zip** |
| **How long?**  |  **Social Security Number:**  |
| **Telephone:**  |
| **Date of Birth (D.O.B):** **Are you at least 18 years of age? Yes** **[ ]  No** **[ ]**  |
| **Position Applying for:**  | **Days/Hours available to work****No Pref Thur** **Mon Fri** **Tue Sat** **Wed Sun**  |
| **How many hours can you work weekly?** **Can you work nights? Yes** **[ ]  No** **[ ]**  |
| **Employment desired** **[ ] FULL-TIME ONLY** **[ ] PART-TIME ONLY** **[ ] FULL- OR PART-TIME** |
| **When available to start?**  |
|  |
|  |
| **TYPE OF SCHOOL** | **NAME OF SCHOOL** | **LOCATION(Complete mailing address)** | **NUMBER OF YEARS COMPLETED** | **MAJOR & DEGREE** |
| **High School** |  |  |  |  |
|  |  |  |  |  |
| **College** |  |  |  |  |
|  |  |  |  |  |
| **Bus. or Trade School** |  |  |  |  |
|  |  |  |  |  |
| **Professional School** |  |  |  |  |
|  |  |  |  |  |
| **Do you have a valid State Registration and State Inspection?** **[ ]  Yes** **[ ]  No** |
| **Can you provide a driving record for the prior three (3) years? Yes** **[ ]  No** **[ ]**  |
|  |

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| --- |
|  |
| **DO YOU HAVE A DRIVER’S LICENSE?** **[ ]  Yes** **[ ]  No** |
| **Have you resided in North Carolina for the past five (5) years of application date? Yes** **[ ]  No** **[ ]**  |
| **Driver’s License Number:** **State of Issue:** **Expiration Date:** **[ ]  Operator (Regular)** **[ ]  Commercial (CDL)** **[ ]  Other:**  |
| **VIN Number:**  |
| **Have you had a driver’s licenses suspension or revocation during the past five years? Yes** **[ ]  No** **[ ]**  | **How many?**  |
| **Have you had any moving violations during the past three years? Yes** **[ ]  No** **[ ]**  | **How Many?**  |
|  | **Commercial Driver Only**  |  |
|  |
|  **❑ Yes CPR/** **[ ]  Yes Typing \_\_\_\_\_ WPM10-key ❑ No First Aid** **[ ]  No \_\_\_\_\_ WPM** |
| **Personal ❑ Yes PC ❑** **Computer ❑ No Mac ❑**  | **Other** **Skills**  |
|  |
| **Please list two references other than relatives or previous employers.** |
| **Name:**  | **Name:** |
| **Position:**  | **Position:** |
| **Company:**  | **Company:** |
| **Address:**  | **Address:** |
|  |  |
| **Telephone:** | **Telephone:** |
|  |
| **An application form sometimes makes it difficult for an individual to adequately summarize a complete background. Use the space below to summarize any additional information necessary to describe your full qualifications for the specific position for which you are applying.** |
|  |
|  |
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| APPLICATION FOR EMPLOYMENT |
|  | **MILITARY** |  |
|  |
| **HAVE YOU EVER BEEN IN THE ARMED FORCES?** **[ ]  Yes** **[ ]  No** |
| **ARE YOU NOW A MEMBER OF THE NATIONAL GUARD?** **[ ]  Yes** **[ ]  No** |
| **Specialty:       Date Entered:       Discharge Date:** |
|  |
| Work Experience | **Please list your work experience for the** past five years **beginning with your most recent job held.If you were self-employed, give firm name. (**Attach additional sheets if necessary.) |
| **Name of employer      Address** | **Name of last supervisor** | **Employment dates** | **Pay or salary** |
| **City, State, Zip Code      Phone number** |  | **From****To** | **Start****Final** |
|  | **Your last job title** |
| **Reason for leaving (be specific)** |
| **List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.** |
|  |
|  |
|  |
| **Name of employer      Address** | **Name of last supervisor** | **Employment dates** | **Pay or salary** |
| **City, State, Zip Code      Phone number** |  | **From****To** | **Start****Final** |
|  | **Your Last Job Title** |
| **Reason for leaving (be specific)** |
| **List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.** |
|  |
|  |
|  |
| **May we contact your present employer?** **[ ]  Yes** **[ ]  No** |
| **Did you complete this application yourself** **[ ]  Yes** **[ ]  No** |
| **If not, who did?**  |

|  |
| --- |
| **PLEASE READ CAREFULLY** |
| **APPLICATION FORM WAIVER** |
| In exchange for the consideration of my job application by Divine Measures Home Healthcare, LLC (hereinafter called “the Company”), I agree that:Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of and Divine Measure Home Health Care, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the President /General Manager of the Company. Both the undersigned and Divine Measure Home Health Care may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits. |
| I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the Company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Company from any liability as a result of such contract. |
| I also understand that (1) the Company has a drug and alcohol policy that provides for pre-employment testing as well as testing after employment; (2) consent to and compliance with such policy is a condition of my employment; and (3) continued employment is based on the successful passing of testing under such policy. I further understand that continued employment may be based on the successful passing of job-related physical examinations. |
| I understand that, in connection with the routine processing of your employment application, the Company may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics, and mode of living. Upon written request from me, the Company will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act. |
| I further understand that my employment with the Company shall be probationary for a period of sixty (60) days, and further that at any time during the probationary period or thereafter, my employment relation with the Company is terminable at will for any reason by either party. |
|  |
| This Company is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this Company depends solely on your qualifications. |
|  *Thank you for completing this application and for your interest in our business.* |

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**JOB DESCRIPTION**

A. Responsibilities

* Follow instructions for transporting client(s) safely to medical appointment(s)
* Follow **ALL** safety and liability requirements for transporting client(s)
* Report changes in the client’s destination should not be approved **UNLESS** approved by a staff member
* Be on call during normal scheduled hours
* **MUST** arrive to client(s) destination at least 30 minutes prior to scheduled pick up time
* **MUST** have reliable transportation to accommodate trips
* Maintain a clean vehicle free of trash and clutter during times of servicing

B.Organization Relationships

All driver’s (private, bus, or van) works directly under Divine Measure Home Health Care.

**JOB QUALIFICATIONS:**

A. Driver Requirements (Private Driver’s Only)

* Vehicle **MUST** have a valid registration/inspection in licensee name
* Vehicle **MUST** have valid full coverage insurance (*at least at state minimum*)
* **MUST** submit current driving record for the last three (3) years prior to date of application

B. License Requirements (All Driver’s)

* Valid NC Driver’s License

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**Reference Card**

TO BE COMPLETED BY APPLICANT

|  |  |  |  |
| --- | --- | --- | --- |
| *Applicant Name*       |   |       |  *Social Security Number*      |
| *Previous Employer* |  | *Address* | *Telephone #* |
| From       | To       |  |       |
| *Dates of Employment* |  |  | *Position(s) held* |

I hereby authorize you to disclose any information concerning my employment with your agency to Divine Measures Home Healthcare, LLC I understand this in accordance with all applicable Federal and State laws.

**>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>**

**TO BE COMPLETED BY REFERENCE**

**Because we care so much about pleasing our clients, we are asking you to help....** The applicant named below has applied for a position with Divine Measures Home Healthcare, LLC and has listed you as a previous employer. We would appreciate your assistance in verifying this applicant’s employment and evaluating his/her job performance so that we will be able to maintain our standards for offering the highest caliber of personnel. All information provided will be held in the strictest of confidence. **Thank you**

Does the information below correspond with your records? [ ] yes [ ] no

From To

|  |  |  |
| --- | --- | --- |
| Dates of Employment |  | Position(s) held |
| Signature | Title | Date |
| Agency Name |  |  |

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Criminal Background Check Consent Form

I,       hereby authorize Divine Measures Home Healthcare, LLC full consent to conduct a background check. I understand that upon hire, background checks must be completed every five (5) years to maintain compliance with state requirements and annually to maintain compliance with the county. I also understand that in addition to a standard background check, if I have not resided in the State of North Carolina five (5) years prior to the submission date of this application that I am subject to a fingerprint-based criminal check.

|  |  |  |
| --- | --- | --- |
| Full Name:       | Social Security #:       | D.O.B:       |
| Address:       | Previous Name (if applies):        | Date of change:       |

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Drug Test Consent Form

I,       hereby authorize Divine Measures Home Healthcare, LLC full consent to conduct a background. I understand that while I am employed, I am subject to random drug test screenings to maintain compliance with the State and County requirements. I also understand that my employment status/application can be terminated based on positive results of my drug test.

|  |  |  |
| --- | --- | --- |
| Full Name:       | Social Security #:       | D.O.B:       |
| Address:       | Previous Name (if applies):        | Date of change:       |

