



Lormax Rehabilitation And Health Care Services

P: 1-866-495-KIDS
F: 1-866-495-2445

WWW.LORMAX.ORG

JOB APPLICATION

This establishment does not discriminate on the basis of age, race, religion, color, sex, national origin, marital status, physical or mental disability or any other lawfully protected status. Thank you for taking the time to accurately apply for a position with our agency.

NAME _____ TODAY'S DATE _____

PRESENT ADDRESS _____

TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

ALTERNATE PHONE NUMBER / CELL _____

EMAIL: _____ REFERRED BY: _____

Have you ever applied for work here before? Yes _____ No _____ If yes, when? _____

Positions for which you are applying

Other _____ PT _____ OT _____ SLP _____ DT _____

Do you want: Full time _____ Part time _____ PRN _____ After school hours _____

If full time, which shift would you prefer? Day _____ Evening _____ Weekends _____

If part time, how many hours per week? _____

What shifts are you available for? Day _____ Eve _____ Weekends _____

Which days per week are you available (Please circle days that you can work)

Sun Mon Tues Wed Thurs Fri Sat

After what date are you available to work? _____

If licensed or certified by any State in the health care field, please give number and State of License.

GENERAL INFORMATION:

Special Pediatric Training and Skills: _____

Pediatric Therapy Experiences: _____

Home Health Experiences: _____

EDUCATION:

Name and location of high school or college	From To	Degree or diploma	Major subject
High School	From To		
College or University	From To		
Technical School	From To		

Account for all periods of employment (List most current employment first)

FROM	TO	EMPLOYER	ADDRESS	DUTIES	REASON FOR LEAVING

May we contact the employers listed above? _____

If not, indicate which ones you do not wish us to contact _____

Therefore, you are authorized by my signature below to make such initial investigations, as you deem necessary as to personal character, reputation, work history, convictions or other such lawful inquiries prior to providing pediatric therapy services.

I understand that this application will be active for 60 days if not contacted; thereafter, I will have to reapply.

Signature _____ Date _____

Reference name: _____ Phone #: _____

Professional Relationship: _____

Office Use:

Reference name: _____ Phone #: _____

Professional Relationship: _____

Office Use:

Reference name: _____ Phone #: _____

Professional Relationship: _____

Office Use:

