

**Therapeutic Relations Healthcare Services LLC**

5685 Ridge Rd  
Parma, OH 44129

**Employment Application****A. Personal Information**

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
ADDRESS/APT# /SUITE #		DATE OF BIRTH	HOME/CELL PHONE (   )
CITY	STATE	ZIPCODE	DRIVERS LICENSE NUMER

**B. Employment Objective**

POSITION (S) DESIRED  1.  2.  3.	HOURLY WAGE DESIRED:
	TYPE OF EMPLOYMENT DESIRED  FULL TIME  PART TIME

**C. Employment History** Accurately list your previous employment beginning with the most recent employer first.  
Include military service. Applications without complete information will not be considered.

COMPANY		DATES OF EMPLOYMENT FROM:      TO:	
ADDRESS/P.O. BOX	CITY	STATE	ZIPCODE
NAME AND TITLE OF SUPERVISOR		JOB TITLE	
DESCRIPTION OF DUTIES			
REASON FOR LEAVING			
NOTES: OFFICE USE ONLY			

COMPANY		DATES OF EMPLOYMENT	
		FROM:	TO:
ADDRESS/P.O. BOX	CITY	STATE	ZIPCODE
NAME AND TITLE OF SUPERVISOR		JOB TITLE	
DESCRIPTION OF DUTIES			
REASON FOR LEAVING			
COMPANY		DATES OF EMPLOYMENT	
		FROM:	TO:
ADDRESS/P.O. BOX	CITY	STATE	ZIPCODE
NAME AND TITLE OF SUPERVISOR		JOB TITLE	
DESCRIPTION OF DUTIES			
REASON FOR LEAVING			
COMPANY		DATES OF EMPLOYMENT	
		FROM:	TO:
ADDRESS/P.O. BOX	CITY	STATE	ZIPCODE
NAME AND TITLE OF SUPERVISOR		JOB TITLE	
DESCRIPTION OF DUTIES			
REASON FOR LEAVING			

## D. Education

HIGH SCHOOL NAME		DID YOU GRADUATE HIGH SCHOOL? CIRCLE (1) ONE		(IF NO) DID YOU OBTAIN YOUR G.E.D?
HIGH SCHOOL NAME (IF ATTENDED MORE THAN ONE SCHOOL)		YES          NO		
		COURSE OF STUDY/MAJOR:		NO:  YES: (IF YES, WHAT YEAR)
CITY	STATE	HIGHEST YEAR COMPLETED		
		1   2   3   4		
GRADUATE COLLEGE OR OTHER (TRADE, ETC.) NAME		DID YOU GRADUATE		DEGREE TYPE:
		YES          NO		
CITY	STATE	HIGHEST YEAR COMPLETED		MAJOR
		1   2   3   4		
GRADUATE COLLEGE OR OTHER (TRADE, ETC.) NAME		DID YOU GRADUATE		DEGREE TYPE:
		YES          NO		
CITY	STATE	HIGHEST YEAR COMPLETED		MAJOR
		1   2   3   4		
LICENSES NUMBER (STNA, LPN, RN ONLY)	TYPE	STATE ISSUED		DATE EXPIRES

## E. Professional References (Please Do Not Include Family, Friends, Co-Workers. Management Preferred)

NAME	PHONE (   )	RELATIONSHIP
NAME	PHONE (   )	RELATIONSHIP
NAME	PHONE (   )	RELATIONSHIP

## F. General Information

Are you over twenty-one 21 years of age?	YES          NO
Have you lived in Ohio continuously for the last five (5) years? <b>(Proof will be required upon hire)</b>	YES          NO
Do you have a valid Ohio driver's license?	YES          NO
Do you currently have three (2) or less moving violations on your driving record? (stop sign, traffic light, speeding, at-fault accident)	YES          NO
Do you have reliable transportation?	YES          NO
Are you able to lift at least fifty (50) pounds safely?	YES          NO
Are you able to get down on your knees to perform CPR?	YES          NO

If applicable for the position for which you are applying, are you available to work mornings, evenings, nights, split shifts, and/or weekends?	YES                  NO
OTHER TRAININGS/CERTIFICATIONS (CPR, FIRST AID, CPI, MED PASSING, ETC)	ARE YOUR CERTIFICATIONS STILL VALID? YES                  NO
Have you ever been convicted of a criminal misdemeanor or felony? <b>(Include sealed and expunged)</b> <i>(Criminal convictions are not always a bar to employment. However, TRHS complies fully with the guidelines in the Ohio Revised Code defining those crimes that bar employment.)</i>	YES                  NO
If Yes, Please Provide Details and Date:	
Have you ever applied for a position or been employed by Therapeutic Relations Healthcare Services?	YES                  NO
If yes, what position and approximate date of application or employment:	
POSITION	DATES OF EMPLOYMENT/APPLICATION FROM:                  TO:
POSITION	DATES OF EMPLOYMENT/APPLICATION FROM:                  TO:

### G. Certification and Agreement

**Submitting this application online or by mail:** If invited for an interview, the applicant will be requested to sign a statement certifying the accuracy of the information provided on this application as well as a statement outlining Therapeutic Relations Healthcare Services LLC's application and employment policies. The applicant will also be asked to authorize the release of necessary information from past employment, criminal history and information from other consumer reporting agencies. Applications will remain active for three (3) months from the date of submission.

**Email:** [mrjohnson@therapeuticrhs.com](mailto:mrjohnson@therapeuticrhs.com)

**Mail:** Therapeutic Relations Healthcare Services LLC  
9701 Brookpark Rd Suite 260  
Parma, OH 44129  
Attn: Mr. KenJuan Johnson

***Therapeutic Relations is an equal opportunity employer dedicated to a drug free workplace!***

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_