

Location Name: \_\_\_\_\_

Location Number: \_\_\_\_\_

## Employment Application Supplement

I attest that to the best of my knowledge that I am not an “Ineligible Person” who is currently excluded, debarred or otherwise ineligible to participate in the federal health care programs or in federal procurement or non-procurement programs. To the best of my knowledge, I am not listed on the General Services Administration’s List of Parties Excluded from Federal Programs nor on the HHS/OIG List of Excluded Individuals/Entities. Furthermore, I have never been convicted of any felony criminal offense.

Social Security Number: \_\_\_\_\_

Print Full Name: \_\_\_\_\_  
*First Name, Middle Name, Last Name*

**I understand that any falsification of information on this form will be grounds for termination of my employment from NHC. I understand that NHC will use information on this form to determine if I am an “Ineligible Person” by comparing information on this form to the General Services Administration’s List of Parties Excluded from Federal Programs and to the HHS/OIG List of Excluded Individuals/Entities. Further, I understand that a criminal background check of public records will be made to determine if I have ever been convicted, plead guilty to or plead nolo contendere to any felony or misdemeanor offense.**

\_\_\_\_\_  
*(Signature)*

\_\_\_\_\_  
*(Date)*

**This completed form should be attached to the applicant’s original employment application.**