Assisting Hands® Home Care

Quality Home Care You Can Trust®

Employment Application

Position: Date:

Personal Information (Print) Are you over the age of 18? Y/N

_____

Name (Last, First, Middle) Telephone Number

_____

Address

_____

City/State/Zip Email Address

Are you legally authorized to work in the United States? Yes_____ No_____

Are you applying for: F/T_____ P/T_____ Temp_____

Check off the shift (s) and days you will work?

Days____ Evenings____ Nights____ Weekends____ Holidays_____

Sun____ Mon____ Tues____ Wed____ Thurs____ Fri____ Sat____

2-3 hr Shift ____ 8 hr Shift____ 12 hr Shift____ 24 hr Shift Live-In Shift ___

Have you ever been convicted of a crime other than a minor traffic violation? Yes_____ No_____
(If yes, please explain on back)

Have you been involved in the substantiated abuse or neglect of children or adults under the laws of this or any other state of the United States? Yes_____ No_____ (If yes, please explain on back)

Have you been sanctioned, cited, reported or excluded from participation in Medicare, Medicaid, or any other healthcare related law or regulation? Yes_____ No _____ (if yes, please explain on back.)

If you answered "Yes" to any of the above, you will not be automatically disqualified from employment consideration, except as required by state or federal law.

Do you have a current driver's license? Yes_____ No_____

Have you had your driver's license suspended or revoked in the last 3 years? Yes_____ No____

EDUCATION Highest level of education completed and where

PROFESSIONAL CERTIFICATIONS/LICENSES

Certification/License Type Expiration Date

EMPLOYMENT HISTORY- Begin with the most recent employment

Dates From To Company Name City/State

Titles/Duties Pay Start $ Final $

Reason for Leaving Supervisor Name Telephone Number

May we Contact? Yes_____ No_____

Dates From To Company Name City/State

Titles/Duties Pay Start $ Final $

Reason for Leaving Supervisor Name Telephone Number

May we Contact? Yes_____ No_____

Dates From To Company Name City/State

Titles/Duties Pay Start $ Final $

Reason for Leaving Supervisor Name Telephone Number

May we Contact? Yes_____ No_____

REFERENCES- List three professional references. People who have supervised you in the past. DO NOT LIST RELATIVES OR CO-WORKERS.

_____

Name Telephone Occupation

_____

Name Telephone Occupation

_____

Name Telephone Occupation

CAREGIVER EXPERIENCE:

Have you attended either a certified caregiver, CNA or other formalized training program for this type of work? Yes_____ No_____

Do you have caregiver experience? Yes_____ No_____ If Yes, please list below:

Name and phone number of employer Dates

_____ _____

_____ _____

_____ _____

Do you speak any languages other than English? Yes_____ No_____ If Yes, Please List: _____
Will you work with a client who is incontinent? Yes_____ No_____
Will you work in a situation where most of the work is housekeeping? Yes_____ No_____
Can you work around the following? Animals_____ Smoke_____ Dust_____

EXPERIENCE CHECKLIST: HAVE YOU WORKED WITH/DONE THE FOLLOWING? Please check Yes

SKILLS:

Blood Pressure Check _____ Transfer Board _____ Hoyer Lift _____

Give Bed Bath _____ Light Lift _____ Full Lift _____

Change Diapers (adults) _____ Empty Catheter Bag _____ Prepare Meals _____

Walking Assistance _____ Check Pulse _____ Personal Care _____

Change Sheets while patient is in bed _____

DIAGNOSIS/CONDITIONS:

Alzheimer's/Dementia _____ Diabetes _____ Paraplegic _____

Quadriplegic _____ Parkinson's _____ Stroke _____

Client receiving Oxygen _____

PLEASE READ EACH STATEMENT CAREFULLY BEFORE SIGNING:

I certify that all information provided on this employment application (and accompanying resume, if any) is true and complete. I understand that any false information or omission may disqualify me from further consideration for employment and may result in my dismissal if discovered at a later date.

I authorize the investigation of any or all statements contained in this application. I also authorize, whether listed or not, any person, school, current employer, past employers and organizations to persons and organizations from any legal liability in making such statements.

I authorize Assisting Hands Home Care to perform the following and understand that these items need to be completed before starting to work:

1. Drug screening
2. Criminal background check
3. Professional license check
4. Driver's License check
5. Auto insurance check
6. TB Test

I understand I may be required to successfully pass a drug screening examination. I hereby consent to a pre and/or post –employment drug screen as a condition of employment, if required.

I consent to the release of any or all medical information as may be deemed necessary to judge my capability to do the work for which I am applying.

I hereby acknowledge that I am free of any communicable diseases that could infect, or deemed to be contagious to any clients.

I understand that I am an hourly employee and that this application does not create a contract of neither employment nor guarantee employment for any definite period of time.

I have read, understand and by signing consent to the above statements.

Signature_____ Date_____

This application for employment will remain active for six months. Please notify us of any changes in your telephone number so that we may contact you.