

Caregiver Employment Application

| Personal Information | | | | Please print legibly |
|------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| Last Name | First Name | Middle Initial | Date | |
| | | | | |
| Full Street (Mailing) Address (including apartment number) | | City | State | ZIP |
| | | | | |
| Social Security Number | Day Telephone | Evening Telephone | Fax Number (if available) | |
| | | | | |
| Available starting date | Hours available to work | Days available to work | Desired salary range | |
| | | | | |
| 18 years of age or older? | Do you smoke? | If no, do you object to smoking? | Are you legally eligible to work in the U.S.? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you have a driver's license? | Since When? | List state and license number | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Have you ever had a moving or driving related violation or traffic accident (include tickets)? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, list specifics. | | | | |
| Have you ever been arrested and convicted of a felony and/or a misdemeanor? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain. | | | | |
| Have you ever been the subject of a substantiated complaint of sexual abuse? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain. | | | | |
| Are you certified in First Aid? | Are you certified in CPR? | Do you swim? | Are you certified in lifesaving? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are you willing to become certified in these programs? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If no, please list which programs you are NOT willing to become certified in | | | | |
| Are you comfortable caring for adults when they are mildly ill? | | | Do you need health insurance? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Please list any pets you would NOT be comfortable being around/living with. | | | | |
| Emergency Information | | | | |
| Who should we contact in an emergency? | Relationship? | Telephone | | |
| | | | | |
| Alternate emergency contact? | Relationship? | Telephone | | |
| | | | | |



| Medical Information | | | |
|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| Do you have any medical condition that could affect your ability to provide mobility assistance to a senior? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain. | | | |
| For each of the following, please indicate if you are willing to submit to, at no expense to you. | | | |
| Physical Examination | Drug screening | T.B. test | HIV test |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been immunized against the common childhood diseases? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If no, which ones have you NOT been immunized against? | | | |
| Do you have any diet restrictions? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain | | | |
| Do you have any current or history of emotional health problems? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain | | | |
| Educational Background | | | |
| Do you have a high school diploma/GED? | | Please list name of high school | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Please list name of college (if attended) | | Dates attended | Major |
| | | | |
| Degree/Certificate Received | | Phone Number | |
| | | | |
| Please list any other special training you would like us to be aware of | | | |
| | | | |
| Employment History | | | |
| Current Employer (if a company, full company name) | | Supervisor's Name / Phone Number (if different) | |
| | | | |
| Employer's full mailing address | | City | State |
| | | | |
| Employer's Telephone Number | Position you held | Employed since | Ending salary |
| | | | |
| Reason for Leaving | | | May we contact? |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |



List ALL SENIORCARE References for the Past FIVE Years

| | | | | |
|-------------------------------------------------|--------------------------|---------------------------|--------------|----------------------------------------------------------|
| Company/Family Name | | Date Employed From | | To |
| | | | | |
| Employer's full mailing address | | City | State | ZIP |
| | | | | |
| Employer's Telephone Number | Position you held | Ending salary | | May we contact? |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reason for leaving | | | | |
| | | | | |
| Describe your responsibilities in detail | | | | |
| | | | | |
| Company/Family Name | | Date Employed From | | To |
| | | | | |
| Employer's full mailing address | | City | State | ZIP |
| | | | | |
| Employer's Telephone Number | Position you held | Ending salary | | May we contact? |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reason for leaving | | | | |
| | | | | |
| Describe your responsibilities in detail | | | | |
| | | | | |
| Company/Family Name | | Date Employed From | | To |
| | | | | |
| Employer's full mailing address | | City | State | ZIP |
| | | | | |
| Employer's Telephone Number | Position you held | Ending salary | | May we contact? |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reason for leaving | | | | |
| | | | | |
| Describe your responsibilities in detail | | | | |
| | | | | |
| Company/Family Name | | Date Employed From | | To |
| | | | | |
| Employer's full mailing address | | City | State | ZIP |
| | | | | |
| Employer's Telephone Number | Position you held | Ending salary | | May we contact? |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reason for leaving | | | | |
| | | | | |
| Describe your responsibilities in detail | | | | |
| | | | | |



| Personal, Character or Professional References | | | | | | | | |
|------------------------------------------------------------------------------------------|------------------|----------------------------|----------------------------------------------------------|-----|-------|--------|-----|--------|
| PERSONAL, CHARACTER OR PROFESSIONAL REFERENCE 1 | | | | | | | | |
| Name | | Relationship | | | | | | |
| | | | | | | | | |
| Phone Number | | Length of time known | | | | | | |
| | | | | | | | | |
| PERSONAL, CHARACTER OR PROFESSIONAL REFERENCE 2 | | | | | | | | |
| Name | | Relationship | | | | | | |
| | | | | | | | | |
| Phone Number | | Length of time known | | | | | | |
| | | | | | | | | |
| Caregiving Preferences (circle) | | | | | | | | |
| Companionship Care | Meal Preparation | Activities (puzzles/games) | Medication Reminders | | | | | |
| Dementia/Alzheimers | Laundry | Personal Care | Housekeeping | | | | | |
| Driving Appts/Shopping /Errands <input type="checkbox"/> Yes <input type="checkbox"/> No | | OTHER: | | | | | | |
| Have you had to handle a caregiving emergency of any kind? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If yes, please explain | | | | | | | | |
| Any other information you wish to share? | | | | | | | | |
| AVAILABILITY | | | | | | | | |
| | | Monday | Tuesday | Wed | Thurs | Friday | Sat | Sunday |
| Shift | From: | | | | | | | |
| | To: | | | | | | | |

I CERTIFY THAT I HAVE ANSWERED ALL THE QUESTIONS ON THIS APPLICATION ACCURATELY AND TO THE BEST OF MY KNOWLEDGE. I HAVE NOT WITHHELD ANY INFORMATION WHICH WOULD CAUSE THE INFORMATION GIVEN ABOVE TO BE MISLEADING. IN THE EVENT OF MY EMPLOYMENT AS A RESULT, IN FULL OR IN PART, FROM THE INFORMATION CONTAINED ON THIS APPLICATION, I UNDERSTAND THAT ANY INACCURATE OR MISLEADING INFORMATION IS GROUNDS FOR IMMEDIATE TERMINATION OF EMPLOYMENT.

Signature of Applicant

Date