HOMEWORK SOLUTIONS

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

E-Mail Address	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.?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a driver's license?	Since When?	List state and license number
☐ Yes ☐ No		

Have you ever had a moving or driving related violation or traffic accident (include tickets)?	☐ Yes ☐ No
If yes, list specifics.	
Have you ever been arrested and convicted of a felony and/or a misdemeanor?	☐ Yes ☐ No
If yes, please explain.	
Have you ever been the subject of a substantiated complaint of sexual abuse?	☐ Yes ☐ No
If yes, please explain.	

Are you certified in First Aid?	Are you certified in CPR?	Do you swim?	Are you certified in lifesaving?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Are you willing to become certified in these programs?	☐ Yes ☐ 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?
☐ Yes ☐ No	☐ Yes ☐ 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

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Medical Information

Do you have any medical condition that could affect your ability to provide mobility assistance to a senior?	☐ Yes ☐ 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
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Have you been immunized against the common childhood diseases?	☐ Yes ☐ No
If no, which ones have you NOT been immunized against?	
Do you have any diet restrictions?	☐ Yes ☐ No
If yes, please explain	
Are you willing to receive an annual flu shot?	☐ Yes ☐ No
If no, please explain	

Educational Background

Do you have a high school diploma/GED?	Please list name of high school	
☐ Yes ☐ 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	ZIP
Employer's Telephone Number	Position you held	Employed since		Ending salary
Reason for Leaving				May we contact?
				☐ Yes ☐ No

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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?
				☐ Yes ☐ 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?
				☐ Yes ☐ 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?
				☐ Yes ☐ 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?
				☐ Yes ☐ No
Reason for leaving				
Describe your responsibilities in detail				

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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 ☐ Yes ☐ No		OTHER:	
Have you had to handle a caregiving emergency of any kind?		☐ Yes ☐ No	
If yes, please explain			
Any other information you wish to share?			

AVAILIBILITY

		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