



# 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

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## PROFESSIONAL CERTIFICATIONS/LICENSES

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Certification/License Type

Expiration Date

**EMPLOYMENT HISTORY- Begin with the most recent employment**

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Dates from

To

Company Name

City/State

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Titles/Duties

Pay Start \$

Final \$

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Reason for Leaving

Supervisor Name

Telephone Number

May we Contact? Yes \_\_\_\_\_ No \_\_\_\_\_

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Dates from

To

Company Name

City/State

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Titles/Duties

Pay Start \$

Final \$

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Reason for Leaving

Supervisor Name

Telephone Number

May we Contact? Yes \_\_\_\_\_ No \_\_\_\_\_

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Dates from

To

Company Name

City/State

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Titles/Duties

Pay Start \$

Final \$

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Reason for Leaving \_\_\_\_\_ Supervisor Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

May we Contact? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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Name \_\_\_\_\_ Telephone \_\_\_\_\_ Occupation \_\_\_\_\_

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Name \_\_\_\_\_ Telephone \_\_\_\_\_ Occupation \_\_\_\_\_

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Name \_\_\_\_\_ Telephone \_\_\_\_\_ Occupation \_\_\_\_\_

CAREGIVER EXPERIENCE:

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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 \_\_\_\_\_

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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 One Care Companion 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.

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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.