

ALLIED HOME CARE LICENSED PERSONNEL APPLICATION

Please advise us if you need accommodation to complete this application

Date of Application _____ **Social Security #** _____ **Skill** _____

Last Name: _____ First Name: _____ Middle Initial _____

Street Address _____ Apt. # _____ Home Phone # _____

City _____ State _____ Zip Code _____ Message Phone# _____

Are you at least 18 years old? Yes No Will you work in a home with a pet? Yes No

Date of Birth _____ Do you have access to public transportation? Yes No

Do you have access to a car? Yes No Do you have a driver's license? Yes No

Driver License # _____ State _____ Expiration Date _____

Have you been convicted* of a felony within the last 7 years? Yes No If Yes, please explain: _____

*(Conviction will not necessarily disqualify an applicant from employment)

Professional License # _____ State _____ Expiration Date _____

Do you have professional liability insurance? Yes No If Yes, Who is carrier? _____

What is amount of coverage? _____ Have you ever been bonded? Yes No

How were you referred to ALLIED HOME CARE? Newspaper (Name) _____

Friend Name of Friend: _____ Other: _____

I am fluent in the following languages: _____

***Skill Inventory A** (check areas in which you have experience or training)*

Skill	Experience	Training	Skill	Experience	Training
Head Nurse			Pediatrics		
Home Care			Peds – ICU		
Staff Relief			OB / GYN		
Private Duty			Neonatal – ICU		
Hospital			Med – Surg		
Nursing Home			ICU – CCU		
Industrial Nurse			IV Therapy		
Public Health Nurse			Psychiatric		
School			Oncology		
Geriatrics			Neurology		
Orthopedics			Other		
Staff Relief					

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

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Skill Inventory B (check areas in which you are proficient)

Meds: IV	<input type="checkbox"/>	Ztrack	<input type="checkbox"/>	Kangaroo Pump.....	<input type="checkbox"/>
PO	<input type="checkbox"/>	Interdermal	<input type="checkbox"/>	Gastro Tube Feed.....	<input type="checkbox"/>
IM	<input type="checkbox"/>	Sub Q	<input type="checkbox"/>	Suctioning.....	<input type="checkbox"/>
Heparin Lock.....	<input type="checkbox"/>			Trach Care.....	<input type="checkbox"/>
Subclavian.....	<input type="checkbox"/>				
Dressings: Sterile	<input type="checkbox"/>			Respirators.....	<input type="checkbox"/>
Catheterization: Male... <input type="checkbox"/>	Female..... <input type="checkbox"/>			Respiratory Therapy..	<input type="checkbox"/>
Apnea Monitor	<input type="checkbox"/>			IV's.....	<input type="checkbox"/>
Cardiac Monitor.....	<input type="checkbox"/>			Ostomy Care.....	<input type="checkbox"/>
Fetal Monitor.....	<input type="checkbox"/>			Hyperalimentation...	<input type="checkbox"/>
EKG.....	<input type="checkbox"/>			Oxygen Therapy.....	<input type="checkbox"/>
				Other _____	

What are your work preferences? _____

What Days/Hours are you NOT available? _____

Education	High School	College	Other
School Name, City, State			
Graduated?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Degree or Major			

Previous Employment: List your last 3 employers (both permanent and temporary)						
Dates	Name/Address of employer	Phone #	Supervisor	Position	Salary	Reason for leaving
From	To					

Personal References (No Family)				
Name	Address	Occupation	Phone #	Number of years known

Are you capable of performing in a reasonable manner the activities involved in the job or occupation for which you have applied? A description of the activities involved in such a job is attached. Do not answer this question unless you have been informed about the requirements of the job for which you are applying. Yes No

I certify that answers given herein are true and complete to the best of my knowledge.
 I understand that, in the event of employment, false or misleading information given in my application or interview may result in discharge.
 I authorize investigation of all references and statements contained in the application for employment as may be necessary in arriving at an employment decision.
 I understand that after meeting all other job prerequisites, and after I am offered a job, employment will be contingent upon the satisfactory outcome of a medical examination.
 I understand that if I am offered employment, I will be working for ALLIED HOME CARE, on its payroll, at its client's premises.
 I understand that my employment may be terminated by ALLIED HOME CARE at any time, without liability to me for wages and salary except as have been earned by me at the date of such termination.

Applicant's Signature: _____ Date: _____