

# ALLIED HOME CARE 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: \_\_\_\_\_

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<br>From To   | Name/Address of employer | Phone # | Supervisor | Position | Salary | Reason for leaving |
|  |                          |         |            |          |        |                    |
|  |                          |         |            |          |        |                    |
|  |                          |         |            |          |        |                    |

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

**WE ARE AN EQUAL OPPORTUNITY EMPLOYER**

## ALLIED HOME CARE PERSONNEL APPLICATION

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

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: \_\_\_\_\_

LICENSED NURSING PERSONNEL APPLICATION 12/99