EMPLOYMENT APPLICATION

RESPONSE SENIOR CARE

CAREGIVER INFORMATION												
Last name		First		M.I.	Date							
Street address					Apartment/Unit #							
City		State		Zip								
Phone	(home)		(cell)		E-mail:							
Place of birth		Date of birth		SSN								
Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐	NO ☐							
Do you own a vehicle?	YES ☐	NO ☐	If so, can you use it for work?									
Drivers License Number:												

AVAILABILITY												
Full time / hourly	YES ☐	NO ☐	Live-in full time	YES ☐	NO ☐							
Weekend shifts	YES ☐	NO ☐	Live-in weekends	YES ☐	NO ☐							
Night shifts	YES ☐	NO ☐	Are you currently employed?	YES ☐	NO ☐	Date you can start: _____/_____/_____						
Do you have a nursing uniform such as smock tops or scrubs?	YES ☐	NO ☐	(Colorful nursing outfits are permitted)									

EDUCATION AND SPECIAL SKILLS – LIST THE HIGHEST LEVEL OF EDUCATION ATTAINED												
Institution				Location of institution								
From		To		Did you graduate?	YES ☐	NO ☐	Degree					
Are you a CNA, CGNA, or CMA?	Specify which: _____			School/Institution: _____								
License number:		Year completed:		License expiration date:								
re you a CPR certified?	YES ☐	NO ☐	Card expiration date: _____									
Are you First Aid certified?	YES ☐	NO ☐	Card expiration date: _____									
Hobbies and interests:												

PREVIOUS EMPLOYMENT – LIST MOST RECENT FIRST												
Company or Employer's Name				Phone								
Address				City, State, Zip								
Supervisor's name			Supervisor's phone #			Salary						
Supervisor's email address												
From	To		Reason for leaving									
May we contact your previous supervisor for a reference?	YES ☐	NO ☐										

From mth/yr	To mth/yr	Employer, Patient, or Family	Phone #	Pay (hourly or weekly)	Reason for leaving

CAREGIVING EXPERIENCE

INDICATE ANY OF THE FOLLOWING SKILLS FOR WHICH YOU HAVE EXPERIENCE

Transferring patients: bed/wheelchair/chair	YES ☐ NO ☐	Proper lifting	YES ☐ NO ☐
Using a Hoyer lift	YES ☐ NO ☐	Taking blood pressure/vital signs	YES ☐ NO ☐
Assisting stroke victims with paralysis	YES ☐ NO ☐	Caring for diabetic patients	YES ☐ NO ☐
Using incontinence products for incontinent patient	YES ☐ NO ☐	Using oxygen equipment	YES ☐ NO ☐
Caring for Dementia or Alzheimer's patients	YES ☐ NO ☐	Cooking meals	YES ☐ NO ☐

Other skills:

HEALTH STATUS

Are you currently being treated by a physician for any specific medical condition? YES ☐ NO ☐

Have you ever been exposed to TB?	YES ☐ NO ☐	Lifting restrictions or back problems?	YES ☐ NO ☐
Have you been tested for TB? YES ☐ NO ☐	Test date: _____	Do you have allergies to animals?	YES ☐ NO ☐
What were the results of the TB test?	Positive ☐ Negative ☐	If yes, what type of allergy?	
Are you free of infectious diseases?	YES ☐ NO ☐	Would you work with cats present?	YES ☐ NO ☐
Do you smoke?	YES ☐ NO ☐	Would you work with dogs present?	YES ☐ NO ☐

If yes, would you work in a non-smoking environment? YES ☐ NO ☐

If no, would you work in a smoking environment? YES ☐ NO ☐

Do you /have you ever had a problem with drugs or alcohol? YES ☐ NO ☐

Other (specify):

BACKGROUND INFORMATION

Have you ever been charged with or convicted of a felony or misdemeanor, including but not limited to assault, sexual and drug abuse, which have not been expunged dismissed, or sealed by a court? Are you currently being treated by a physician for any specific medical condition?
YES ☐ NO ☐ If yes, explain below: *(A criminal background review will be completed prior to work assignments)*

CHARACTER REFERENCES – DO NOT LIST FAMILY MEMBERS

Name	Phone #	Address	Relationship

EMERGENCY CONTACTS

Name	Phone #	Address	Relationship

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. Further, I understand that false or misleading information given herein, or during the interview, may result in cancellation of any contractual commitments between me and Response Senior Care, and/or in legal action. I authorize, consent, and give permission to have all information verified and employment and character references contacted either/both in written and/or verbal format.

I understand that a physical and PPD (test for Tuberculosis) is required at my own expense.

Signature Date

Note: A copy of the following documents must be submitted with this application

- Driver's license
- Social Security card
- CNA/GNA licenses/certifications
- CPR card
- First Aid training card
- Alien Registration card (if applicable)