



1. PERSONAL INFORMATION

Last Name: _____		First Name: _____		MI: _____	
Address: _____ (Street)		(Apt. #)	(City)	(State)	(Zip Code)
How long have you been living at this address _____					
SS #: _____	Place of Birth: _____	Date of Birth: ____/____/____		Height _____	
Telephone: (____) _____	(____) _____	(____) _____	Weight _____		
	Home	Cellular	Alternate		
Do you have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you own a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		Year: _____	Make: _____	Model: _____	

Drivers License No. _____	State _____	Expiration Date ____/____/____
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2. AVAILABILITY

Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, where? _____
On what date can you start working? _____	
Are you willing to work:	Other Availability
Full time live-in (5 -7 days per week)?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Live-in on the weekends?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Full time live-out (8 to 12 hours weekday)?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Night shift live-out	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
<i>Write in any special request or any special circumstance with regards to your availability:</i>	

3. SPECIAL SKILLS & CERTIFICATES (List any work-related licenses or certificates you have :)

NAME OF INSTITUTION	YEAR COMPLETED	DESCRIPTION OF CERTIFICATE
		CNA <input type="checkbox"/> HHA <input type="checkbox"/> SCA <input type="checkbox"/>
		CNA <input type="checkbox"/> HHA <input type="checkbox"/> SCA <input type="checkbox"/>
		CNA <input type="checkbox"/> HHA <input type="checkbox"/> SCA <input type="checkbox"/>

Check any of the following skills that you have good experience in (Check all boxes that apply)

<input type="checkbox"/> Transfer patients from chair, bed, etc.	<input type="checkbox"/> Using a hooyer lift	<input type="checkbox"/> Giving tube feedings
<input type="checkbox"/> Caring for patient with Alzheimer	<input type="checkbox"/> Handling colostomy bags	<input type="checkbox"/> Operating oxygen system
<input type="checkbox"/> Administering insulin injections	<input type="checkbox"/> Emptying catheters	<input type="checkbox"/> Caring for diabetic patients
<input type="checkbox"/> Taking vital signs / Blood pressure	<input type="checkbox"/> Cooking and Meal Preparation	<input type="checkbox"/> Caring for stroke victims
<input type="checkbox"/> Changing incontinent patients	<input type="checkbox"/> Cooking Kosher meals	

4. WORK EXPERIENCE (At least five years of employment history or complete history if less)

FROM MO/YR	TO MO/YR	FAMILY OR EMPLOYER	PHONE NUMBER	PAY	REASON FOR LEAVING

5. EDUCATION

HIGHEST LEVEL	NAME AND LOCATION OF INSTITUTION	DEGREE/DIPLOMA	DATE COMPLETED

6. REFERENCE:

List three recent clients you have worked for in the last 2 years: (Care recipient or next of kin)				
Name	Phone Number	From	To	Reason for Leaving

7. BACKGROUND

Have you ever been convicted or charged with a crime (felony or misdemeanor) by a court? Yes No

If yes, what was the nature of the offense?

Date of conviction: _____ City & State where convicted: _____

Deposition: (Sentence, probation, etc.)

Have you lived in the Atlanta metro for fewer than 5 years? Yes No

If yes, list the addresses for the last 5 years:

Street Address	City	State	Zip Code	From	To

8. HEALTH INFORMATION

Have you ever been exposed to Tuberculosis (TB)? Yes No

Have you had a TB test within the last year? Yes No

Are you currently under a Physicians care? Yes No

Are you restricted from lifting any amount of weight for medical reason? Yes No

Are you allergic to cats? Yes No

Are you allergic to dogs? Yes No

Are you afraid of pets? Yes No

Do you smoke? Yes No

If you do smoke, can you work in a non-smoking environment? Yes No

If you do not smoke, can you work in a smoking environment? Yes No

Please explain any restrictions, medical conditions, allergies, or any other conditions from the above questions.

9. FOR EMERGENCIES (List family members or friends that can be contacted in the case of an emergency)

Name	Address	Telephone #	Relationship

10. SIGN AND DATE

I Hereby declare the information provided by me in this application is true, correct, and complete to the best of my knowledge. I understand that any misstatement or omission of fact on this application may result in cancellation of any contractual commitments between myself and Alternative Home Care For Seniors Inc.

Signature

Date