Caregiver Application Form

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| Date: [MM/DD/YYYY] | | |  | | | | | | | | | |
| First Name: | | |  | | | | | Last Name: | |  | | |
| Full Address: | | | | | | | | | | | | |
| Email: |  | | | | | SSN/SIN # | | | |  | | |
| Phone: |  | | | | | Work Permit: | | | |  | | |
| DOB: | | | | |  | | | | | | | |
| Position you are applying for: | | | | |  | | | | | | | |
| Do you have a First Aid/CPR certificate?  [If YES, please attach copy of certificate to application] | | | | | | | | | | | | YES NO |
| Certification Registration # | | | |  | | | Expiry Date [MM/YYYY] | | | | |  |
| **AVAILABILITY** | | | | | | | | | | | | |
| Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday | | | | | | | | | | | | |
| Desired wage amount: | | $ | | | Hourly Weekly Monthly Salary | | | | | | | |
| How many hours can you work weekly?  4-16 16-26 26-40 | | | | | | Can you work nights? | | | | | YES NO | |
| Can you work weekends? | | | | | YES NO | |
| Can you work holidays? | | | | | YES NO | |
| Type of employment desired:  FULL-TIME PART-TIME  LIVE IN FULL TIME  ON CALL | | | | | | | | | | | | |
| What date are you available to start work? [MM/DD/YYYY]: | | | | | | | | |  | | | |
| NOTES: | | | | | | | | | | | | |

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| **WORK EXPERIENCE** | | | | | | | | |
| **JOB 1** | | | | | | | | |
| Name of Business/Employer: | | |  | | Job Title/Position: | |  | |
| Employment Dates: | | Start [MM/YY] | |  | End [MM/YY] |  | | |
| Phone/Email: |  | | | | Location: |  | | |
| Person to Contact |  | | | | Position in Company | | |  |
| Reason for Leaving Company: | | | | | | | | |
| Can a representative from our company contact your most recent employer? | | | | | | | YES NO | |

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| **WORK EXPERIENCE** | | | | | | | | |
| **JOB 2** | | | | | | | | |
| Name of Business/Employer: | | |  | | Job Title/Position: | |  | |
| Employment Dates: | | Start [MM/YY] | |  | End [MM/YY] |  | | |
| Phone/Email: |  | | | | Location: |  | | |
| Person to Contact |  | | | | Position in Company | | |  |
| Reason for Leaving Company: | | | | | | | | |
| Can a representative from our company contact this previous employer? | | | | | | | YES NO | |

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| **WORK EXPERIENCE** | | | | | | | | |
| **JOB 3** | | | | | | | | |
| Name of Business/Employer: | | |  | | Job Title/Position: | |  | |
| Employment Dates: | | Start [MM/YY] | |  | End [MM/YY] |  | | |
| Phone/Email: |  | | | | Location: |  | | |
| Person to Contact |  | | | | Position in Company | | |  |
| Reason for Leaving Company: | | | | | | | | |
| Can a representative from our company contact this previous employer? | | | | | | | YES NO | |

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| **TRANSPORTATION** | | | | |
| Do you currently hold a driver’s licence? | | | YES NO | |
| What is your current mode of transportation? |  | | | |
| Driver’s License Number# |  | | | |
| Location where the licence was issued |  | | | |
| Licence Expiration Date [MM/DD/YY] | | |  | |
| Would you be willing to provide a driving record? | | | YES NO | |
| Any driving accidents in the past three years? | YES NO | How many? | |  |
| If yes, please explain: | | | | |
| Any driving violations in the past three 3 yrs.? | YES NO | How many? | |  |
| If yes, please explain: | | | | |

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| **COMMUNICATION** | | |
| Check the technology devices that you use: | Cell Computer Tablet | |
| Do you have a data plan on your mobile device? | | YES NO |
| Will you be willing to fill out a caregiver daily checklist after each visit? | | YES NO |
| Additional Notes: | | |

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| **PERSONAL REFERENCE CONTACTS** | | | |
| Reference 1 | | | |
| Name: |  | Connection: |  |
| Phone: |  | Email |  |
| Have they been notified that they are a reference? | | | YES NO |
| Reference 2 | | | |
| Name: |  | Connection: |  |
| Phone: |  | Email: |  |
| Have they been notified that they are a reference? | | | YES NO |
| Reference 2 | | | |
| Name: |  | Connection: |  |
| Phone: |  | Email: |  |
| Have they been notified that they are a reference? | | | YES NO |

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| **EDUCATION INFORMATION** | | | |
| LEVEL OF EDUCATION | NAME OF SCHOOL | PROGRAM | COMPLETED |
|  |  |  | ☐YES ☐NO |
|  |  |  | ☐YES ☐NO |
|  |  |  | ☐YES ☐NO |
|  |  |  | ☐YES ☐NO |
|  |  |  | ☐YES ☐NO |
|  |  |  | ☐YES ☐NO |
|  |  |  | ☐YES ☐NO |
|  |  |  | ☐YES ☐NO |

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| **RECOGNITION(S) OR ACCOMPLISHMENT(S)** | |
| LIST BELOW | DATE [MM/DD/YY] |
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| **CRIMINAL BACKGROUND** | |
| Have you ever been charged with a criminal offence? | YES NO |
| If so, please explain: | |

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| Referral Source:  Employee TV Google Search Social Media Medical Professional  If a current employee, please specify: |

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| **PLEASE READ CAREFULLY** | | | |
| I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the employer permission to contact schools, previous employers (unless otherwise indicated), and references.  This is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, or age. We assure you that your opportunity for this employment position depends solely on your qualifications. | | | |
| **Signature of Applicant** | **X** | | |
| Full Name of Applicant |  | DATE |  |
| Thank you for completing this application form and for your interest in our company | | | |

**Office Use Only:**

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| --- | --- | --- |
|  |  | **X** |
| **Full name of authorized personnel** |  | **Signature of authorized personnel** |
|  |  |  |
| **Position title of authorized personnel** |  | **Date [MM/DD/YYYY]** |