



Thank you for your interest in joining our team!
Please complete and submit the application below to be considered for a position.

APPLICATION FOR EMPLOYMENT

APPLICANT INFORMATION		LOCATION:	FREMONT	COLUMBUS	NORFOLK	BLAIR
FIRST NAME:	M.I.:	LAST NAME:				
ADDRESS:						
CITY:				STATE:		ZIP:
PHONE:				ALT PHONE:		
ARE YOU 19 YEARS OR OLDER? [Y] [N]				EMAIL:		
SOCIAL SECURITY #:				LANGUAGES:		

HOW DID YOU HEAR ABOUT PROMEDCARE? (PLEASE SPECIFY): _____

HAVE YOU EVER SUBMITTED AN APPLICATION HERE BEFORE?: [Y] [N] IF YES, WHEN?:

HAVE YOU EVER BEEN EMPLOYED HERE BEFORE?: [Y] [N] IF YES, WHEN?:

ARE YOU ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF THE JOB FOR WHICH YOU ARE APPLYING WITH OR WITHOUT REASONABLE ACCOMODATION?: [Y] [N]

SKILLS <i>Please check the box next to each of the skills you have experience with.</i>					
<input type="checkbox"/>	COMPANIONSHIP	<input type="checkbox"/>	MEDICATION REMINDERS	<input type="checkbox"/>	GAIT BELT
<input type="checkbox"/>	COOKING / MEAL PREPARATION	<input type="checkbox"/>	FEEDING	<input type="checkbox"/>	TRANSFERS
<input type="checkbox"/>	LIGHT HOUSEKEEPING	<input type="checkbox"/>	BATH / SHOWER/ SPONGE	<input type="checkbox"/>	HOYER LIFT
<input type="checkbox"/>	OUT-OF-HOME ACTIVITIES	<input type="checkbox"/>	DRESSING / GROOMING	<input type="checkbox"/>	INCONTINENCE
<input type="checkbox"/>	CAR / TRANSPORTATION	<input type="checkbox"/>	AMBULATION	<input type="checkbox"/>	DEMENTIA CARE
<input type="checkbox"/>	APPOINTMENTS / ERRANDS / SHOPPING	<input type="checkbox"/>	WALKER / WHEELCHAIR	<input type="checkbox"/>	HOSPICE CARE
<input type="checkbox"/>	LIGHT EXERCISE	<input type="checkbox"/>	TOILETING	<input type="checkbox"/>	BED BOUND CARE
<input type="checkbox"/>	MONITOR / WANDERING / SUPERVISION	<input type="checkbox"/>	FALL RISK / PREVENTION	<input type="checkbox"/>	

<input type="checkbox"/>	OK WITH PETS	<input type="checkbox"/>	OK WITH SMOKING	<input type="checkbox"/>	HAS OWN VEHICLE
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HOW MANY YEARS OF EXPERIENCE DO YOU HAVE AS A CAREGIVER?:

CERTIFICATIONS & CREDENTIALS *Check all that apply and enter expiration date (any other notes if applicable).*

TYPE	LICENSE # / CERTIFICATION #	EXPIRATION DATE
CPR CERTIFICATION		
CNA LICENSE		
CMA CERTIFICATION		
REGISTERED NURSE		
TUBERCULOSIS TEST		

BACKGROUND & DRIVING RECORD *Indicate work eligibility, driving record, and vehicle information.*

ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES?: [Y] [N]

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR IN THE PAST SEVEN (7) YEARS? [Y] [N]

IF YES, PLEASE DESCRIBE: _____

(CONVICTION WILL NOT NECESSARILY DISQUALIFY APPLICANT FROM EMPLOYMENT)

HAVE YOU HAD ANY MOVING TRAFFIC VIOLATIONS?: [Y] [N]

IF YES, PLEASE DESCRIBE:

DO YOU HAVE A VALID DRIVER'S LICENSE?: [Y] [N]

STATE ISSUED:

DRIVER'S LICENSE #:

DRIVER'S LICENSE EXPIRATION DATE:

DO YOU HAVE VALID CAR INSURANCE?: [Y] [N]

INSURANCE EXPIRATION DATE:

EDUCATION & TRAINING *Please provide educational degrees and institutions attended.*

PLEASE INDICATE THE HIGHEST GRADE LEVEL COMPLETED:

GRADE SCHOOL: 6 7 8 HIGH SCHOOL: 9 10 11 12 COLLEGE: 13 14 15 16 16+

	NAME	CITY, STATE	MAJOR SUBJECTS	# YEARS ATTENDED	GRADUATE
HIGH SCHOOL:					[Y] [N]
COLLEGE:					[Y] [N]
VOCATIONAL:					[Y] [N]

ARE YOU VETERAN OF THE UNITED STATES ARMED SERVICES?: [Y] [N]

IF YES, PLEASE PROVIDE DATES OF ACTIVE DUTY:

BRANCH OF SERVICE:

RANK:

TYPE OF DISCHARGE:

EMPLOYMENT HISTORY*Provide your current and/or most recent positions of employment.*

ARE YOU CURRENTLY EMPLOYED?: [Y] [N]

MAY WE CONTACT YOUR CURRENT AND/OR PREVIOUS EMPLOYERS?: [Y] [N]

EMPLOYER:		PHONE:
SUPERVISOR:		PHONE:
ADDRESS:		
CITY:	STATE:	ZIP:
DATES EMPLOYED:		
TITLE:		SALARY:
DUTIES:		
REASON FOR LEAVING:		
BEST TIME TO CALL:		

EMPLOYER:		PHONE:
SUPERVISOR:		PHONE:
ADDRESS:		
CITY:	STATE:	ZIP:
DATES EMPLOYED:		
TITLE:		SALARY:
DUTIES:		
REASON FOR LEAVING:		
BEST TIME TO CALL:		

EMPLOYER:		PHONE:
SUPERVISOR:		PHONE:
ADDRESS:		
CITY:	STATE:	ZIP:
DATES EMPLOYED:		
TITLE:		SALARY:
DUTIES:		
REASON FOR LEAVING:		
BEST TIME TO CALL:		

PERSONAL REFERENCES*Provide professional and/or long-time personal references.*

NAME:	RELATIONSHIP:
OCCUPATION:	NUMBER OF YEARS ACQUAINTED:
PHONE:	ALT PHONE:

NAME:	RELATIONSHIP:
OCCUPATION:	NUMBER OF YEARS ACQUAINTED:
PHONE:	ALT PHONE:

NAME:	RELATIONSHIP:
OCCUPATION:	NUMBER OF YEARS ACQUAINTED:
PHONE:	ALT PHONE:

AVAILABILITY*Indicate the days and hours you are available to work. (No guarantee can be made of hours or schedule).*

WHAT DATE ARE YOU AVAILABLE TO BEGIN WORK?:

ARE YOU INTERESTED IN FULL TIME, PART TIME OR BOTH?: FULL TIME PART TIME BOTH

TOTAL HOURS PREFERRED TO WORK PER WEEK:

PREFERRED HOURS:

MORNINGS	AFTERNOON	EVENINGS	OVERNIGHTS	WEEKENDS
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PREFERRED DAYS:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
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HOW MANY MILES FROM HOME ARE YOU WILLING TO TRAVEL?: 0 – 5 6 – 15 16 - 25 25+

EMERGENCY CONTACT*Please provide a person to be notified in case of accident or emergency.*

NAME:	RELATIONSHIP:		
PHONE:	ALT PHONE:		
ADDRESS:	CITY:	STATE:	ZIP:

CERTIFICATION & RELEASE AUTHORIZATION

I certify that I have not purposely withheld any information that might adversely affect my chances for hiring. I attest to the fact that the answers given by me are true and correct to the best of my knowledge and ability. I understand that any omission (including any misstatement) of material fact on this application or on any document used to secure can be grounds for rejection of application or, if I am employed by this company, terms for my immediate expulsion from the company. I also understand that use of illegal drugs is prohibited during employment. I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment.

SIGNATURE

DATE

RELEASE OF INFORMATION

I permit the company to examine my references, record of employment, education record and any other information I have provided. I authorize the references I have listed to disclose any information related to my work record and my professional experiences with them, without giving me prior notice of such disclosure. In addition, I release the company, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such examination or revelation.

AUTHORIZATION TO SECURE REPORT

I authorize PROMEDCARE to make whatever inquiries it may deem necessary, in connection with my course of employment. As part of such inquiries, PROMEDCARE has my permission to contact persons who may have information regarding my suitability for employment and to secure reports. I authorize and instruct any person or agency contacted, to participate or conduct inquiries at its request, to compile information, and to furnish any information obtained as a result of such inquiries.

AUTHORIZATION TO CONDUCT BACKGROUND CHECK

I agree to allow PROMEDCARE to conduct a thorough background check, prior to employment. Applicants and current employees must consent to and pass a background check, which includes: **APS/CPS Registry, Sexual Offender, Criminal, EPLS or www.sam.gov and OIG or Office of the Inspector General**, prior to any final appointment. PROMEDCARE performs background checks in accordance with the Fair Credit Reporting Act and applicable and state and local law. I understand that continued employment is contingent on satisfactory results of the company’s screening process, no matter when those results are discovered.

CONSENT FOR INSURANCE CONFIRMATION

I give my current insurance broker authorization to release my employer, information including but not limited to automobile insurance policy(s) information and copies of automobile policy(s) and certificates of insurance. I also give authorization to advise my employer of any changes in my automobile insurance. I am aware and acknowledge the information is used by the employer to confirm adequate and proper insurance coverage of my automobile while being used in the course of my employment.

AUTHORIZATION FOR DRUG SCREENING

I consent to drug testing to detect the presence of alcohol or the illegal use of drugs prior to employment and during employment at random. If this test is positive, and for this reason I am not hired, I understand that I will be given the opportunity to explain the results of the test.

EQUAL OPPORTUNITY EMPLOYER

PROMEDCARE is an Equal Opportunity Employer. This company does not, and will not, discriminate in employment and personnel practices on the basis of race, sex, age, handicap, religion, national origin or any other basis prohibited by applicable law. Hiring, transferring and promotion practices are performed without regard to the above listed items.

By signing, I understand this is not a contract of employment.

I hereby acknowledge that I have read and understand the above disclosures

PRINTED NAME

DATE

SIGNATURE

DATE