

Caregiver Application Form

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

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?			<input type="checkbox"/> YES <input type="checkbox"/> NO

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?			<input type="checkbox"/> YES <input type="checkbox"/> NO

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?			<input type="checkbox"/> YES <input type="checkbox"/> NO

TRANSPORTATION

Do you currently hold a driver's licence?		<input type="checkbox"/> YES <input type="checkbox"/> 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?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Any driving accidents in the past three years?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many?	
If yes, please explain:			
Any driving violations in the past three 3 yrs.?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many?	
If yes, please explain:			

COMMUNICATION			
Check the technology devices that you use:		<input type="checkbox"/> Cell	<input type="checkbox"/> Computer <input type="checkbox"/> Tablet
Do you have a data plan on your mobile device?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Will you be willing to fill out a caregiver daily checklist after each visit?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Additional Notes:			

PERSONAL REFERENCE CONTACTS (Excluding family members)			
Reference 1			
Name:		Connection:	
Phone:		Email:	
Have they been notified that they are a reference?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Reference 2			
Name:		Connection:	
Phone:		Email:	
Have they been notified that they are a reference?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Reference 2			
Name:		Connection:	
Phone:		Email:	
Have they been notified that they are a reference?		<input type="checkbox"/> YES <input type="checkbox"/> NO	

EDUCATION INFORMATION

LEVEL OF EDUCATION	NAME OF SCHOOL	PROGRAM	COMPLETED
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

RECOGNITION(S) OR ACCOMPLISHMENT(S)

LIST BELOW	DATE [MM/DD/YY]

CRIMINAL BACKGROUND

Have you ever been charged with a criminal offence?

YESNO

If so, please explain:

