



NOTES (Office use only)

Application for Employment

It is the policy of Foothill HomeCare Partners, Inc. to provide equal employment opportunities to all applicants without regard to any legally protected status such as race, color, religion, gender, national origin, age, disability or veteran status.

Personal Information

Name _____ Date _____
First Last Preferred Name

Address _____
Street City State Zip

Phone _____ Date of Birth _____
Home Cell

E-Mail Address _____ Social Security # _____

CA Driver's License _____ or CA ID Card _____ Exp. Date _____

Emergency Contacts _____
Name Relationship Phone

Caregiver Registration

Have you been a caregiver in the past? Yes No

If yes: HCA # _____ Date of Live Scan _____

Can you provide proof of a negative TB test or chest X-Ray in last two years? Yes No

Have you ever been convicted of a felony? Yes No

Availability

When are you available to begin work? _____ Employment Desired: Full-Time Part-Time

How many hours can you work weekly? _____ Can you work: Weekdays Weekends Nights

Please indicate the days of the week as well as the earliest and latest times that you are available for work.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

Skills & Preferences

Please check if you have experience with the following:

Activities of Daily Living:

- Companionship
- Bathing
- Dressing
- Cooking
- Light Housekeeping
- Laundry
- Grocery/Errands
- Medication reminders
- Toileting Assistance

Advanced Skills & Equipment:

- Transfer Assist
- Hoyer Lift Transfer
- Catheter Care
- Colostomy Care
- Gait Belt

Conditions/Diagnoses:

- Alzheimer's
- Dementia
- Incontinence
- Hospice/End of Life Care

Other Applicable Skills: _____

Do you prefer male or female client?

- Male Female Either

Are you okay with clients who smoke?

- Yes No

Are you ok with pets?

- Yes No

If yes, what animals? _____

Transportation

Please note, driving is not a condition of employment as not all clients have transportation needs.

Do you drive?

- Yes No

Do you have dependable transportation to/from work?

- Yes No *Explain* _____

Are you willing to use your vehicle to transport clients?

- Yes No Not Applicable

If yes: Make & Model _____ Year _____ License Plate # _____

Insurance Provider _____ Policy # _____ Exp. Date _____

How far are you willing to commute to work? _____

Education

High School _____ Location _____

College _____ Location _____

Trade School/Other _____ Location _____

Certified Nursing Assistant (CNA) Yes No *If yes, CAN License #* _____

Degrees/Certificates _____

Languages other than English that you speak _____

Personal References

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Employment History

Please complete in order of most recent.

Company _____ City _____ From _____ To _____

Title _____ Contact _____ Phone _____

Responsibilities _____

Company _____ City _____ From _____ To _____

Title _____ Contact _____ Phone _____

Responsibilities _____

Company _____ City _____ From _____ To _____

Title _____ Contact _____ Phone _____

Responsibilities _____

Are you currently working for your most recent employer? Yes No

May we contact your current employer? Yes No

Were you referred to us by someone? If so, Who? _____

I certify that the information provided on this application is truthful and accurate. I understand that providing false or misleading information will be the basis of immediate termination.

Applicant Signature _____ Date _____