

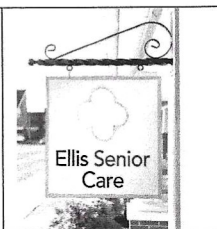
Ellis Senior Care, LLC



EMPLOYMENT APPLICATION for HOME CARE WORKER

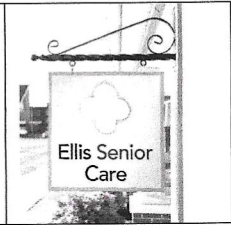
Personal Information	
Name	First _____ 2 nd Initial _____ Last: _____
Address	Street: _____ Apartment: _____ City: _____ State: _____ Zip: _____
Phone	Home: _____ Cell: _____ Other: _____
Electronic	Email Address: _____
Date of Birth	Day: _____ Month: <u>N/A</u> Year: _____
SIN	Social Insurance Number: _____
Gender	Male: _____ Female: _____
Language	What languages do you speak? _____ _____
Emergency Contact	Name & Phone Number of Person to contact in the event of an emergency: Local: _____ Out-of-Area: _____
Education	
Formal	Diploma: _____ Certificate: _____ Degree: _____ Other: _____ Other: _____

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Informal	Do you have current First Aid Certification (State Level): _____ Expiry Date: _____ Do you have current CPR? _____ Expiry Date: _____ Have you taken a Food Safety course? _____ Other: _____ <div style="text-align: center;">(Specify)</div> Other: _____ <div style="text-align: center;">(Specify)</div>
Restrictions	
Work Limitations	List any work limitations that you may have and briefly describe: Hearing: ___ Yes ___ No _____ Speech: ___ Yes ___ No _____ Lifting: ___ Yes ___ No _____ Health: ___ Yes ___ No _____ Physical: ___ Yes ___ No _____ Emotional: ___ Yes ___ No _____ Other: ___ Yes ___ No _____
Availability for Work	
Hours & Days Available for Work	_____ Full-time _____ Part-time _____ Short-notice _____ Split Shift Indicate Days and List Hours Available for Work: ___ Sunday: From: _____ To: _____ ___ Monday: From: _____ To: _____ ___ Tuesday: From: _____ To: _____ ___ Wednesday: From: _____ To: _____ ___ Thursday: From: _____ To: _____ ___ Friday: From: _____ To: _____ ___ Saturday: From: _____ To: _____ What is the minimum number of hours you will work in one day? _____ What is the maximum number of hours you will work in one day? _____
Type of Work Seeking	
Type of Position(s) Preferred	_____ Home Maker _____ Personal Care _____ Companion _____ Live-In _____ Registered Nurse: Other: _____ <div style="text-align: center;">(Specify)</div> Live-in care usually requires that you to in a client's home continuously for 3-4 days at a time every week. Indicate which shifts you will accept: ___ Weekdays (Monday a.m. to Friday a.m.) _____ Weekends: (Friday a.m. to Monday a.m.)

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Clients Not Willing/Able to Work With	<input type="checkbox"/> Dementias/Alzheimer's <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Smokers <input type="checkbox"/> Pets <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Females <input type="checkbox"/> Behavioral Disorders <input type="checkbox"/> Males <input type="checkbox"/> Elderly (over 65) <input type="checkbox"/> Client use of marijuana for medicinal purposes <input type="checkbox"/> Children <input type="checkbox"/> HIV Positive/Aids <input type="checkbox"/> Other: _____ <div style="text-align: right;"><i>(Specify)</i></div>
Duties Not Willing/Able to Perform	<input type="checkbox"/> Bathing <input type="checkbox"/> Housekeeping <input type="checkbox"/> Grooming <input type="checkbox"/> Laundry <input type="checkbox"/> Oral Care <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Dressing <input type="checkbox"/> Shopping <input type="checkbox"/> Bowel Care <input type="checkbox"/> Transportation <input type="checkbox"/> Bladder Care <input type="checkbox"/> Medication Reminding <input type="checkbox"/> Feeding <input type="checkbox"/> Friendly Reassurance Phone Call/Home Visit <input type="checkbox"/> Ambulation <input type="checkbox"/> Other _____
Experience	Indicate which of the following you have experience in: <input type="checkbox"/> Bathing/Showering <input type="checkbox"/> Housekeeping <input type="checkbox"/> Grooming <input type="checkbox"/> Laundry <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Dressing <input type="checkbox"/> Shopping <input type="checkbox"/> Bowel Care <input type="checkbox"/> Transportation <input type="checkbox"/> Bladder Care <input type="checkbox"/> Medication Reminding <input type="checkbox"/> Feeding <input type="checkbox"/> Friendly Reassurance Phone Call or Home Visit <input type="checkbox"/> Ambulation <input type="checkbox"/> Socialization <input type="checkbox"/> Toileting <input type="checkbox"/> Other _____ <div style="text-align: right;"><i>(Specify)</i></div>
Assignment Location	Are you restricted in the geographical location you are willing/able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ _____
Transportation	
Type	<input type="checkbox"/> Private Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Bike <input type="checkbox"/> Other: _____ <div style="text-align: right;"><i>(Specify)</i></div>
Driver's License	Do you have a valid Driver's License?: _____
Transporting Clients	Are you willing to transport clients in your private vehicle? _____ Do you have adequate vehicle insurance? _____ Are you willing to drive a client's vehicle? _____ Are you willing to escort a client in their own vehicle? _____ Are you willing to escort a client on public transportation? _____ Comments: _____

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Reference Information

Work Related #1 (Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____. Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #2 (2nd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____. Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #3 (3rd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____. Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Personal #1	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, family etc.</i>) _____ (<i>Other than relative.</i>)
Personal #2	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, family etc.</i>) _____ (<i>Other than relative.</i>)

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I certify that, to the best of my knowledge, the answers given are true and complete and that purposeful misrepresentation may result in rejection of my application. I authorize investigation of all statements contained in this application, as required. Additionally, I authorize former employers, references and any other individual/organizations to provide information to Ellis Senior Care, LLC and I hereby release and discharge any of the above and Ellis Senior Care, LLC from any liability of any kind or nature. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary

I agree to a physical examination, if requested, and understand that failure to meet any medical and/or health requirements for the position may prevent my employment with the Agency. I also understand that employment, for certain positions, may be conditional upon successful completion of a substance abuse screening test and a criminal background check

If further understand that, if hired, I may be required to provide proof that I am a citizen of the United States or proof that I am currently authorized to work in the United States.

Applicant's Signature

Date