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Visiting Angels

CAREGIVER APPLICATION

Visiting Angels is an equal opportunity employer, dedicated to a policy of non-discrimination on any basis including race, color, age, sex, religion, disability, national origin or marital status. All information on this application is confidential.

General Contact Info

Date Of Birth: _____ Age: _____

SS Number: _____

| | | |
|-------------|----------------------|-------------|
| Last Name: | First Name: | Middle Int. |
| Address | | Apt #: |
| City: | State: | Zip: |
| Home Phone: | Cell Phone/Provider: | |
| E-Mail: | Date: | |

Position & Availability

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------|------------------------------------|
| I'm applying for a position as: | | | |
| Hours you are available: | Schedule Desired: | Times Not Available: | Are you available for emergencies? |
| Are you available for 24hr live-in position? Yes <input type="checkbox"/> No <input type="checkbox"/> 3 Days <input type="checkbox"/> 4 Days <input type="checkbox"/> 5 Days <input type="checkbox"/> | | | |
| Hourly Wage Required: | | Are you a legal US citizen Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Are you eligible to work in the US? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| Comments: | | | |

Transportation

| | | |
|-----------------------------------------------------------------------------------------------------------------------|---------------|-----------|
| <i>Some caregiving positions require a valid driver's license or a car, including valid insurance coverage</i> | | |
| Do you have a valid license? Yes <input type="checkbox"/> No <input type="checkbox"/> | State: | License # |
| Do you have a car? Yes <input type="checkbox"/> No <input type="checkbox"/> | Make & Model: | |
| If yes, do you have valid insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Proof of Insurance (see attached photocopy) | | |

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Education

| | | |
|----------------------------|-------------|--------|
| High school: | City/State: | Dates: |
| College: | City/State: | Dates: |
| Other: | City/State: | Dates: |
| Degree/certification: | | |
| Special skills or training | | |

Experience

| |
|-----------------------------------------------------------------|
| Discuss any training or experience you've had with the elderly: |
| What do you enjoy most about working with the elderly? |
| What do you like the least about working with the elderly? |

Criminal History

| |
|-------------------------------------------------------------------------------------------------------------------|
| Have you ever been arrested, felony or misdemeanor? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you ever been convicted of a felony or misdemeanor? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you have any pending charges, felony or misdemeanor? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If yes, please explain |

Emergency Contact Information

| | | |
|--------------|--------------|--------------|
| Name | Address | Relationship |
| Phone (cell) | Phone (home) | |

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Employment History

| | | | |
|----------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|-----|
| Current Employer | | May we contact your current employer? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Company: Address: State : Zip code: | | From: | To: |
| Job Title: | | Reason for leaving? | |
| Duties: | | | |
| Supervisor / Contact Person: | | Phone number: | |

| | | | |
|---------------------------------------------------------------|--|---------------------|-----|
| Company: Address: State: Zip code: | | From: | To: |
| Job Title: | | Reason for leaving? | |
| Duties: | | | |
| Supervisor / Contact Person: | | Phone number: | |

| | | | |
|---------------------------------------------------------------|--|---------------------|-----|
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| | | | |
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| Job Title: | | Reason for leaving? | |
| Duties: | | | |
| Supervisor/ Contact Person: | | Phone number: | |

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Application must be filled out in its entirety to be considered.

Certification and Release: "I certify that the statements made by me on this application are true and complete to the best of my knowledge and are made in good faith. I understand that if I knowingly make any misstatements of fact, I am subject to disqualification, dismissal, or other action pursuant to employment agency policy and procedure, and subject to criminal penalties as prescribed by law."

Restrictive Covenant: I agree not to do business directly with any individual or business entity that Visiting Angels has introduced to me or by entering into employment with such individuals or businesses.

Applicant's Signature: _____ Date: _____

=====

For Office Use Only

Application
Reviewed By: _____ Date: _____

CG Interviewed By: _____ Date: _____

NO WALK-INS - PLEASE
Visiting Angels
264 Amity Road – Suite 208
Woodbridge, CT 06525
203-298-9700
203-298-9677 - Fax

Visiting Angels

CRIMINAL BACKGROUND CHECK AUTHORIZATION

Applicant Name: _____ SSN: _____

Maiden Name or Other Name _____ Sex: _____ Race: _____

Date of Birth: _____ Driver's Lic. # _____ Lic. State: _____

(Information regarding DOB, race and sex is used solely for purposes of identification in connection with the data-base searches. It is not used for any other purpose.)

Please provide your current residential address and the addresses of all of your residences during the last 7 years:

| | <u>DATES</u> | <u>STREET ADDRESS</u> | <u>CITY</u> | <u>STATE</u> | <u>ZIP CODE</u> |
|----|--------------|-----------------------|-------------|--------------|-----------------|
| 1. | _____ | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ | _____ |

Have you ever been convicted of a misdemeanor or felony criminal offense? Yes ☐ No ☐

If you answered YES, please provide the details for each such conviction, including the date of the conviction, the name of the offense, whether the offense was a misdemeanor or felony, the disposition and the jurisdiction in which the conviction occurred.

You must report each and every conviction, regardless of the date of the conviction, and regardless whether the conviction arose from a trial, guilty plea or no contest plea. It is your responsibility to make sure that the information you provide is accurate and complete. If you are hired and we determine that you have failed to accurately report your criminal history, your employment will be terminated.

AUTHORIZATION TO CONDUCT CRIMINAL BACKGROUND CHECKS

I certify that all of the above information is true and correct to the best of my knowledge, information and belief. As a condition of my application for employment, I hereby authorize Visiting Angels to conduct any and all criminal background checks and/or motor vehicle driver's screenings on me that Visiting Angels deems appropriate. I also agree that Visiting Angels may hire or retain third parties to perform such criminal background checks. Further, I authorize the custodian of any records or information relating to my criminal history to release any and all records and information regarding my criminal history to Visiting Angels and/or its agents. In the event that I am hired, I understand and agree that Visiting Angels and/or its agents may, from time to time, conduct additional criminal background checks on me without further notice to me.

Applicant's signature

Date

Skills Check List

Name _____ Date _____

- | | | |
|-------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Ability to Communicate | <input type="checkbox"/> Fall Risk Frequent UTI's | <input type="checkbox"/> Prepare Light Meals |
| <input type="checkbox"/> AIDS Related Patient | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Shower |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hair Dressing | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Set-up |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hemophiliac | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hospice | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> Amputee | <input type="checkbox"/> Hoyer Lift | <input type="checkbox"/> Slightly Confused or Depressed |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Social and emotional Interaction |
| <input type="checkbox"/> Assist with Dressing | <input type="checkbox"/> Knitting | <input type="checkbox"/> Speech Impediment |
| <input type="checkbox"/> Assist with Transfers | <input type="checkbox"/> Legally Blind | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed Baths | <input type="checkbox"/> Lifting Required | <input type="checkbox"/> Walks Independently |
| <input type="checkbox"/> Bed Bound | <input type="checkbox"/> Light Housekeeping | <input type="checkbox"/> Take to Appointments |
| <input type="checkbox"/> Bilingual | <input type="checkbox"/> Limited Personal Care | <input type="checkbox"/> Therapy |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Meal Preparation | <input type="checkbox"/> Verbal or Physical Abuse |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Medication Reminders ONLY | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Colostomy Bag | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Complete Care | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Muscular Dystrophy | |
| <input type="checkbox"/> Crutches or Cane | <input type="checkbox"/> Oral Hygiene and Denture Care | |
| <input type="checkbox"/> CPR | <input type="checkbox"/> Oxygen | |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Parkinson's | |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Paraplegic | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pets | |
| <input type="checkbox"/> Dietary Restriction | | |
| <input type="checkbox"/> DNR | | |

Additional Skills
