PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE

Employment Application Form

The Agency is an Equal Opportunity Health Care Provider and EEO/Affirmative Action provider committed to excellence through diversity, Contract offers are made on the basis of qualifications, and without regard to race, sex, religion, national or ethic, disability, age, veteran status, or sexual orientation.

PLEASE TYPE OR PRINT. Complete the entire application. You may attach a resume, but you must still complete all questions; or your application will be deemed incomplete and may not be considered.

Personal Information

PLEASE COMPLETE ALL QUESTIONS, PAGES 1-4 | **Date:**

Name: Last: | First: | Middle:

Present Address: Street: | City: | Sate: | Zip:

How long at this address?: | Social Security No.:

Home Phone: | Business Phone: | Cell Phone:

Please list age (if under 18):

Position applied for:
Have you ever applied here before: Yes______No______

Salary range desired:

Please indicate the days and times you are available to work:
❑ Anytime

Mon – From: To:
Tue – From: To:
Wed – From: To:
Thur – From: To:
Fri – From: To:
Sat – From: To:
Sun – From: To:

How many hours can you work weekly? | Are you available to work nights? ❑ Yes ❑ Some ❑ None

Are you available to work weekends? ❑ Yes ❑ Some ❑ None | Would you consider live-in? ❑ Yes ❑ No

Employment desired: ❑PART-TIME ONLY ❑FULL- OR PART-TIME ❑FULL-TIME ONLY

Are you legally authorized to work in the US:? ❑ Yes ❑ No | When are you available to start work?:

Where did you hear about us? | Email address:

Education Information

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (City, State)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. Or Trade School				
Professional School				

Have you ever been convicted of a crime? ❑ Yes ❑ No

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation (A conviction will not necessarily result in the denial of employment):

Have you ever worked under a different name? ❑ Yes ❑ No

If YES, what was it and what was the reason?

Do you have any relatives or friends that work for the Company? ❑ Yes ❑ No

If YES, what is their name?

In Case of Emergency, Please Contact: Name: Relation:
Home Phone: Business Phone:

Driving Information

Do you have a driver's license? ❑ Yes ❑ No   Do you have active auto insurance? ❑ Yes ❑ No

Do you have a car? ❑ Yes ❑ No   If NO, how would you get to work?

Driver's License No.:   State of Issue: Expiration Date:

Have you had any accidents during the past three years? ❑ No ❑ Yes How many? ____________

Have you had any moving violations during the past three years? ❑ No ❑ Yes How Many? ____________

Personal Reference Information

List two personal references. **DO NOT LIST relatives or previous supervisors.**

Name: ______________________________   Name: ______________________________

❑ Friend ❑ Co-worker ❑ Teacher ❑ Pastor   ❑ Friend ❑ Co-worker ❑ Teacher ❑ Pastor
❑ Current Client ❑ Former Client   ❑ Current Client ❑ Former Client

Company: ______________________   Company: ______________________

Address: ______________________   Address: ______________________

Telephone where person can be reached 9a – 5p   Telephone where person can be reached 9a – 5p

(_____)______________________________   (_____)______________________________

An application form sometimes makes it difficult to adequately summarize a complete background. Use the space below to summarize any additional information necessary to describe your full qualifications to be a caregiver. Please note any experience with caregiving professionally, for your parents, spouse, children or friends. Use additional sheets, if necessary.

Why do you enjoy caregiving?

Describe some of your volunteer work:

Please check any Certification(s) you currently possess:

❑ Certified Nursing Assistant
❑ Medication Technician
❑ Certified Medicine Aide
❑ CPR certification
❑ Geriatric Nursing Assistant
❑ First Aid Certification
❑ CIJIS Report
❑ MANDT Certification
❑ DDA Certification

Work Experience

Please list **at least two** of your work experiences for the past five years **beginning with your most recent job held. If you were self-employed, give company name.** Attach additional sheets if necessary.

Name and address of employer:	Name of last supervisor	Employment dates	Pay or salary
		From: To:	Start: Final:
Phone number:	Your Last Job Title:		
Reason for leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked here:			

May we contact your present employer? ❑ Yes ❑ No

If NO, Please Explain Why and Please Provide Us With Another Work Reference:

Name and address of employer:	Name of last supervisor	Employment dates	Pay or salary
		From: To:	Start: Final:
Phone number:	Your Last Job Title:		
Reason for leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked here:			

May we contact this employer? ❑ Yes ❑ No

If NO, Please Explain Why and Please Provide Us With Another Work Reference On Separate Sheet:

Skill Information

How would you rate yourself on your experience with the following aspects of caregiving?

1 = No Experience 2 = Some Experience 3 = Good Experience 4 = Excellent Experience

Companionship	❑ 1	❑ 2	❑ 3	❑ 4	Incontinence Care	❑ 1	❑ 2	❑ 3	❑ 4
Meal Preparation	❑ 1	❑ 2	❑ 3	❑ 4	Dementia / Alzheimer's Care	❑ 1	❑ 2	❑ 3	❑ 4
Light Housekeeping	❑ 1	❑ 2	❑ 3	❑ 4					
Bathing / Showering	❑ 1	❑ 2	❑ 3	❑ 4	Comments				
Dressing / Grooming	❑ 1	❑ 2	❑ 3	❑ 4					
Transferring	❑ 1	❑ 2	❑ 3	❑ 4					

PLEASE READ CAREFULLY

APPLICATION FORM WAIVER

I certify that the information on this application and its supporting documents is accurate and complete. I understand and agree that failure to fully complete the form, or misrepresentation or omission of facts, represents grounds for elimination from consideration for employment, or termination after employment if discovered at a later date. I authorize Able Healthcare to investigate, without liability, all statements contained in this application and supporting materials. I authorize references and former employers, without liability, to make full response to any inquiries in connection with this application for employment. If requested, I agree to submit to a physician exam, criminal and credit background investigation, and/or screening for illegal substances upon conditional offer of employment. I understand that this document is NOT an offer of employment and that an offer of employment, if tendered, does NOT constitute a contract for continued guaranteed employment. I undertint that staff employee at Able Health Care serve at-will, and the employment relationship may be terminated at any time by either party, or any or no reason, other than a reason prohibited by law. If employed, I will be required to furnish proof of eligibility to work in the United States, to file state security questionnaire and State loyalty oath, and to comply with company and departmental regulations. I understand that if employed on a temporary basis, I would be paid for hours worked only, and would be ineligible for benefits including paid time off. I understand that first ninety days of regular employment represents a provisional period, during which I would not be eligible to apply for unemployment benefits and during which I may be terminated without right of appeal.

I CERTIFY THAT ALL ANSWERS GIVEN BY ME ARE TRUE, ACCURATE AND COMPLETE. I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the Company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Company from any liability as a result of such contract.

Signature of applicant:____ Date:____________________

Printed name: ____

Please return this application to our office at your earliest convenience
or email to info@ablehealthcaremd.com

7131 Liberty Road Suite 200
Gwynn Oak, MD, 21207
410-637-3005
(Fax) 410-510-1522