

Today's Date: \_\_\_\_\_

Applicants for Employment are considered without regard to race, creed, color, religion, sex, sexual orientation, marital status, national origin, age, disability, status as a Veteran, or being a member of the Reserves or National Guard.

Please Print

Position Applying For:  Home Health Aide  Nurse Assistant  
 Homemaker Other \_\_\_\_\_

How did you hear about Okelani Home Healthcare?

- Advertisement (where?) \_\_\_\_\_
- Care Center: \_\_\_\_\_
- Okelani Employee (whom?): \_\_\_\_\_
- Other: \_\_\_\_\_

General Information

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Are you legally able to be employed in the United States:  Yes  No  
Proof of your eligibility and identity will be required upon employment.

Have you ever filed an application with us before?  
 Yes  No If yes, when? \_\_\_\_\_

Please list any relatives working with or is a client of Okelani Home Healthcare.

\_\_\_\_\_  
\_\_\_\_\_

General Information, cont.

In case of emergency, notify: (check one)  Relative  Friend

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Education**

	Name of School	Course of Study	Years Completed	Degree
High School				
Undergraduate College				
Graduate (Professional)				
Other (specify)				

**Training Record**

Please check the box to any certificates that you have received and list the year you received the certificate.

- Certified Home Health Aide Year: \_\_\_\_\_
- Certified Nurse Aide Assistant Year: \_\_\_\_\_
- Certified Homemaker Year: \_\_\_\_\_
- Other \_\_\_\_\_ Year: \_\_\_\_\_

**Languages**

Please indicate all languages that you can speak, read, and/or write and whether you are good at said language, fair, or fluent.

**Specialized Skills**

Check skills / Equipment Operated:

- CPR
- Hoyer Lift
- Hospice
- Alzheimer's
- Feeding Tube
- Slide board
- Stroke
- Parkinson's
- Catheter
- Oxygen
- Cancer

**Employment History**

Please list your most recent job. Include any job related military service assignments and volunteer activities.

**Explain any gaps in your work history, using the space at the bottom of the employment history.**

Are you currently employed?  Yes  No

If yes, may we contact your current employer?

If no, can we contact your previous employer?

Employer: \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Job Title: \_\_\_\_\_

Hourly  Salary: Starting \_\_\_\_\_ Final \_\_\_\_\_

Supervisor: \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Employer: \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Job Title: \_\_\_\_\_

Hourly  Salary: Starting \_\_\_\_\_ Final \_\_\_\_\_

Supervisor: \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Employer: \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Job Title: \_\_\_\_\_

Hourly  Salary: Starting \_\_\_\_\_ Final \_\_\_\_\_

Supervisor: \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

**Employment Gaps (if any)** \_\_\_\_\_  
Explain: \_\_\_\_\_

**Availability** \_\_\_\_\_

Are you available to work:  Full Time  Part Time

On what date would you be available to start working? \_\_\_\_\_

Are you available to work Holidays?  Yes  No

Are you interested in working as a live-in home health aide?  Yes  No

If yes, please check which days you are available:

- 5 day live-in Monday through Friday's
- 2 day live-in Saturday and Sunday's only
- Both Monday through Friday's and Weekends
- Respite / Emergency fill-in only

Are you interested in working hourly cases?  Yes  No

**Please read carefully  
Before signing**

If you have any questions regarding the following statements, please ask for assistance. It is my understanding that this employment application, or the granting of an oral interview, does not represent a contract of employment or a promise of future benefits by Okelani Home Healthcare. **I understand and agree that if hired, my employment will be at-will in nature and may be terminated, with or without cause, at any time, by either myself or my employer. I also understand that this written statement supersedes any and all oral representations made by agents or representatives of Okelani Home Healthcare.**

**AGREEMENT:** I certify that the information on this application is true, complete, and correct. I hereby authorize the investigation of my past employment, education, and activities, and I release from all liability all persons, companies and corporations supplying such information. I understand that false answers, statements or significant omissions made by me on this form shall be sufficient cause for denial of employment or discharge.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_