**Millie’s Home Care** (**Application for employment)**

| **APPLICANT INFORMATION** |
| --- |

| **Last Name:** | **First Name:** | **M. I.:** | **Date:** |
| --- | --- | --- | --- |

| **Street Address:** | **Apt #:** |
| --- | --- |

| **City:** | **State:** | **Zip code:** |
| --- | --- | --- |

| **Phone #:** | **Email Address:** |
| --- | --- |

| **Date Available:** | **Social Security #:** |
| --- | --- |

| **Position Applying For:** |
| --- |

| **Are you a citizen of the United States: [ ] Yes [ ] No**  **If not, are you authorized to work in the U. S.? [ ]Yes [ ] No (Provide evidence of authorization)** |
| --- |

| **Have you ever worked for this company? [ ] Yes [ ] No If yes, Please provide month and year: \_\_\_\_\_\_\_\_** |
| --- |

| **EDUCATION** |
| --- |

| **High School:** | **Address:** |
| --- | --- |

| **From: To:** | **Did you graduate? [ ] Yes [ ] No** | **Degree:** |
| --- | --- | --- |

| **College:** | **Address:** |
| --- | --- |

| **From: To:** | **Did you graduate? [ ] Yes [ ] No** | **Degree:** |
| --- | --- | --- |

| **Other:** | **Address:** |
| --- | --- |

| **From: To:** | **Did you graduate? [ ] Yes [ ] No** | **Degree:** |
| --- | --- | --- |

**Millies Home Care Application for Employment cont.**

| **REFERENCES: *Please list two professional references*** |
| --- |

**1.**

| **Full Name:** | **Relationship:** |
| --- | --- |
| **Company Name/ Address:** | **Phone number/ Email Address:** |

**2.**

| **Full Name:** | **Relationship:** |
| --- | --- |
| **Company Name/ Address:** | **Phone number/ Email Address:** |

| **PREVIOUS EMPLOYMENT** |
| --- |

| **Company Name:** | **Phone Number:** |
| --- | --- |

| **Address:** | **Supervisor:** |
| --- | --- |

| **Job Title:** | **Starting Salary:** | **Ending Salary:** |
| --- | --- | --- |

| **Responsibilities:** |
| --- |

| **From: To:** | **Reason for leaving:** |
| --- | --- |

| **May we contact your previous supervisor for a reference: [ ] Yes [ ] No** |
| --- |

| **Company Name:** | **Phone Number:** |
| --- | --- |

| **Address:** | **Supervisor:** |
| --- | --- |

| **Job Title:** | **Starting Salary:** | **Ending Salary:** |
| --- | --- | --- |

| **Responsibilities:** |
| --- |

| **From: To:** | **Reason for leaving:** |
| --- | --- |

| **May we contact your previous supervisor for a reference: [ ] Yes [ ] No** |
| --- |

**\*Please provide a copy of your resume for additional reports of work history and educational experience.\***

| **LICENSING INFORMATION** |
| --- |

| **Type of License held: [ ]RN [ ]LPN [ ]HHA [ ]N.A.** | **License Number:** |
| --- | --- |

| **License issuing authority or board:** | **License Expiration:** |
| --- | --- |

| **Applicants malpractice insurance policy number, where applicable:**  **Insurance Carrier Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| --- |

| **MILITARY SERVICE** |
| --- |

| **Branch** | **From: To:** |
| --- | --- |

| **Rank at Discharge:** | **Type of Discharge:** |
| --- | --- |

| **If other than honorable, explain:** |
| --- |

**GENERAL INFORMATION:**

| **Have you ever been convicted of a felony or misdemeanor crime? [ ]Yes [ ]No**  **(This does not apply if the conviction has been expunged, is contained in a sealed record, or was a juvenile conviction.) A criminal conviction will not necessarily bar you from employment. We will consider the nature of the crime, the time that has expired since its occurrence and any rehabilitation you have undergone. *If yes, please state the basis for each conviction and the date of the conviction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| --- |

| **Are you able to perform the tasks according to the job description without accommodation? [ ]Yes [ ]No**  **If accommodations are needed please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| --- |

**DISCLAIMER AND SIGNATURE:**

| **I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Millies Home Care to request and receive from all prior employers within one year of the date of this application, and all the pertinent information concerning my prior employment and its termination, including the reasons for such terminations.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Applicant Signature Date** |
| --- |

**PHYSICIAN STATEMENT OF HEALTH**

**(MILLIES HOME CARE)**

**EMPLOYEE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF EXAM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIAGNOSIS/SIGNIFICANT HEALTH CONCERNS:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT MEDICATIONS:**

| **MEDICATION**  **NAME** | **DOSE** | **FREQUENCY** | **DIAGNOSIS** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**IMMUNIZATIONS:**

**TETANUS/DIPHTHERIA (every 10 years): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**HEPATITIS B: 1)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/ 2) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ 3) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**FLU SHOT: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**COVID VACCINE: 1)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ 2)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ 3)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ 4)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**TUBERCULOSIS SCREENING:**

**DATE GIVEN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ DATE READ: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ RESULTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHEST X-RAY DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ RESULTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHYSICIAN STATEMENT OF HEALTH:**

**(PLEASE SIGN, STAMP, DATE BELOW IF THE ABOVE NAMED HAS BEEN EXAMINED AND FOUND PHYSICALLY CAPABLE TO PERFORM DUTIES AS A HOMEMAKER/HOME HEALTH AIDE)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINT PHYSICIAN NAME PHYSICIAN SIGNATURE & STAMP DATE**

**Millie’s Home Care**

**Develop check off according to information given from inspection. Review binder!!**

**Application Completed Status**

**(Check off list)**

❐ Completed application

❐ Statement of Health

❐ Copy of Certification/License (Signed and dated)

❐ CPR Certification (Can be submitted prior to start date once hired)

❐ Copy of Consumer Affairs License Verification (Sign and dated yearly)

❐ Mental Health Assessment

Comments:

**FOR OFFICE USE ONLY**

| **EMPLOYEE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| --- |