



PERSONNEL APPLICATION

TEHC HEALTHCARE IS AN EQUAL OPPORTUNITY EMPLOYER

PLEASE PRINT BLACK INK ONLY

Date of Application: _____ Social Security#: _____ Skill: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address _____ Apt.#: _____

City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Cell Phone#: _____ Pager#: _____

Are you at least 18 years old? Yes No Will you work in a home with a pet? Yes No

Do you have access to public transportation? Yes No Next of Kin / Emergency contact:

Do you have access to a car? Yes No Name: _____

Do you have a Driver's License? Yes No Phone#: _____

Drivers License#: _____ State: _____ ExpirationDate: _____

Have you been convicted* of a crime other than a traffic violation within the last 7 years? Yes No

If yes, please explain: _____

(*Conviction will not necessarily disqualify an applicant from employment)

Training Certificate#: _____ Issued by: _____ Expiration Date: _____

Have you ever been bonded? Yes No How were you referred to TEHC? Newspaper Friend

Name of Friend: _____ Other: _____

I am fluent in the following languages: _____

Skill Inventory A (Check areas in which you have experience or training)

	Experience	Training		Experience	Training
Hospital	<input type="checkbox"/>	<input type="checkbox"/>	Geriatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Home	<input type="checkbox"/>	<input type="checkbox"/>	Pediatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Private Home	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	AIDS Care	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	Mother/Child Care	<input type="checkbox"/>	<input type="checkbox"/>
Special Diets	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Retardation Care	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	Oncology/Hospice	<input type="checkbox"/>	<input type="checkbox"/>
CVA	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

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Skill Inventory B (Check only the areas in which you are knowledgeable)

- | | | | |
|---------------------------|--------------------------|---------------------|--------------------------|
| Transfer ROM | <input type="checkbox"/> | Foley Care | <input type="checkbox"/> |
| Bathing | <input type="checkbox"/> | Supervise Meds | <input type="checkbox"/> |
| TPR | <input type="checkbox"/> | Intake and Output | <input type="checkbox"/> |
| Blood Pressure | <input type="checkbox"/> | Test Diabetic Urine | <input type="checkbox"/> |
| Dressing Change Unsterile | <input type="checkbox"/> | Specimen Collection | <input type="checkbox"/> |
| Warm/Cold Compresses | <input type="checkbox"/> | Ostomy Care | <input type="checkbox"/> |
| Hoyer Lift | <input type="checkbox"/> | Other _____ | |

What are your work preferences? _____

What Days / Hours are you **NOT** available? _____

Are you available for live-in assignments? Yes No

Education		High School	College	Other			
School Name, City, State							
Graduated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Degree or Major							
Previous Employment: List your last 3 employers (Both permanent and temporary):							
Dates From	To	Name/Address of Employer	Phone #	Supervisor	Position	Salary	Reason for Leaving
Personal Reference (No Family)							
Name		Address	Occupation	Phone#	No. of Years Known		

Are you capable of performing in a reasonable manner the activities involved in the job or occupation for which you have applied? A description of the activities involved in such a job is attached. Do not answer this question unless you have been informed about the requirements of the job for which you are applying. Yes No

I certify that answers given herein are true and complete to the best of my knowledge.

I understand that, in the event of employment, false or misleading information given in my application or interview may result in discharge.

I authorize investigation of all references and statements contained in the application for employment as may be necessary in arriving at an employment decision.

I understand that after meeting all other job prerequisites, and after I am offered a job, employment will be contingent upon the satisfactory outcome of a medical examination.

I understand that if I am offered employment, I will be working for TEHC HealthCare, on its payroll, at its client's premises.

I understand that my employment may be terminated by TEHC HealthCare at any time, without liability to me for wages and salary except as have been earned by me at the date of such termination.

APPLICANTS SIGNATURE: _____ DATE: _____



EMPLOYEE REFERENCE CARD

Because we care so much about pleasing our clients, we are asking you to help.....

The applicant named below has applied for a position with TEHC HealthCare and has listed you as a previous employer. We would appreciate your assistance in verifying this applicant's employment and in evaluating his/her job performance so that we can maintain our high standards. All information provided will be held in strict confidence. Thank You.

Does the information below correspond with your records? YES NO If No, please give correct information:

Would you rehire this employee? YES NO If No, please explain:

FOR SKILLED PERSONNEL – If Applicable : I certify that the applicant has had experience in:

- TPN IV Chemotherapy IV Antibiotic Therapy Blood Draw – Peripheral/Central Hickman/Broviac/Ports
 Urokinase PICC Insertion Mechanical Ventilators IV Pain Management/CADD Pumps Peripheral IV Insertion

FOR PARAPROFESSIONAL PERSONNEL – If Applicable: I certify that the applicant has had experience in the following under RN Supervision:

- Home Health Aide Skills, and / or Personal Care Aide Skills

EVALUATION:

CRITERIA	EXCELLENT	GOOD	AVERAGE	POOR	CRITERIA	EXCELLENT	GOOD	AVERAGE	POOR
Attendance					Job Knowledge				
Punctuality					Accepts Supervision				
Dependability					Approp. Attire				
Quality of Work					Caring Demeanor				

COMMENTS: _____

 SIGNATURE

 TITLE

 DATE

TO BE COMPLETED BY APPLICANT

 APPLICANT NAME (PLEASE PRINT)

 DATE

PREVIOUS EMPLOYER

 FULL ADDRESS

FROM

TO

 DATES OF EMPLOYMENT

 APPROX.#OF HRS. PER WEEK

 POSITON (S) HELD

REASON FOR LEAVING

 WAGE RATE

I hereby authorize you to disclose all and any information concerning my employment with your firm to TEHC HealthCare. I understand this is in accordance with all applicable Federal and State Laws.

 SIGNATURE OF APPLICANT

 DATE