



CARE PROVIDER REGISTRATION

PERSONAL INFORMATION

Date _____

Name (Last, First)		Social Security Number	
Address	City	State	Zip
email address	Cell Phone	Home Phone	

LICENSES/CERTIFICATES HELD

<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> C.N.A. <input type="checkbox"/> HHA	Date Available to Start	
Are you currently employed?	If so, may we contact your employer?	
Have you worked for other Registries or Agencies?		
If so, which one(s)?		

EMPLOYMENT HISTORY

Dates	Employer Name & Address	Position	Salary
		Supervisor	Phone #
Reason for Leaving			
Dates	Employer Name & Address	Position	Salary
		Supervisor	Phone #
Reason for Leaving			
Dates	Employer Name & Address	Position	Salary
		Supervisor	Phone #
Reason for Leaving			

How did you hear about An Answer to Care? _____

EDUCATION

High School	Years Attended	Graduate?	Major
College	Years Attended	Graduate?	Major
Special Training	Years Attended	Graduate?	Major

LIMITS, ALLERGIES, ETC.

Do you Smoke? (required information for Oxygen Clients) _____

Are you willing to work with a client that smokes? _____

Do you have any pet allergies or fears? _____ If so, describe _____

Do you speak any languages other than English? _____ If so, which one(s) _____

Lifting Abilities: Can you lift 50 lbs? _____ 100 lbs? _____ Use a gait belt? _____

Do you Drive? _____ Year, Make & Model of Vehicle _____

Have you ever been convicted of a crime? _____

If Yes, Please provide the details

EMERGENCY CONTACT INFORMATION

Name	Phone # (s)	Relationship
Name	Phone # (s)	Relationship

DISCLAIMER AND SIGNATURE

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

If this application leads to referral, I understand that false or misleading information in my application or interview may result in my release.

Signature _____

Date _____

Equal Opportunity Employer Statement

An Answer to Care is an Equal Opportunity Employer. This company does not and will not discriminate in employment and personnel practices on the basis of race, sex, age, handicap, religion, national origin or any other basis prohibited by applicable law. Hiring, transferring and promotion practices are performed without regard to the above.



Care Provider Availability

Name _____

Date _____

Please indicate your availability below by indicating what hours you are available or unavailable for work (be sure to indicate am or pm as applicable)

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Please check off the areas you are willing to work:

St Lucie County

Martin County

Indian River County

Palm Beach County (north)

Palm Beach County (south)

Okeechobee County

Are you willing to do?

Bath Visits _____

Live-Ins _____

Holidays _____

Split Shifts _____

Babysitting _____

Shift Preferences:

12 Hour Shifts Yes No

Live-Ins Yes No

Short Visits Yes No

Overnights Yes No

Comments Regarding Availability:



Name: _____

HHA/CNA Skills Checklist

<p>DIRECTIONS Carefully assess your strengths and experience level for each skill. This information will be used to match you to a client that best suits your skills.</p>	<p>A - Extremely Confident B - Experienced C - May need assistance D - No Experience in this area</p>
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	A	B	C	D		A	B	C	D
Vital Signs					Housekeeping Duties				
Temperature - Oral					Laundry				
Temperature - Rectal					Dishes				
Temperature - Auxillary					Mopping				
Blood Pressure					Dusting				
Pulse					Grocery Shopping				
Respirations					Errands				
					Changing occupied bed				
Patient Transfer									
Hoyer Lift					Elimination				
Repositioning in bed					Use of Bedpan				
Range of Motion ROM-Upper Body					Use of Bedside Commode				
Range of Motion ROM-Lower Body					Empty Foley Cathetar Drainage bag				
Assist with Ambulation									
Transfer					Care Experience				
					Alzheimers				
Personal Care					Diabetic				
Bed Bath					Stroke				
Shower					Amputee				
Nail & Skin Care					Parkinsons				
Hair Care					Paraplegic/Quadraplegic				
Oral Hygiene					Respiratory Trouble				
Denture Care					Bed Bound				
Assist with Dressing					Hospice				
Shave					Oxygen				
Dressing incapacitated client									
Assess skin tears					Companion Activities				
					Reading				
Meal Preparation					Shopping				
Cooking					Crafts				
Low Salt Diet					Games				
Diabetic Diet					Cards				
Special Diet Instructions					Movies				
Feeding					Sewing Assistance				
					Swimming				
Transporation					Attend Church with Client				
Assist in/out of vehicle					Plan visits or outings with client				
use of wheelchair					Companionship & Conversation				
Use of Client's car					Take client for walks				
Use of Own Car					Beach				
Public Transportation					Travel with client				