10689 N. 99th Ave., Peoria, AZ 85345
Phone: (623) 977-3977 Fax: (623) 977-5067

Application for Employment

Personal Information

Please do not leave any spaces blank. Write "N/A" if not applicable

Date: _____

Name: (Last, First, MI)

_____

Previous/Maiden Name:_____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Cell: _____ Fax: _____

Social Security Number: Email:

Employment Desired

Position Applied for: _____ Date you can start? _____

Select desired shift:

Day: _____
Evening: _____
Overnight: _____
Weekdays ONLY: _____
Weekends ONLY: _____
Other: _____

Please list hours available each day:

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday: _____

How did you hear about this opening? _____

Have you ever applied to All Valley? □ Yes □ No When? _____

Have you previously worked for All Valley? □ Yes □ No? When? _____

Reason for leaving? _____

Have you been convicted of a crime? □ Yes □ No

If so when? _____ Explain: _____

_____

Languages spoken? _____

What skills do you have that would be useful in this line of work? _____

_____

Tell us about yourself._____

_____

What do you hope to learn or experience if employed with All Valley? _____

_____

References

Excluding relatives please list 1 work reference and 2 personal references we may contact. All Valley Home Health Care is required by State Mandate Law to obtain Employment Verification and personal references on all employees. It is extremely important that you list current contact telephone numbers. We must be able to contact and verify these references. **PLEASE do not write in the notes area, For office use ONLY.**

Employment Verification:

Employer Name: _____ From: _____ To: _____

Contact: _____ Ph: _____ Fax: _____

Notes: _____

Personal References:

Name: _____ Relationship: _____

Years known: _____ Ph: _____ Cell: _____

Notes: _____

Name: _____ Relationship: _____

Years known: _____ Ph: _____ Cell: _____

Notes: _____

_____

By signing you are authorizing All Valley Home Health Care & Nursing to contact references listed above.

Signature: _____ Administrative Assistant: _____

Date: Human Resources:

Education

	Location	Dates Attended	Degree Earned
High School			
College/ University			
Trade/ Vocational			
Other			

Employment History

List below your previous work experience. Applicant must provide all information requested including Employer, Dates of Employment, Supervisor, Phone Number, Fax, Address, Position, Duties, and Reason for Leaving.

Employer Name: _____ From: _____ To: _____

Supervisor: _____ Ph: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Position: _____ Duties: _____

Reason for leaving: _____

Employer Name: _____ From: _____ To: _____

Supervisor: _____ Ph: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Position: _____ Duties: _____

Reason for leaving: _____

Employer Name: _____ From: _____ To: _____

Supervisor: _____ Ph: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Position: _____ Duties: _____

Reason for leaving: _____

Emergency Contact Information

Name: _____ Home Phone: _____

Cell Phone: _____ Other: _____ Relationship: _____

Do you have reliable transportation? □ Yes □ No

Do you currently hold any state licenses or certifications? □ Yes □No

If yes, please list _____

_____

Employment Agreement

This agency does not discriminate in hiring based on race, color, sex, citizenship, national origin, ancestry, Vietnam era, veteran status, age, physical, or mental disability – related to the ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this agency the right to make a thorough investigation of my past employment and activities. I agree to cooperate in such investigation and release from liability or responsibility all persons companies or corporations supplying such information. I consent to take the physical examination, and future physical examinations as may be required. I understand that employment may be contingent on passing the physical examination as it relates to the essential duties I would be required to perform.

I understand that my employment is "at will". Either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form. If employed, I will complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility of employment.

_____ _____

Signature Date

Phone: (623) 977-3977 Fax: (623) 977-5067

Employment Verification/ Authorization

I, _____, grant permission for this employer to release the indicated information to All Valley Home Health Care & Nursing. I also release employer from any and all liability resulting from the release of such information. I understand that the employer, if so directed by the courts, may release other information.

Position Applied for: _____

Applicant Signature _____ Date: _____

*****APPLICANT, Please do not fill out or write below this line*****

To: Name of Employer _____

Address: _____

City: _____ State: _____ Zip: _____ Ph: _____

This individual, _____, has applied for employment with All Valley Home Health Care & Nursing. Please complete the following form and return via fax to (623) 977-5067.

Employer Section

Performance Evaluation

	Comments		Comments
Currently Employed	**Yes** **No**	**Dependability**	
Dates of Employment		**Quality of Work**	
Position Held		**Reason for Leaving**	
Eligible for Rehire	**Yes** **No**		

_____ _____

Signature Date

_____

Print Name Title Date

Job Task Analysis

	Yes	No	Unsure
Are you able to provide care to clients knowing that you have not been exposed to tuberculosis?			
Are you able to keep yourself in proper body position while transferring a client?			
Are you able to bend at the waist, and lift 50 pounds without any results of swollen or painful joints?			
Are you able to perform various duties for the client without the results of dizziness or fainting spells?			
Are you able to care for your client, knowing you are able to fully hear your clients needs when expressed during communication?			
Are you able to care for your client in a stressful atmosphere, without putting your own physical health in jeopardy?			
Are you able to evaluate the situation around you and report any critical information to appropriate personnel to help initiate corrective action when necessary?			
Are you able to maintain accurate records and logs?			
Are you able to develop trust, tolerance, and co-operation with the client and the office members?			

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.

_____ _____

Signature Date

Task/ Skills Inventory

- Please indicate with a check mark your level of experience in the following areas:

Personal Care	**None**	**Limited**	**Moderate**	**Proficient**
Bed Bath				
Shower				
Oral Care / Dentures				
Hair Care				
Perineal Care				
Skin/ Back Care				
Lotion/ Massage				
Incontinent Care Bowel/ Bladder				
Catheter Assist/ Empty Urinal Bags				

Activities	**None**	**Limited**	**Moderate**	**Proficient**
Ambulation w/ assistive devices				
Stand/ Pivot/ Transfer, Full Transfer				
Wheel Chair Use				
Hoyer Lift				
ROM (range of motion) Exercise				
Positioning				
Teaching ADL's				

Nutrition/ Meal Preparation	**None**	**Limited**	**Moderate**	**Proficient**
Plan Meals				
Prepare Nutritional Meals/ Snacks				
Assist Feeding				
Monitor/ Record I & O (intake & output)				

Homemaking	**None**	**Limited**	**Moderate**	**Proficient**
Occupied bed linen change				
Unoccupied bed linen change				
Laundry/ Wash				
Light Housekeeping				
Grocery Shopping				

Signature _____ **Date** _____