

Winds of Agape Home Care Agency

1414 Grant Boulevard
Syracuse, New York 13208
Phone: (315) 425-0547
Fax: (315) 295-0264

UNLICENSED NURSING PERSONNEL APPLICATION

Please advise us if you need an accommodation to complete this application.

Date of Application _____ Social Security # _____ Skill _____
Last Name: _____ First Name: _____ Middle Initial _____
Street Address _____ Apt.# _____ Home Phone # _____
City _____ State _____ Zip Code _____ Message Phone # _____

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 Driver's License # _____ State _____

Do you have access to a car? Yes No Expiration Date _____

Do you have a driver's license? Yes No

Have you been convicted* of a felony within the last 7 years? Yes No If yes, please explain:

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

Date Background Check Done - Local _____ National _____

Position Applied for _____ C.H.H.A. Certification Date _____ Certification/License# _____

Position Applied for _____ C.N.A. Certification Date _____ Certification/License# _____

Position Applied for _____ P.C.A. Certification Date _____ Certification/License# _____

Position Applied for _____ C.N.A. Certification Date _____ Certification/License# _____

Position Applied for _____ Geriatric Companion

Training Certificate # _____ Issued by: _____ Expir.Date:(if applicable) _____

Have you ever been bonded? Yes No

How were you referred to Winds of Agape? Newspaper (Name) _____

Friend (WHO?) _____ Other _____

Student Nurse who has completed 1 yr of clinical and theory. Name of Program: _____

Date(s) Attended: _____

I am fluent in the following languages: _____

Do you have any physical, mental or medical conditions which would prevent you from performing specific duties?

Yes No

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

	<u>Experience</u>	<u>Training</u>		<u>Experience</u>	<u>Training</u>
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/Dying Patient Care (Hospice)	<input type="checkbox"/>	<input type="checkbox"/>
CVA	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

We are an equal opportunity employer.

We are an equal opportunity employer.

Skill Inventory B (Check 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"/>	Other: _____	
Ostomy Care	<input type="checkbox"/>	_____	

What are your shift preferences? 7a-3p ___ 3p-11p ___ 11p-7a ___ Other ___ Available for on-call cases? Yes No

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		NAME/ADDRESS OF EMPLOYER	PHONE NO.	SUPERVISOR	POSITION	SALARY	REASON FOR LEAVING
FROM	TO						

PERSONAL REFERENCES (NO FAMILY)				
NAME	ADDRESS	OCCUPATION	PHONE NO.	NUMBER 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 Winds of Agape on its payroll, at its clients' premises.

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

APPLICANT'S SIGNATURE: _____ DATE: _____