APPLICATION FORM

YOUR INFORMATION

NAME

YOUR ADDRESS INFORMATION

ADDRESS LINE 1

ADDRESS LINE 2

CITY

STATE

COUNTRY

ZIP CODE

YOUR CONTACT INFORMATION

PHONE #

CELL #

EMAIL

LANGUAGES

- ☐ English
- ☐ Spanish
- ☐ Creole
- ☐ Hebrew
- ☐ Yiddish
- ☐ French
- ☐ Chinese
- ☐ Dutch
- ☐ German
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Portuguese
- ☐ Russian
- ☐ Others

SKILLS

- ☐ Peg Tube Feedings
- ☐ Alzheimer/Dementia Experience
- ☐ Autism
- ☐ Catheter Care
- ☐ Child Care
- ☐ Colostomy
- ☐ Diabetic Care
- ☐ Fractures/Ortho
- ☐ Heart/CHF
- ☐ Hip Relacement
- ☐ Hip replacement
- ☐ Hospice Care
- ☐ Hoyer Lift
- ☐ IV Certification
- ☐ Lifting Required
- ☐ Ostomy Care
- ☐ Oxygen
- ☐ Parkinsons
- ☐ Psych Exp.
- ☐ PT Taught ROM
- ☐ Renal Failure
- ☐ RN Wound Care
- ☐ Stroke/CVA/TIA
- ☐ Thyroid Disorder
- ☐ Traumatic Brain Injuries

GENERAL QUESTIONS

WHAT IS YOUR CLASSIFICATION?

Homemaker ○	Companion ○
CNA ○	HHA ○
LPN ○	RN ○

LOWEST ACCEPTABLE HOURLY RATE

LOWEST ACCEPTABLE A 24 HOUR LIVE-IN RATE

HOW DID YOU HEAR ABOUT US?

Word of Mouth	Job Fair
Newspaper	Online Search
Indeed	Other Caregiver

ARE YOU A US CITIZEN OR LEGALLY ELIGIBLE TO HOLD EMPLOYMENT IN USA?

Yes	No

DO YOU HAVE A WORK AUTHORIZATION CARD?

Yes	No

ARE YOU AT LEAST 18 YEARS OLD?

Yes	No

HAVE YOU EVER REGISTERED WITH OUR COMPANY?

Yes	No

DO YOU HAVE ANY DISABILITIES THAT MAY LIMIT YOUR ABILITY TO PERFORM THE WORK FOR WHICH YOU ARE REQUESTING REFERRALS?

Yes	No

HAVE YOU EVER BEEN CONVICTED (FOUND GUILTY) OF ATTEMPTING OR COMMITTING ANY CRIME OTHER THAN A MINOR TRAFFIC VIOLATION?

Yes	No

A conviction record will not necessarily bar individuals from registration and referral. You are not required to reveal records which have been judicially expunged, sealed or eradicated

DO YOU HAVE A LEVEL II BACKGROUND SCREENING?

Yes	No

WHEN ARE YOU AVAILABLE TO WORK?

- ☐ Full-Time
- ☐ Part-Time
- ☐ Temp
- ☐ Days
- ☐ Evenings
- ☐ Weekends
- ☐ 24 Hour Live in

WHEN CAN YOU START ACCEPTING CLIENT REFERRALS?

DO YOU HAVE PROFESSIONAL LIABILITY INSURANCE?

Yes No

WHAT IS EXPIRATION DATE?

DO YOU HAVE YOUR ALZHEIMERS CERTIFICATE?

Yes No

DO YOU HAVE YOUR HIV/AIDS/OSHA CERTIFICATE?

Yes No

DO YOU HAVE A PHYSICAL DATED WITHIN THE PAST 6 MONTHS STATING "FREE FROM COMMUNICABLE DISEASE"?

Yes No

DO YOU HAVE A CHEST X-RAY OR TB TEST DATED WITHIN PAST 2 YEARS?

Yes No

DO YOU HAVE A CURRENT AND ACTIVE CPR CARD?

Yes No

DO YOU HAVE A SOCIAL SECURITY CARD?

Yes No

DO YOU HAVE AUTO INSURANCE IN YOUR OWN NAME?

Yes No

DO YOU HAVE A FLORIDA DRIVERS LICENSE?

Yes No

WHAT IS YOUR DRIVER LICENSE NUMBER?

TECHNICAL, TRADE, GRAD SCHOOL OR OTHER

WHERE DID YOU OBTAIN YOUR RN LICENSE, LPN LICENSE, CNA CERTIFICATE OR HHA TRAINING?

STREET

CITY

STATE

3 PROFESSIONAL REFERENCES

MAY WE CONTACT YOUR REFERENCES?

Yes

No

COMPANY NAME

PERSON'S NAME

WHAT IS THEIR PHONE NUMBER?

WHAT IS THEIR POSITION IN COMPANY?

COMPANY NAME

PERSON'S NAME

WHAT IS THEIR PHONE NUMBER?

WHAT IS THEIR POSITION IN COMPANY?

COMPANY NAME

PERSON'S NAME

WHAT IS THEIR PHONE NUMBER?

WHAT IS THEIR POSITION IN COMPANY?

APPLICANT WAIVER

I hereby certify that the information hereunder is correct to the best of my knowledge and understand that falsification of this information is grounds for refusal to process my registration application or provide me with client referrals.

I hereby authorize any of the persons or organizations listed in my application to give all information concerning my previous employment, education, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application, and release all such parties from all liability that may result from furnishing such information to you.

I authorize you to request and receive such information. In consideration for my registraton and my being considered for client referrals by your company, I agree to adhere to the rules and regulations of the AHCA and hereby acknowledge that these rules and regulations may be changed by at any time, without any prior notice.

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Signature