ACCLAIM PROFESSIONAL HEALTHCARE
754 W. Boyd R.
Pleasant Hill CA 94523

Employment Application

FULL NAME: ______________________ DATE OF BIRTH: ______________

HOME PHONE: ______________ CELL NO: ______________ SSN: ______________

FULL ADDRESS: ____

EMERGENCY CONTACT: ______________________ PHONE: ______________

EDUCATION:

_______ HS DIPLOMA OR EQUIVALENT

_______ UNDERGRADUATE DEGREE

_______ C.N.A. / EXPIRATION: ______________

_______ ACUTE CARE

_______ H.H.A. / EXPIRATION: ______________

OTHER: ______________

DRIVING _________ YES _________NO WITH CAR _______ YES _________NO

WORK HISTORY (Start with the most recent)

PREVIOUS EMPLOYER (1): ____

DATES OF EMPLOYMENT: ______________________ TITLE/ JOB DESCRIPTION: ______________

DUTIES: ____

____

SUPERVISOR: ______________________ PHONE: ______________

Can we contact this employer? _______ Yes _______ No

PREVIOUS EMPLOYER (2): ____

DATES OF EMPLOYMENT: ______________________ TITLE/ JOB DESCRIPTION: ______________

DUTIES: ____

____

SUPERVISOR: ______________________ PHONE: ______________

Can we contact this employer? _______ Yes _______ No

PREVIOUS EMPLOYER (3): ____

DATES OF EMPLOYMENT: ______________________ TITLE/ JOB DESCRIPTION: ______________

DUTIES: ____

____

SUPERVISOR: ______________________ PHONE: ______________

Can we contact this employer ? _______ Yes _______ No

Name: ______________________________

PROFESSIONAL REFERENCES (PLEASE PROVIDE THREE WORK REFERENCES)

NAME: ______________________________ PHONE: ______________________________

COMPANY: ______________________________ JOB TITLE: ______________________________

NAME: ______________________________ PHONE: ______________________________

COMPANY: ______________________________ JOB TITLE: ______________________________

NAME: ______________________________ PHONE: ______________________________

COMPANY: ______________________________ JOB TITLE: ______________________________

Skills/Experience

______ Hoyer Lift	_____ Wheelchair	____ Catheter	_____ Gait Belt
______ Walker	_____ Hospital Bed	____ Colostomy	_____ Chair Lift
______ Alzheimer's	_____ Dementia	____ Parkinson's	_____ Stroke
______ Quadriplegic	_____ Sundowner's	____ Hospice	

Pet Allergies: ______________________________ Smoking __________ Non-Smoking __________

Availability

_________ Hourly _______Live-In

	AM	PM	Evening
Monday	________	________	________
Tuesday	________	________	________
Wednesday	________	________	________
Thursday	________	________	________
Friday	________	________	________
Saturday	________	________	________
Sunday	________	________	________

Authorization

I, ______________________________ (print applicant name) hereby authorize Acclaim Professional Healthcare to perform a check of my references and background check on my criminal history, driving record and credit report for employment purposes.

Signature: ______________________________ Date: ______________________________