JOB/EMPLOYMENT APPLICATION – PERSONAL CAREGIVER	
Personal Information	
Name	First _____Middle Initial_____ Last: _____
Address	Street: _____Apartment: _____ City: _____State: _____ Zip: _____
Contact	Home: _____Cell: _____ Email Address: _____
Date of Birth	Day: _____ Month:_____ Year: _____
SSN	Social Security Number: _____
Gender	Male: _____ Female: _____
Language	What languages do you speak? _____ _____
Emergency Contact	Name & Phone Number of Person to contact in the event of an emergency: Local: _____ Out-of-Area: _____
Referral	How did you hear about Whoo's Caring?_____
Education	
Formal	Diploma: _____ Certificate: _____ Degree: _____ Other: _____ Other: _____
Informal	Do you have current First Aid Certification (State Level): _____Expiry Date:_____ Do you have current CPR? _____ Expiry Date: _____ Other: _____ (Specify) Other: _____ *(Specify)*

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Restrictions

Work Limitations

List any work limitations that you may have and briefly describe:

Hearing: ___ Yes ____ No _____

Speech: ___ Yes ____ No _____

Lifting: ___ Yes ____ No _____

Health: ___ Yes ____ No_____

Physical: ___ Yes ____ No_____

Emotional: ___ Yes ____ No_____

Other: ___ Yes ____ No _____

Availability for Work

Hours & Days Available for Work

_____Full-time _____ Part-time _____ Short-notice _____Split Shift

Indicate Days and List Hours Available for Work:

____Sunday: From: _____ To: _____

____Monday: From: _____ To: _____

____Tuesday: From: _____To: _____

____Wednesday: From: _____To: _____

____Thursday: From: _____To: _____

____ Friday: From: _____To: _____

____Saturday: From: _____ To: _____

What is the minimum number of hours you will work in one day? _____

What is the maximum number of hours you will work in one day? _____

Client Types and Work Duties

Type of Position(s) Preferred

_____ Hourly _____ Live-In

Live-in care usually requires that you to in a client's home continuously for 3-4 days at a time every week. Indicate which shifts you will accept:

____Weekdays (Monday a.m. to Friday a.m.) _____Weekends: (Friday a.m. to Monday a.m.)

Clients Not Willing/Able to Work With

_____ Dementias/Alzheimer's
_____ Smokers
_____Mental Retardation
_____Behavioral Disorders
_____ Elderly (over 65)
_____ Children
_____ Physical Disabilities
_____ Pets
_____ Females
_____ Males
_____ Client use of marijuana for medicinal purposes
_____ HIV Positive/Aids
_____ Other: _____
(Specify)

Duties <u>Not</u> Willing/Able to Perform

_____ Bathing
------- Grooming
____ Oral Care
____ Dressing
____ Bowel Care
____ Bladder Care
____ Feeding
____ Ambulation
____ Housekeeping
____ Laundry
____Meal Preparation
____Shopping
____ Transportation
____ Medication Reminding
____ Friendly Reassurance Phone Call/Home Visit
____ Other _____

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Experience	Indicate which of the following you have experience in: _____ Bathing/Showering ------- Grooming ____ Personal Hygiene ____ Dressing ____ Bowel Care ____ Bladder Care ____ Feeding ____ Ambulation ____ Toileting ____ Housekeeping ____ Laundry ____Meal Preparation ____Shopping ____ Transportation ____ Medication Reminding ____ Friendly Reassurance Phone Call or Home Visit -------- Socialization ____ Other _____ *(Specify)*
Assignment Location	Are you restricted in the geographical location you are willing/able to work? ___Yes ___No Explain: _____ _____
Transportation	
Type	_____Private Vehicle _____Bus _____Bike _____Other: _____ *(Specify)*
Driver's License	Do you have a valid Driver's License? _____
Abuse Investigation	
	Have you ever been investigated for abuse, neglect or domestic violence? If "yes", explain: ____ Yes _____ NO _____ _____ _____
Reference Information	
Work Related #1 (Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name_____ Position Held: _____ Dates of Employment: _____ Reason for Leaving: _____
Work Related #2 (2nd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name_____ Position Held: _____ Dates of Employment: _____ Reason for Leaving: _____

JOB/EMPLOYMENT APPLICATION – PERSONAL CAREGIVER	
Work Related #3 (3rd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name_____ Position Held: _____ Dates of Employment: _____ Reason for Leaving: _____
Personal #1	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship *(friend, co-worker, family etc.)* _____ (*Other than relative.*)
Personal #2	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (friend, co-worker, teacher etc.) _____ (Other than relative.)

I certify that, to the best of my knowledge, the answers given are true and complete and that purposeful misrepresentation may result in rejection of my application. I authorize investigation of all statements contained in this application, as required. Additionally, I authorize former employers, references and any other individual/organizations to provide information to Whoo's Caring, Inc. and I hereby release and discharge any of the above and Whoo's Caring, Inc. from any liability of any kind or nature. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary

I agree to a physical examination, if requested, and understand that failure to meet any medical and/or health requirements for the position may prevent my employment with the Agency. I also understand that employment, for certain positions, may be conditional upon successful completion of a substance abuse screening test, if part of the Agency's pre-employment policy.

I understand that, if hired, I may be required to provide proof that I am a citizen of the United States or proof that I am currently authorized to work in the United States.

_____ _____

Applicant's Signature Date

Whoo's Caring, Inc.	WHOO'S CARING SENIOR ASSISTANCE

PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION

I, _____, understand that as part of the employment process, Whoo's Caring, Inc. needs to complete a background check on me regarding:

1. Criminal record;
2. Sex and Violent Offenders Record;
3. Employment Verification;
4. Education Verification;
5. License Verification;
6. Personal/Professional Reference Verification;
7. Medical Suitability
8. Drugs/Alcohol

- I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to Whoo's Caring, Inc. or its authorized agent(s).
- I understand that this authorization is to be part of the written and signed employment application.
- I also understand that I do not have to give authorization for a background check but if I don't give permission, my employment application will not be processed further.
- I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant State law.
- I further authorize that a photocopy of this authorization may be considered as valid as the original.
- I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment with Whoo's Caring, Inc. is contingent upon successful completion of a background check.

_____ _____

Signature Date

Full Name _____Telephone No. _____

Former Name(s) and Date(s) used: _____

Current Address_____

Date of Birth_____ Social Security Number: _____

Current Driver's License: _____ State: _____

List any other cities, states and dates of residency during last 5 years (Use back of sheet, if necessary.)

City	State	From: Month/Year	To: Month/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City: _____ State: _____ Zip Code _____

Other Names Used _____ Telephone _____ - _____ - _____

States Where You Have Lived? _____

☐ Male ☐ Female Race _____ Height _____ Weight _____ Date of Birth _____ Social Security Number _____

(Enter a letter from below)

Hair Color _____ Eye Color _____ Place of Birth _____

Race	**A**	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____

(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____

(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****