

Preliminary Screening

Minimum Requirements

- | | | | |
|-----|---|-----|----|
| 1. | At least 18 years of age | YES | NO |
| 2. | Current valid driver's license | YES | NO |
| 3. | Current automobile insurance | YES | NO |
| 4. | Dependable transportation | YES | NO |
| 5. | Ability to lift a minimum of 50 #'s | YES | NO |
| 6. | Ability to drive day or night | YES | NO |
| 7. | Working telephone | YES | NO |
| 8. | Prior Felony conviction
If answered as (YES)", applicant must attach and /or provide clarification. | YES | NO |
| 9. | Any prior DUI convictions
If answered as (YES)", applicant must attach and /or provide clarification. | YES | NO |
| 10. | Criminal Charges or Arrest Pending
If answered as (YES)", applicant must attach and /or provide clarification. | YES | NO |



APPLICATION FOR EMPLOYMENT

Home of Hope does not discriminate in its hiring decisions or in any other employment decisions on the basis of race, color, sex, religion, citizenship, national origin, veteran status, age or upon a physical or mental disability which is unrelated to the applicants/employees ability to perform the essential functions of the position.

EMPLOYMENT DESIRED

Position(s) applied for: _____

Date of Application: _____

PERSONAL INFORMATION

Name: _____
(Last) (First) (Middle)

Former Name(s): _____

Mailing Address: _____
(City) (State) (Zip)

Phone Number: (Day) _____ (Evening) _____ Cell Number: _____

List any relative(s) employed with HOH, Inc. _____

Have you previously worked for HOH, Inc.? "....." If Yes, When? _____

Were you referred to HOH, Inc. for employment by a HOH, Inc. employee? If Yes, What is the Employee's name?

EDUCATIONAL BACKGROUND (List all educational schools attended with degrees, diplomas or certificates received).

High School or GED _____
College _____

School Attended _____
School(s) Attended _____

Graduated _____
Graduated _____

CERTIFICATION

If you hold a current certification as a nurse aide (I), check the appropriate certification(s) below:

- _____ Long Term Care (LTC)
- _____ Adult Day Care (ADC)
- _____ Developmental Disability Aide (DDA)
- _____ Medication Administration Technician (MAT)
- _____ Home Health Aide (HHA)
- _____ Residential Care Aide (RCA)
- _____ Certified Medication Aide (CMA)

If you are a CMA, have you obtained your hours of continuing education for this calendar year? ___ Yes ___ No

Technical or special skills, education honors, certificates, licenses or memberships not previously listed:

Begin with the most recent or current employer:

Employers Name: _____ Address/City/St/Zip: _____
Phone (_____) _____ Position Held: _____ Supervisor: _____
Dates Employed: From (month/year) _____ to (month/year) _____ Wages: _____
Reason for Leaving: _____

Employers Name: _____ Address/City/St/Zip: _____
Phone: (_____) _____ Position Held: _____ Supervisor: _____
Dates Employed: From (month/year) _____ to (month/year) _____ Wages: _____
Reason for Leaving: _____

Employers Name: _____ Address/City/St/Zip: _____
Phone: (_____) _____ Position Held: _____ Supervisor: _____
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Employers Name: _____ Address/City/St/Zip: _____
Phone: (_____) _____ Position Held: _____ Supervisor: _____
Dates Employed: From (month/year) _____ to (month/year) _____ Wages: _____
Reason for Leaving: _____

Professional References

Please provide the names and phone numbers of three (non relatives) professional references.

1. _____
2. _____
3. _____

May we contact your present employer? _____ Yes _____ No _____ Not applicable

Have you ever been terminated or asked to resign from any position? _____ Yes _____ No If YES, Why?

