PRO QUALITY HOME CARE INC.
EMPLOYMENT APPLICATION

Instructions: Please answer all questions completely and accurately. This application form is intended for use in evaluating your qualifications for employment**. Misleading or false information on this form or during the interview will be grounds for termination of the application process. If Misleading or false statements are discovered after employment this will also be grounds for termination of employment.**

Please **print in black ink**. Incomplete or illegible applications may not be processed.

DATE OF APPLICATION:	POSITION APPLIED FOR:

How did you hear about *PRO QUALITY INC.?* ____

NAME: ____
Last First Middle Maiden

ADDRESS: ____
Number Street City State Zip Code

MAILING ADDRESS: ____
Number Street City State Zip Code

PREVIOUS ADDRESS: ____
Number Street City State Zip Code

HOME PHONE: _________________**MOBILE PHONE:** _________________**WORK PHONE:** ___________________

EMERGENCY CONTACT: (Name and Phone) ____

E-MAIL: ____

Valid Driver's License	State Issued	Expiration Date:
Auto Insurance Company	Policy Number (Policy must be in applicant's name)	
Auto Insurance Agent	Phone Number	
Make of Vehicle(s)	Year of Vehicle(s)	

EMPLOYMENT HISTORY

Are you employed now? _____Yes _____No If yes, may we contact your present employer? _____yes _____no
Have you ever been discharged or asked to resign from any employment in lieu of voluntary termination? _____Yes _____No
If yes, please explain:

____

____

Please begin with your most recent employment

1. EMPLOYER Name of Company	Employed From MO YR	Starting Salary	Reason for Leaving	Name & Title of Immediate Supervisor
		Ending Salary		
Company Address: City	State	Zip	Phone	
Describe Your Position and Duties:				

OFFICE USE ONLY	**Verified by & Date Called:**						
Would you employ them back?	**Yes**		**No**		**No Comment Per Company Policy**	**Yes**		**No**	
Comments/Strengths:							

2. EMPLOYER Name of Company	Employed From MO YR	Starting Salary	Reason for Leaving	Name & Title of Immediate Supervisor
		Ending Salary		
Company Address: City	State	Zip	Phone	
Describe Your Position and Duties:				

OFFICE USE ONLY	**Verified by & Date Called:**								
Would you employ them back?	**Yes**		**No**		**No Comment Per Company Policy**	**Yes**		**No**	
Comments/Strengths:									

PERSONAL REFERENCES: Please list two non-relatives

1. FULL NAME	**Phone Number and Area Code**	**Relationship**	**Number of Years Known**
OFFICE USE ONLY	**Verified by & Date Called:**		
Comments:			

2. FULL NAME	**Phone Number and Area Code**	**Relationship**	**Number of Years Known**
OFFICE USE ONLY	**Verified by & Date Called:**		
Comments:			

EDUCATION: Please Circle Highest Completed: Middle School: 6 7 8

	Name of School	City and State	Major	# of Years Attended	Diploma, GED or Degree
High School					
College/University					
Vocational					
Other (Specify)					

APPLICATION AND AVAILABLILITY

Applications remain current for 30 days from the date of application. Employment is based on the information you provide for your availability.

Pro Quality Inc. reserves the right to assign you to the needs of the agency. The employee must be available to work days, evening's weekends, 12-hour overnights, 24 shifts and holidays.

About how many hours per week do you wish to work? ________ When are you available to begin work? _________

ACKNOWLEDGEMENT AND AUTHORIZATION FOR THE RELEASE OF INFORMATION:

I acknowledge the facts set forth in my application for employment are true and complete to the best of my knowledge and belief.

- I do understand that if employed, any false, omission or misleading statements on this application or interview may result in rejection of the application process or immediate termination at any time during my employment.
- I authorize PQHC and/or its agents, including consumer-reporting bureaus, to verify any of this information that includes and is not limited to, my criminal history and motor vehicle driving records.
- I authorize all persons, schools, companies and law enforcement authorities to supply any information concerning my background.
- I release any said person(s) from any liability for any damage whatsoever for issuing this information.
- I understand that the information of a confidential, personal and/or privileged nature may be included.
- I understand. will keep all information provided confidential and will not be disclosed to myself.
- I understand that the use of alcohol or the use of illegal drugs is prohibited during employment. If *PQHC Inc.* policy requires, I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment.

Caregiver Signature: ____ Date: _________________

Administrator or Designee Signature: ___________________________________ Date: _________________

Note: All qualified applicants will receive consideration without discrimination because of gender, marital status, pregnancy, religion, race, age, creed, national origin, presence of disabilities, sexual orientation, screening or testing information, or any other characteristic protected under applicable State or Federal law.

CAREGIVER SKILLS COMPETENCY EVALUATION

Name: ____ Date: ______________________

FOLLOW DIRECTIONS.

- **Please write an *E* if you <u>have had</u> previous experience or write an *N* if you <u>have no</u> experience performing the listed task in column 2.**
- **Rate yourself in column 3 from 1-4 on how comfortable you feel performing the listed task.**
- **4 - feel comfortable and can teach the task 3 – comfortable 2 – need review 1 – need training prior to performing the task.**

Skill	Write *E* or *N*	Rating 1-4	Skill	Write *E* or *N*	Rating 1-4
Home Care Tasks			Assisted Ambulation w/cane		
Vacuuming, Sweeping			Assisted Ambulation/wheelchair		
Cleaning/sanitizing Bathroom			Assisted Ambulation/Hoyer		
Cleaning/sanitizing Kitchen			**Vital Signs**		
Laundry			Blood Pressure		
Dusting			Respiratory rate		
Garbage Removal			Temperature		
Change Linen			Pulse		
Personal Care Tasks			**Nutrition**		
Shaving			Meal Preparation/cooking		
Oral Care			Meal Planning		
Assist with ambulation			Assist with feeding client		
Assist with transfer			Diabetic Diet		
Stand by assist			Shopping		
Lotion/Skin Care			**Body Mechanics**		
Assist with dressing			Use of gait belt		
Incontinent Ca			Lifts –Hoyer/Sit-to-stand)		
Catheter care (Maintenance only)			Pivot transfer		
Walking			Slide-Board transfers		
ROM			Transfers (bed to W/C, W/C to bed)		
Grooming/Dressing Client			Transfer in and out of a car		
Bed Bath			Turning and repositioning		
Tub bath/Shower			**Universal Precautions**		
Change Linen			Blood Bourne Pathogens		
Skin Care			Infection Control		
Wound Care/change dressing			**Hospice Care**		
Medication Administration			Hospice RN orders		
Glucose Monitoring			Hospice Medications		
Med. Reminder Only			**Post mortem care**		
Med. Assistance			Hospice Client (Call Hospice)		
Med. Set-Up			Regular Client (Call 911)		
Med. Administration			**Documentation**		
Mobility and/or Movement			Chart completed tasks		
Range of Motion Exercises			Chart significant event		
Assisted Ambulation/Gait Belt			Document care need /changes		
Assisted Ambulation w/cane					
Assisted Ambulation/wheelchair					
Assisted Ambulation/Hoyer					

Caregiver Certification: I, ____ understand that I may only provide agency listed tasks that have documented evidence of competency to perform. If I believe I need additional training, I will contact my administrator immediately to arrange for additional training.

CG Signature: ____ Date: ______________________

Administrator or Designee: __________________________________ Date: ______________________