Caress Health Care Services, Inc.
3125 45th Street, Highland, IN 46322-3206
Tel: 219-924-8830 Fax: 219-924-8834

APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE

AN EQUAL OPPORTUNITY EMPLOYER

NAME: (Last Name, First, MI)				Social Security No.	
Present Address:		Apt #	City	State	Zip
Permanent Address:		Apt#	City	State	Zip
Are You 18 Years or Older? ( ) Yes ( ) No	Phone #				

Last First Middle

Desired Employment

Position		Date You Can Start	Salary Desired
Are You Employed Now? ( ) Yes ( ) No	If So May We Inquire Of Your Present Employer? ( ) Yes ( ) No		
Ever Applied to This Company Before? ( ) Yes ( ) No		Where?	When?
Reason for Leaving:			
Name of Last Supervisor at this Company			
Who Referred You to this Company? ( ) Employment Agency ( ) Newspaper Advertising ( ) Friends ( ) State Employment Office ( ) College Placement Services ( ) Walk In ( ) Other			

Education

School Level	Name and Location of School	No. of Years attended	Did You Graduate	Subjects Studied
Grammar School				
High School				
College				
Trade, Business or Correspondence School				

General

Subject of Special Study or Research Work
Special Training
Special Skills

FORMER EMPLOYERS

LIST BELOW LAST THREE EMPLOYERS, STARTING WITH THE MOST RECENT

NAME OF PRESENT OR LAST EMPLOYER			
ADDRESS	CITY	STATE	ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY	MAY WE CONTACT YOUR SUPERVISOR?	( ) Yes ( ) No
NAME OF SUPERVISOR	TITLE	PHONE	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF PREVIOUS EMPLOYER			
ADDRESS	CITY	STATE	ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY	MAY WE CONTACT YOUR SUPERVISOR?	( ) Yes ( ) No
NAME OF SUPERVISOR	TITLE	PHONE	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF PREVIOUS EMPLOYER			
ADDRESS	CITY	STATE	ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY	MAY WE CONTACT YOUR SUPERVISOR?	( ) Yes ( ) No
NAME OF SUPERVISOR	TITLE	PHONE	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

LIST ALL STATE LICENSURES / CREDENTIALS			
LICENSE RECEIVED BY:	STATE EXAM	ENDORSEMENT	WAIVER
CPR CERTIFIED ( ) YES ( ) NO EXP DATE:		ACLS CERTIFIED ( ) YES ( ) NO EXP DATE:	
IDENTIFY ANY ACTION THAT MAY HAVE BEEN TAKEN OR IS PRESENTLY PENDING ON YOUR PROFERSSIONAL LICENSE OR CREDENTIAL:			
HAVE YOU EVER HELD ANY PROFESSIONAL LICENSE UNDER ANY OTHER NAME (S) OR ALIASES IN THIS STATE OR ANY OTHER? ( ) YES ( ) NO			
IF YES, PLEASE EXPLAIN:			
IDENTIFY AND EXPLAIN ANY PROFESSIONAL LIABILITY CLAIMS IN WHICH YOU ARE, OR HAVE BEEN NAMED AS A DEFENDANT?			

ARE YOU, OR ARE YOU PRESENTLY RECEIVING TREATMENT FOR A DRUG OR ALCOHOL DEPENDENCY?	( ) YES	( ) NO
HAVE YOU EVER BEEN HOSPITALIZED FOR TREATMENT OF CHEMICAL DEPENDENCY?	( ) YES	( ) NO
DO YOU HAVE ANY IMPAIRMENT, PHYSICAL OR MENTAL, WHICH WOULD INTERFERE WITH YOUR ABILITY TO PERFORM ASSIGNMENT FOR WHICH YOU HAVE APPLIED FOR?	( ) YES	( ) NO
IF YES, PLEASE DESCRIBE THE IMPAIRMENTS AND EXPLAIN ANY WORK LIMITATIONS.		

DO YOU HAVE MALPRACTICE INSURANCE? ( ) YES ( ) NO	IF YES, GIVE COMPANY NAME & NUMBER:
HAVE YOU EVER BEEN CONVICTED OF A CRIME? ( ) YES ( ) NO	IF YES, DESCRIBE IN FULL:

HAVE YOU EVER BEEN REPORTED TO THE STATE BOARD OF NURSING / OR TO THE STATE PROFESSIONAL BOARD?	( ) YES	( ) NO
IF YES, DESCRIBE IN FULL:		
HAVE YOU EVER FILED A WORKER'S COMPENSATION CLAIM?	( ) YES	( ) NO

CERTIFICATION/SPECIALIZED TRAINING PROVIDE LENGTH OF TRAINING & DATES		
PLEASE EXPLAIN ANY ADDITIONAL QUALIFICATIONS, EDUCATION OR TRAINING:		
DO YOU HAVE CERTIFICATES OR WRITTEN DOCUMENTATION, IF ANY FOR THE ABOVE?	( ) YES	( ) NO

ADDITIONAL PERSONAL INFORMATION:		
APPLICANT'S MOBILE PHONE No:	PAGER No:	
EMERGENCY CONTACT PERSON:		
ADDRESS:		
HOME PHONE No:	MOBILE PHONE No:	PAGER No:

ON WHAT DATE WILL THE APPLICANT BE AVAILABLE FOR REFERRAL?						
HOURS REGISTRANT IS AVIALABLE FOR REFERRAL:	7A-3P	3P-11P	11P-7A	7A-7P	7P-7A	
DAYS AVAILABLE FOR REFERRAL:	MON	TUE	WED	THU	FRI	SAT SUN
ANY SPECIAL REQUESTS:						
SPECIALTY AREAS:	1ST CHOICE _____	2ND CHOICE: _____	3RD CHOICE: _____			
REFERRALS WILLING AND QUALIFIED TO ACCEPT COMMENTS / AREA PREFERENCE						
HOSPITAL STAFF	( ) YES	( ) NO				
CONTRACTS-LOCAL	( ) YES	( ) NO				
TRAVEL-LOCAL	( ) YES	( ) NO	TRAVEL-LONG TERM	( ) YES	( ) NO	

REFERENCES

BELOW, GIVE THE NAMES OF PERSONS YOU ARE NOT RELATED TO, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	BUSINESS ADDRESS	POSITION	PHONE NUMBER
NAME	BUSINESS ADDRESS	POSITION	PHONE NUMBER
NAME	BUSINESS ADDRESS	POSITION	PHONE NUMBER

I certify that the facts in this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained herein and the reference listed above to give you any and all information concerning my previous employment and any pertinent information that they may have personal or otherwise and release all parties from all liability for any damage that may result from furnishing same to you.

Signature: _____ Date: _____

Date Hire: _____