

APPLICATION FOR EMPLOYMENT

**Northwest Senior Management Services, Inc.
7821 SE Stark St.
Portland, OR 97215**

PRE-EMPLOYMENT
QUESTIONNAIRE
AN EQUAL OPPORTUNITY EMPLOYER

PERSONAL INFORMATION

E-MAIL:

NAME (LAST NAME FIRST)		SOCIAL SECURITY NO.	PHONE	CELL PHONE
PRESENT ADDRESS		APT.NO.	CITY	STATE ZIP
PERMANENT ADDRESS		APT.NO.	CITY	STATE ZIP
DATE OF BIRTH	DRIVERS LICENSE NO.	STATE OF ISSUE	AUTO INSURANCE:	

DESIRED EMPLOYMENT

POSITION		DATE YOU CAN START		
ARE YOU EMPLOYED NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO		
EVER APPLIED TO THIS COMPANY BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHERE?	WHEN?	
EVER WORKED FOR THIS COMPANY BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHERE?	WHEN?	
WHO REFERRED YOU TO THIS COMPANY?		<input type="checkbox"/> FRIEND <input type="checkbox"/> CRAIG'S LIST <input type="checkbox"/> INTERNET <input type="checkbox"/> PHONE BOOK <input type="checkbox"/> OTHER		

EDUCATION

SCHOOL LEVEL	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
HIGH SCHOOL				
COLLEGE				
TRADE/ BUSINESS				

GENERAL

SPECIAL TRAINING
SPECIAL SKILLS

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FORMER EMPLOYERS

LIST BELOW LAST THREE (3) EMPLOYERS, STARTING WITH THE MOST RECENT ONE FIRST

NAME OF PRESENT OR LAST EMPLOYER			
ADDRESS		CITY	STATE ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
MAY WE CONTACT YOUR SUPERVISOR?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
NAME OF SUPERVISOR		PHONE NUMBER:	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF PREVIOUS EMPLOYER			
ADDRESS		CITY	STATE ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
MAY WE CONTACT YOUR SUPERVISOR?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
NAME OF SUPERVISOR		PHONE NUMBER:	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF PREVIOUS EMPLOYER			
ADDRESS		CITY	STATE ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
MAY WE CONTACT YOUR SUPERVISOR?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
NAME OF SUPERVISOR		PHONE NUMBER:	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

AUTHORIZATION

I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES AND EMPLOYERS LISTED ABOVE TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THEY MAY HAVE PERSONAL OR OTHERWISE AND RELEASE THE COMPANY FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM UTILIZATION OF SUCH INFORMATION.

SIGNATURE

DATE

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REFERENCES

PLEASE LIST BELOW THE NAMES OF THREE PERSONS YOU ARE **NOT RELATED** TO, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR, **THEY SHOULD BE PEOPLE YOU HAVE DIRECTLY WORKED FOR OR WITH** (FOR EXAMPLE:, RN'S, SUPERVISORS, FAMILY MEMBERS OF PATIENTS , THE PATIENTS THEMSELVES, CARE BUSINESS OWNERS, C.N.A.S, LPN'S, ETC.)

PLEASE PRINT CLEARLY

NAME	HOW DO YOU KNOW THIS PERSON?	PHONE	YEARS KNOWN
1			
2			
3			

HAVE YOU OR ARE YOU CURRENTLY USING ILLEGAL DRUGS OR SUBSTANCES? YES NO

HAVE YOU OR ARE YOU CURRENTLY USING ALCOHOL TO EXCESS? YES NO

AUTHORIZATION

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NORTHWEST SENIOR MANAGEMENT SERVICES RESERVES THE RIGHT TO CONDUCT A CRIMINAL BACKGROUND INVESTIGATION OF ANY CAREGIVER REGARDING POSSIBLE ARRESTS OR CONVICTIONS, INCLUDING TRAFFIC CITATIONS. WE ALSO RESERVE THE RIGHT TO CONDUCT RANDOM DRUG TESTING ON ANY CAREGIVER AT ANY TIME DURING EMPLOYMENT.

SIGNATURE

DATE

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Name _____ Date: _____

Availability:

- Yes No Short Term; Partial Shifts
- Yes No Long Term
- Yes No 8-Hour Shift Day Evening Night
- Yes No 12-Hour Shift Day Night
- Yes No 24 Hour (live-in) Shift
- Yes No Travel with Clients

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Check days available							
List Hours of availability							

Please indicate below any plans for trips, meetings, vacation, etc that you may require time off to participate. Please include dates or time of month (i.e. every other Tuesday).

List any geographic restrictions: _____

Ability to lift? Yes No Number of pounds _____

Have you had experience working with the following types of clients:

- Yes No Frail Elderly
- Yes No Dementia; Alzheimer's Disease
- Yes No Parkinson's Disease
- Yes No Stroke
- Yes No Cancer
- Yes No Hospice
- Yes No Head Injury
- Yes No Mental Illness
- Yes No Elderly Couples
- Yes No Post Hospital Care
- Yes No Cancer
- Yes No Hospice

Have you had experience working in the following environments:

- Yes No Assisted Living

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- Yes No Nursing Home
 Yes No Foster Home
 Yes No In-Home
 Yes No Hospital

What is your least preferred client type: _____

What certifications do you have?

- Yes No CPR
 Yes No HHA
 Yes No Med Aide
 Yes No LPN
 Yes No CNA

Name _____

Date:

Are you registered with the Oregon State Board of Nursing?

- Yes No
 Yes No

If "yes" is your license current?

License number: _____

Have you ever sustained an on-the-job injury? Yes No

If "Yes" what type _____

If "Yes" please explain: _____

Personal Characteristics:

- Yes No I smoke.
 Yes No I will work with people who smoke.
 Yes No I will work with people who have animals.
 Yes No I am self-motivated and keep myself busy.
 Yes No I have my own reliable car.
 Yes No I have a valid driver's license..
 Yes No I have auto liability insurance to include coverage for business use.
 Yes No I have been cited for a traffic offense in the last three years.
 Yes No If "Yes", please explain circumstances and results (use additional space, if required).

(Signature)

(Date Signed)