CAP REVIVAL CARE

Employee Application

Personal Information

Full Name: _____ Date: _____

Address: _____
CITY STATE ZIP CODE

Email: _____ Phone: _____

Social Security Number (SSN): _____ - _____ - _____ Date of Birth: _____

Do you have valid vehicle registration and insurance? YES ☐ OR NO ☐

Do you have a valid driver's license? YES ☐ OR NO ☐

Driver's License Number: _____ State: _____ Exp. Date: _____

Date Available: _____ Job Type: Part-Time ☐, OR Full-Time ☐

Desired Pay: $ _____ Hourly | $ _____ Salary

Shift Schedule: Morning-Shift ☐, Afternoon-Shift ☐, Evening-Shift ☐, OR Overnight-Shift ☐

Position Applying For: _____

Employment Eligibility

Do you possess at least 1 year of patient care experience? YES ☐ OR NO ☐

Are you willing:

- Willingness to travel at least 25%? YES ☐ OR NO ☐
- To service clients in the **HILLSBOROUGH** and **MANATEE** counties? YES ☐ OR NO ☐

Are you at least 18 years old? YES ☐ OR NO ☐

Are you a U.S. citizen? YES ☐ OR NO ☐

If NO, are you allowed to work in the US? YES ☐ OR NO ☐

Have you ever worked for this employer? YES ☐ OR NO ☐

- If yes, please explain: _____

Education

High School/ GED: _____

Address: _____

CITY STATE ZIP CODE

From: _____ to: _____

Graduated: YES ☐ OR NO ☐

College: _____

Address: _____

CITY STATE ZIP CODE

From: _____ to: _____

Graduated: YES ☐ OR NO ☐ Degree: _____

Other: _____

Address: _____

CITY STATE ZIP CODE

From: _____ to: _____

Select the license or certifications that you hold as valid status: RN☐, CNA☐, HHA☐, First Aid☐, CPR☐, AED☐, OTHER ☐ _____, AND/OR OTHER☐ _____.

Employment History

Employer #1: _____

Employer Address: _____

CITY STATE ZIP CODE

Emp. Email: _____ Emp. Phone: _____

Starting Pay: $ _____ Hourly or $ _____ Salary

Ending Pay: $ _____ Hourly or $ _____ Salary

Job Title: _____

Start Date: _____ End Date: _____

Reason For Leaving: _____

Job Duties:

_____

_____

_____

Employer #2: _____

Employer Address: _____
CITY STATE ZIP CODE

Emp. Email: _____ Emp. Phone: _____

Starting Pay: $ _____ Hourly or $ _____ Salary

Ending Pay: $ _____ Hourly or $ _____ Salary

Job Title: _____

Start Date: _____ End Date: _____

Reason For Leaving: _____

Job Duties:

_____

_____

_____

Employer #3: _____

Employer Address: _____
CITY STATE ZIP CODE

Emp. Email: _____ Emp. Phone: _____

Starting Pay: $ _____ Hourly or $ _____ Salary

Ending Pay: $ _____ Hourly or $ _____ Salary

Job Title: _____

Start Date: _____ End Date: _____

Reason For Leaving: _____

Job Duties:

_____

_____

_____

Employer #4: _____

Employer Address: _____
CITY STATE ZIP CODE

Emp. Email: _____ Emp. Phone: _____

Starting Pay: $ _____ Hourly or $ _____ Salary
Ending Pay: $ _____ Hourly or $ _____ Salary

Job Title: _____

Start Date: _____ End Date: _____

Reason For Leaving: _____

Job Duties:

_____

_____

References

Please list two (2) managers, supervisors, or coworkers who are familiar with your work in customer service, patient care, or in a developmental disability setting.

References #1: _____ Relationship: _____

Company: _____ Title: _____

Emp. Email: _____ Emp. Phone: _____

References #2: _____ Relationship: _____

Company: _____ Title: _____

Emp. Email: _____ Emp. Phone: _____

Background Check Consent

IF ASKED, WOULD YOU CONSENT TO A BACKGROUND CHECK? YES ☐ OR NO ☐

Disclaimer

The applicant understands that this is an Equal Opportunity Employer who is committed to excellence through diversity. To ensure this application is acceptable, please print or type with the application being fully completed in order for it to be considered.

I, the Applicant, certify that my answers are true and honest to the best of my knowledge. If this application leads to my eventual employment, I understand that any false or misleading information in my application or interview may result in my employment being terminated.

Signature: _____ Date: _____