

At Ease Home Care

88 East Broadway
Eugene, Oregon 97401
Office: (541) 344-3273 Fax: (541) 744-1213
www.ateasehomecare.com

Registered Nurse Application

**Incomplete Applications Will Not Be Considered.
Please Read Entire Application.**

Void 6 months after the "Date" entered below and will be shredded after 14 months.

According to Oregon Administrative Rules, Division 536; 333-536-0050, 9, "The in home care agency must insure that a criminal background check has been conducted on all individuals employed by or contracting with the agency...." AEHC holds to the DHS guidelines ORS 443.004 regarding specific convictions that prevent them from working with an in-home care agency.

Name: _____ Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

How or Who Referred You? _____ Former AEHC Employee? Y N

Application at a Glance: (Check the box: Y = Yes and N = No)

- | | | | |
|--------------------------------|-------------------------------------------------------|----------------------------------------|-------------------------------------------------------|
| 1) In Home Care Experience? | <input type="checkbox"/> Y <input type="checkbox"/> N | 6) Current Drivers License? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2) Elderly Care Experience? | <input type="checkbox"/> Y <input type="checkbox"/> N | 7) Reliable Vehicle? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3) Infant Care Experience? | <input type="checkbox"/> Y <input type="checkbox"/> N | 8) Current Automobile Insurance? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 4) RN License? | <input type="checkbox"/> Y <input type="checkbox"/> N | 9) Bus / Bike / Non-Driver? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| License #: _____ | | 10) Current TB Screening? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Expires: _____ | | 11) Oregon Food Handler's Certificate? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 5) Other Certifications: _____ | | 12) Can You Pass A Drug Test? | <input type="checkbox"/> Y <input type="checkbox"/> N |

Skills Overview: (Check the Box: Y = Yes and N = No , You may be asked where you received training / experience)

- | | | | |
|----------------------------|-------------------------------------------------------|---------------------|-------------------------------------------------------|
| Charting | <input type="checkbox"/> Y <input type="checkbox"/> N | Alzheimer's Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Gate Belt | <input type="checkbox"/> Y <input type="checkbox"/> N | Dementia | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Wheelchair Transfers | <input type="checkbox"/> Y <input type="checkbox"/> N | Hospice | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hoyer Lift | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Toilet / Incontinent Asst | <input type="checkbox"/> Y <input type="checkbox"/> N | Wound Care | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bathing | <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Medication | <input type="checkbox"/> Y <input type="checkbox"/> N | Catheter | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Range of Motion | <input type="checkbox"/> Y <input type="checkbox"/> N | Colostomy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Developmental Disabilities | <input type="checkbox"/> Y <input type="checkbox"/> N | Feeding Tube | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Infant Care | <input type="checkbox"/> Y <input type="checkbox"/> N | Other: _____ | |

Availability: (Check Shift Preference) Daytime Shifts Overnights 12-hr Shifts 24-hr Shifts Indicate Days and Provide Times Available including am/pm: (Example: ✓ Monday: 7am-10pm)

- Monday: _____ Friday: _____
 Tuesday: _____ Saturday: _____
 Wednesday: _____ Sunday: _____
 Thursday: _____

Employers References: (Incomplete Applications will not be considered.)

- Please explain gaps longer than 6 months in employment
- Provide three Employer References from the last ten years in relation to the Caregiver position you are applying for. **Phone and Fax Numbers must be current.** Provide most recent employer first.

Employer: _____ **Your Job Title:** _____

Phone: _____ **Fax:** _____

Address, City and State: _____

Dates Employed From: _____ to: _____ Supervisor: _____

Starting Wage \$ _____ Ending Wage \$ _____

Reason for Leaving / Are you eligible for rehire? Y N

Job Duties: _____

May we contact employer? Y N

Employer: _____ **Your Job Title:** _____

Phone: _____ **Fax:** _____

Address, City and State: _____

Dates Employed From: _____ to: _____ Supervisor: _____

Starting Wage \$ _____ Ending Wage \$ _____

Reason for Leaving / Are you eligible for rehire? Y N

Job Duties: _____

May we contact employer? Y N

Employer: _____ **Your Job Title:** _____

Phone: _____ **Fax:** _____

Address, City and State: _____

Dates Employed From: _____ to: _____ Supervisor: _____

Starting Wage \$ _____ Ending Wage \$ _____

Reason for Leaving / Are you eligible for rehire? Y N

Job Duties: _____

May we contact employer? Y N

Personal History: (Provide the Following In Order to Accurately Complete Your Required Background Check.)

List Street Addresses, Cities and States, and Dates Residing At These Locations:

Addresses

Dates

List Other Names You Have Used and Dates You Used Them - Including Maiden Name:

Have You Been Convicted of a Crime, Pleaded Guilty, or No Contest? Y N

Explain:

Authorization to Obtain Your Identity Verification Report / Background Check:

I hereby certify that the answers given by me to all the questions contained on this Employment Application are true and correct to the best of my knowledge. If employed by At Ease Home Care, I will comply with all rules and regulations of the company. I agree to submit to a physical and/or drug examination if required. I have read and understand the purpose of this Employment Application. I also understand that if any fraudulent information is given on this Application it may be grounds for immediate termination from my position. I am providing complete and accurate information. Pre-employment screening fees may be applied.

I authorize At Ease Home Care to obtain an Employment/Identity Report for employment purposes. I understand that these inquiry reports may include, but are not limited to: conviction records, motor vehicle records, references, and copies of prior personnel files. I understand that providing my Social Security number and birthday is voluntary. I authorize the use of this information for the purpose of national and/or state criminal history and background checks. I understand that I may be asked to provide further proof of Identity obtained from the Social Security Department if requested. At Ease Home Care, Inc. is an Equal Opportunity Employer. I understand that the job position I am applying for is placed equally without discrimination due to race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.

Name: _____ Date: _____

Signature: _____

Social Security Number: _____ - _____ - _____

Birthday: _____ - _____ - _____

This Authorization is given pursuant to the Fair Credit Reporting Act, 15 U.S.C.1681b(b)(2)(B) .Note: The FCRA requires that an applicant must authorize in advance the procurement of an Employment/Identity Verification Report for employment purposes.

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This Authorization to Obtain Employment Verification / History must be signed before we can conduct References Checks on all Applicants.

AUTHORIZATION TO OBTAIN EMPLOYMENT VERIFICATION / HISTORY

I authorize my former and current employers to give any information they have regarding my employment, whether or not it is on their records, to At Ease Home Care. I hereby release At Ease Home Care and former and current employers from all liability and any damages for issuing said information.

Name: _____ Date: _____

Signature: _____