



AAL-Asinza Assisted Living House Employment Application Form

Personal Information	
Name	First _____ 2 nd Initial _____ Last: _____
Address	Street: _____ Apartment: _____ City: _____ State: _____ Zip: _____
Phone	Home: _____ Cell: _____ Other: _____
Electronic	Email Address: _____
Date of Birth	Day: _____ Month: _____ Year: _____
SSN	Social Security Number: _____
Gender	Male: _____ Female: _____
Language	What languages do you speak? _____ _____
Emergency Contact	Name & Phone Number of Person to contact in the event of an emergency: Local: _____ Out-of-Area: _____
Education	
Formal	Diploma: _____ Certificate: _____ Degree: _____ Other: _____ Other: _____
Informal	Do you have current First Aid Certification (State Level): _____ Expiry Date: _____ Do you have current CPR? _____ Expiry Date: _____ Have you taken a Food Safety course? _____ Other: _____ <div style="text-align: center;">(Specify)</div> Other: _____ <div style="text-align: center;">(Specify)</div>



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Restrictions															
Work Limitations	List any work limitations that you may have and briefly describe: Hearing: ___ Yes ___ No _____ Speech: ___ Yes ___ No _____ Lifting: ___ Yes ___ No _____ Health: ___ Yes ___ No _____ Physical: ___ Yes ___ No _____ Emotional: ___ Yes ___ No _____ Other: ___ Yes ___ No _____														
Availability for Work															
Hours & Days Available for Work	_____ Full-time _____ Part-time _____ Short-notice _____ Split Shift Indicate Days and List Hours Available for Work: _____ Sunday: From: _____ To: _____ _____ Monday: From: _____ To: _____ _____ Tuesday: From: _____ To: _____ _____ Wednesday: From: _____ To: _____ _____ Thursday: From: _____ To: _____ _____ Friday: From: _____ To: _____ _____ Saturday: From: _____ To: _____ What is the minimum number of hours you will work in one day? _____ What is the maximum number of hours you will work in one day? _____														
Client Types and Work Duties															
Type of Position(s) Preferred	_____ Home Maker _____ Personal Care _____ Companion _____ Live-In _____ Other: _____ <div style="text-align: center;"><i>(Specify)</i></div> Live-in care usually requires that you to in a client's home continuously for 3-4 days at a time every week. Indicate which shifts you will accept: _____ Weekdays (Monday a.m. to Friday a.m.) _____ Weekends: (Friday a.m. to Monday a.m.)														
Clients Not Willing/Able to Work With	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">_____ Dementias/Alzheimer's</td> <td style="width: 50%;">_____ Physical Disabilities</td> </tr> <tr> <td>_____ Smokers</td> <td>_____ Pets</td> </tr> <tr> <td>_____ Mental Retardation</td> <td>_____ Females</td> </tr> <tr> <td>_____ Behavioral Disorders</td> <td>_____ Males</td> </tr> <tr> <td>_____ Elderly (over 65)</td> <td>_____ Client use of marijuana for medicinal purposes</td> </tr> <tr> <td>_____ Children</td> <td>_____ HIV Positive/AIDS</td> </tr> <tr> <td>_____ Other: _____</td> <td></td> </tr> </table> <div style="text-align: center;"><i>(Specify)</i></div>	_____ Dementias/Alzheimer's	_____ Physical Disabilities	_____ Smokers	_____ Pets	_____ Mental Retardation	_____ Females	_____ Behavioral Disorders	_____ Males	_____ Elderly (over 65)	_____ Client use of marijuana for medicinal purposes	_____ Children	_____ HIV Positive/AIDS	_____ Other: _____	
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Work Related #1 (Last Position)	Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #2 (2nd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #3 (3rd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Personal #1	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, family etc.</i>) _____ (<i>Other than relative.</i>)
Personal #2	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, teacher etc.</i>) _____ (<i>Other than relative.</i>)

I certify that, to the best of my knowledge, the answers given are true and complete and that purposeful misrepresentation may result in rejection of my application. I authorize investigation of all statements contained in this application, as required. Additionally, I authorize former employers, references and any other individual/organizations to provide information to **SYHC** and I hereby release and discharge any of the above and **SYHC** from any liability of any kind or nature. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary

I agree to a physical examination, if requested, and understand that failure to meet any medical and/or health requirements for the position may prevent my employment with the Agency. I also understand that employment, for certain positions, and may be conditional upon successful completion of a substance abuse screening test, if part of the Agency's pre-employment policy.

I understand that, if hired, I may be required to provide proof that I am a citizen of the United States or proof that I am currently authorized to work in the United States.

Applicant's Signature

Date