



CHESTERFIELD HEALTH SERVICES, INC.
Home Health, Staffing, and Pharmacy

EMPLOYMENT APPLICATION

**For
Home Healthcare/Home Care Assistant**

- Office Locations:** Seattle Everett Kent Longview Vancouver
 Spokane Whitman Yakima Tri-Cities Tri-Counties Walla Walla
 Goldendale Stevenson

Please print clearly. Do not leave any blank spaces.

Name (last, first)		Social Security #	Date of Birth	Application Date
Mailing Address		City	State	Zip Code
Home Phone #	Cell Phone #	Other Phone #	Email Address	
Desired Start Date	Are you over 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	How did you hear about Chesterfield?		
		Have you ever worked for Chesterfield?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Name	Relationship	Home Phone #	Cell Phone #	
Emergency Contact Name	Relationship	Home Phone #	Cell Phone #	

1. Do you have the legal right to work in the United States for any employers? Yes No

2. How many years have you lived in Washington State without living in another state?
 _____ years/ _____ months

3. Have you been convicted for any violations of the law? Yes No

Have you been convicted of a misdemeanor or felony? Yes No

Are there any pending charges against you? Yes No

If "Yes" to any of the 3 questions above, please list the crime, conviction date, and location:

A conviction will not necessarily prevent you from being hired. However, failure to disclose a conviction or a pending conviction is called, "Non-disclosure." "Non-Disclosure" will prevent you from being considered for employment.

4. Do you have a valid driver's license? Yes No

Driver's License #: _____

Expiration Date: _____

5. Do you have automobile insurance? Yes No

Expiration Date: _____

Name & Location of Insurance Company: _____

EDUCATION & TRAINING

School/Training	Name & Location	Course of Study	Years Attended	Degree/Certificate
High School				
Vocational				
College				
Other				

Please list any special skills and/or trainings you have had that will help you perform in this line of work:

Why do you want to work for Chesterfield Health Services?

SKILLS ASSESSMENT

If you have questions about the following home care duties, please ask one of our Program Managers for more information.

Are you able and/or willing to perform these home care tasks/duties?

Ambulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meal Preparation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Assistance w/ Travel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medication Reminders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Personal Hygiene	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Body Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Positioning	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shopping/Errands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating (assistance w/ eating)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Supervision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grooming	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Toileting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Housework	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Transferring	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laundry	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Telephone Assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Meal Planning/Diets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Companionship	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diaper Change	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Perineal Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please explain any experiences that you have had with individuals who have disabilities:

EMPLOYMENT HISTORY

Employer (present or most recent)		Telephone	Address
Position		Supervisor	Reason for Leaving
Dates of Employment	Starting Salary	Final Salary	May we contact this employer?
From: To:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe your duties (It is important to be specific and thorough.)			

Employer (Previous)		Telephone	Address
Position		Supervisor	Reason for Leaving
Dates of Employment	Starting Salary	Final Salary	May we contact this employer?
From: To:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe your duties (It is important to be specific and thorough.)			

Employer (Previous)		Telephone	Address
Position		Supervisor	Reason for Leaving
Dates of Employment	Starting Salary	Final Salary	May we contact this employer?
From: To:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe your duties (It is important to be specific and thorough.)			

ADDITIONAL INFORMATION

What qualifications and skills make you a good candidate for this position?

I certify that the information provided by me in this application is complete, truthful, and accurate to the best of my knowledge. I understand and agree that my failure to provide complete, truthful and accurate information on this application may result in denial of employment, or, if already employed, immediate termination. I understand that my continuous employment may be contingent upon passing for illegal drugs, a health review physical, proof of employment eligibility and/or reference and criminal background check. I authorize Chesterfield Health Services Inc. and its personnel to contact any and all references I have listed on this application for relevant information and release all such persons from all claims, liabilities and damages for whatever reason arising out of furnishing said information. If I am employed, I agree to conform to the rules and regulations of Chesterfield Health Services Inc. I understand that Chesterfield Health Services Inc. is an Equal Opportunity Employer and that all applicants will receive consideration for employment without regard to race, religion, political affiliation, color, gender, age, national origin, disability, marital status, or veteran status.

Name (print)

Signature

Date

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Skill Level: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High Skills Proficiency: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High CNA/NAR/LPN: <input type="checkbox"/> Yes <input type="checkbox"/> No DL/Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Orientation Date: _____ References Checked on: _____ Date of Hire: _____ Starting Salary: _____
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