

DATE: _____



APPLICATION FOR EMPLOYMENT

PLEASE PRINT CLEARLY

Name: _____ SIN # _____
(last) (first)

Email address _____

Telephone Number: (_____) _____ Cell Number: (_____) _____

Address: _____

City: _____ Postal Code: _____

What is your major intersection? _____

Date of Birth: _____ Do you own your own car? YES NO
(Month/Day/Year)

What shifts can you work? Days _____ Afternoons _____ Nights _____ Short Shifts _____

Can you work weekends? YES NO Can you work 12 hour shifts? YES NO

Which license/certificate do you presently hold? RN RPN PSW HCA OTHER: _____

Are you a new graduate? YES NO Registered staff: Do you have a current license? YES NO

Do you speak another language beside English? If so, please list: _____

How did you learn about Everest? _____

Do you work for any other agencies? YES NO If so, what Nursing Homes have they sent you to?

Have you ever been convicted of a criminal offence for which a pardon has not been granted? YES NO

Person to be notified in case of accidents or emergency:

Name	Telephone Number	Cell Number
Address		

WORK EXPERIENCE

Please put a check mark (✓) beside each area you have experience in and beside it how many years of experience you have in that area.

Check	Area of expertise	Years		Check	Area of expertise	Years
	I.M., S.C. injections				Stroke	
	Changing dressings				Palliative Care	
	Physiotherapy				Mental health (Alzheimer's)	
	Occupational Therapy				Brain Injury	
	Personal Care (help with bathing, dressing etc)				Speech Language Therapy	
	Speech Therapy				Social Work	
	IV therapy				Nutritional Counseling	
	Wound care				Homecare	
	Diabetic teaching				Ordering medical supplies/equipment	
	Foot care					

Are you interested in caring for Palliative Care patients? YES NO Years experience in Palliative Care? _____

Have you ever been bonded? If yes, on what jobs? _____

Do you have any physical condition(s) which may limit your ability to perform certain kinds of work? YES NO

If yes, describe condition(s) and specific work limitations: _____

May we contact the employers listed below? If not, please indicate which one(s) you do not wish us to contact.

PLEASE LIST PREVIOUS EMPLOYERS

Last employer: _____ tel : () _____

Address: _____ Position held _____

Salary: _____ from _____ to _____
m y m y

Reason for leaving _____ Supervisor: _____

Last employer: _____ tel : () _____

Address: _____ Position held _____

Salary: _____ from _____ to _____
m y m y

Reason for leaving _____ Supervisor: _____

OTHER REFERENCES:

Name _____ tel: () _____

Name _____ tel: () _____



Write a paragraph stating why you chose this profession:

PLEASE READ CAREFULLY AND SIGN:

TERMS AND CONDITIONS

1. _____ (hereinafter referred to as "YOU", "YOUR", "I", "ME" or "MY") are an employee of Everest Nursing and Community Care Agency Inc. (hereinafter referred to as "Caring Touch") and will be sent to Home and Health Institutions to work (hereinafter referred to as "FACILITIES" or "FACILITY"). YOUR relationship with Caring Touch is entered into as an elect to work arrangement and YOU have the right to decline work without penalty. YOU acknowledge that YOU will not receive termination pay.
2. YOUR working hours will be recorded on an Caring Touch time sheet. YOUR time sheet must be signed by an authorized representative at the FACILITY where YOUR shift was completed. The time sheet is YOUR responsibility and must be completed and forwarded to Caring Touch at the end of each week. If YOU cannot do so, YOU must contact Caring Touch no later than the following Monday morning. This will prevent waiting an extra pay period for YOUR pay.
3. Pay periods are biweekly on Friday.
4. Should any FACILITY that YOU have worked with offers YOU a position, YOU can only accept that position after YOU have worked with Caring Touch for a minimum period of six (6) months, unless otherwise agreed upon between YOU and Caring Touch.
5. If YOU feel that any assignment at a FACILITY that YOU have been asked to perform is not safe, YOU should report this matter immediately to YOUR onsite supervisor and also immediately notify Caring Touch in writing.
6. No alcohol or drugs will be tolerated before or while YOU are at a FACILITY.
7. In case of a personal injury at a FACILITY, YOU must fill out an incident report at the FACILITY and also notify Caring Touch in writing within twenty-four (24) hours of the incident.
8. All notices to Caring Touch must be sent to:

Caring Touch Home Health Care Inc.
4500 Hwy 7, Suite 121
Woodbridge, ON L4L 4Y7

I hereby certify that the facts and statements made by me on this application are true and correct to the best of my knowledge, information and belief. This information may be used to obtain a Fidelity Bond.

I certify that I have read and understood the Terms and Conditions of this agreement and realize that failure to comply may result in the termination of my employment with Caring Touch.

I understand that, if employed, false statements on this application shall be considered sufficient cause for legal action.

Signature: _____ **Date :** _____

