

**INNOVATIVE HEALTHCARE CONSULTANTS, INC.**

**Personal Information**

<b>Name( Last, First, Middle)</b>	<b>Social Security #</b>	<b>Date</b>	
<b>Present Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Phone #</b>	<b>Cell Phone #</b>	<b>Referred By</b>	
<b>Last Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>

	<b>Name and Location of School</b>	<b>Did you Graduate?</b>	<b>Subjects Studied</b>
<b>High School</b>			
<b>College</b>			
<b>Vocational School</b>			

**Subjects of Special Study/or Special Training/Skills**

\_\_\_\_\_

\_\_\_\_\_

**Certificate (Include expiration date)**  
**First Aid** \_\_\_\_\_ **CPR** \_\_\_\_\_ **CNA** \_\_\_\_\_ **CHHA** \_\_\_\_\_ **MA** \_\_\_\_\_

**Former Employers (Include all employment for the last five years)**

<b>Date Month and Year</b>	<b>Name and Address of Employer</b>	<b>Phone #</b>	<b>Position</b>	<b>Pay</b>	<b>Reason for Leaving</b>
<b>From/To</b>					
<b>From/To</b>					
<b>From/To</b>					
<b>From/To</b>					
<b>Position</b>	<b>Date you can start?</b>		<b>Pay Desired</b>		
<b>Are You Currently Employed?</b>	<b>If so, may we inquire of your present employer?</b>				
<b>Will you continue with your current employment?</b>					

Do you have any physical condition or disability, which may limit your ability to perform caregiver duties including lifting and client transfer assistance? YES NO If yes, please explain

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All of our caregivers are required to speak and read English. Are there any other languages that you speak?

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Are you willing to use your personal vehicle to transport clients to and from doctor's appointments and other errands as needed? \_\_\_\_\_

If yes, please provide the following information:

Driver's License Number and Expiration Date: \_\_\_\_\_

Insurance Co. and Policy Number: \_\_\_\_\_

Limits of Liability Insurance: \_\_\_\_\_

Vehicle Make and Model: \_\_\_\_\_

Vehicle License Number: \_\_\_\_\_

I certify, under penalty of perjury, that all of the above is true and correct. Furthermore, I understand that Innovative Healthcare Consultants, Inc. is making no employment offer at this time. I understand that if I am employed, any false, misleading, or otherwise incorrect statements made on this application form or during any interview may be grounds for my immediate discharge. I hereby authorize Innovative Healthcare to contact any company, institution, or individual it deems appropriate to investigate my employment history, character, and qualification. I authorize any third party to release to Innovative Healthcare any and all information and documentation it requests. This information may include, but is not limited to, dates of employment, positions held, responsibilities, base compensation, job performance, education, degrees received, criminal history information, etc. A copy of this authorization may be accepted as an original. In addition, I hereby waive my right to bring any cause of action against these parties for defamation, invasion of privacy, or any other reason because of their statements. I agree that, if I am employed, I will abide by all the rules and regulations of Innovative Healthcare. I further understand that no one at Innovative Healthcare is authorized to enter into any written or verbal employment contracts with me for any definite period of time without express written consent of the President of the Company. I also understand that if I am hired, my employment will be at will and may be terminated by myself or by Innovative Healthcare at anytime for any reason or for no reason, with or without prior notice.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Interviewed by: