



**Classic Caregivers LTD.**

*Health Care with Compassion*

1550 - 1200 West 73rd Avenue,  
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t: 604.263.3621 f: 604.263.4139



# Employee Information Form

The information on this form is collected for the purposes of evaluating your application for employment with our company and should you be offered employment, the application will help us match your skills to appropriate clients. All information collected by Classic Caregivers Ltd. is protected by the Personal Information Protection and Electronic Documents Act and will be kept confidential. All of the questions below are optional and your consent is implied by submitting answers to the questions.

## Background Information

Last name \_\_\_\_\_ First name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_

Alternate # \_\_\_\_\_ Email: \_\_\_\_\_

SIN # \_\_\_\_\_ Birth date \_\_\_\_\_

Allergies? \_\_\_\_\_

Languages Spoken? \_\_\_\_\_

How did you hear about Classic?  Newspaper  Website  Friend  Other \_\_\_\_\_

Do you have a valid Drivers Licence? Yes  No

Driver's licence # \_\_\_\_\_  New  Learners  Class 5  Other \_\_\_\_\_

Do you have your own vehicle? Yes  No

Are you comfortable driving a client's vehicle? Yes  No

Are you comfortable driving a client in your vehicle? Yes  No

What have you done that you are the most proud of? \_\_\_\_\_

Are you willing to work in a smoking environment? Yes  No

Are you willing to work with pets? Yes  No

Availability for work - Please write the hours that you are available for work each day. Also tick whether you can do live in or live out work.

Monday	<input type="checkbox"/>	anytime or from _____	until _____	live in <input type="checkbox"/>	live out <input type="checkbox"/>
Tuesday	<input type="checkbox"/>	anytime or from _____	until _____	live in <input type="checkbox"/>	live out <input type="checkbox"/>
Wednesday	<input type="checkbox"/>	anytime or from _____	until _____	live in <input type="checkbox"/>	live out <input type="checkbox"/>
Thursday	<input type="checkbox"/>	anytime or from _____	until _____	live in <input type="checkbox"/>	live out <input type="checkbox"/>
Friday	<input type="checkbox"/>	anytime or from _____	until _____	live in <input type="checkbox"/>	live out <input type="checkbox"/>
Saturday	<input type="checkbox"/>	anytime or from _____	until _____	live in <input type="checkbox"/>	live out <input type="checkbox"/>
Sunday	<input type="checkbox"/>	anytime or from _____	until _____	live in <input type="checkbox"/>	live out <input type="checkbox"/>

Willing to work overnight shifts? Yes  No

Areas you will work in - The more areas you are available to work in the easier it is to find you work.

<input type="checkbox"/> Vancouver	<input type="checkbox"/> Surrey	<input type="checkbox"/> Langley	<input type="checkbox"/> New Westminister
<input type="checkbox"/> White Rock	<input type="checkbox"/> Richmond	<input type="checkbox"/> Abbotsford	<input type="checkbox"/> Tri Cities
<input type="checkbox"/> West Vancouver	<input type="checkbox"/> Burnaby	<input type="checkbox"/> Chilliwack	<input type="checkbox"/> Tswassassen/Delta
<input type="checkbox"/> North Vancouver	<input type="checkbox"/> Other _____		

Are you working right now? Yes  No

If yes how much notice will you give your present employer and when will you be available ?

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### Education

Have you taken a care aide program? Yes  No

School \_\_\_\_\_ Date Graduated \_\_\_\_\_

Is your CPR up to date? Yes  No   
(Please provide a copy of any certificates and CPR)

Other health related courses or education? \_\_\_\_\_

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Name of your most recent employer: \_\_\_\_\_

Date started \_\_\_\_\_ Date finished \_\_\_\_\_

Reason for leaving \_\_\_\_\_

Duties \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone# \_\_\_\_\_

May we contact your employer?  Yes  No

Previous Employer \_\_\_\_\_

Date started \_\_\_\_\_ Date finished \_\_\_\_\_

Reason for leaving \_\_\_\_\_

Duties \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone# \_\_\_\_\_

May we contact your employer?  Yes  No

Previous employer \_\_\_\_\_

Date started \_\_\_\_\_ Date finished \_\_\_\_\_

Reason for leaving \_\_\_\_\_

Duties \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone# \_\_\_\_\_

May we contact your employer?  Yes  No

**Work Experience** - Please tick duties you have experience with and are comfortable performing.

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Personal Care	<input type="checkbox"/> Colostomy bag	<input type="checkbox"/> Catheter bag	<input type="checkbox"/> Suppositories/Enemas
	<input type="checkbox"/> Personal hygiene	<input type="checkbox"/> Peri Care	<input type="checkbox"/> Bowel care
	<input type="checkbox"/> Bathing	<input type="checkbox"/> Manual transfers	<input type="checkbox"/> Mechanical lifts
			<input type="checkbox"/> Toileting

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Medical Care	<input type="checkbox"/> Quad care	<input type="checkbox"/> Trach care	<input type="checkbox"/> Feeding tubes
	<input type="checkbox"/> Suctioning	<input type="checkbox"/> TED stockings	<input type="checkbox"/> Glucometers
	<input type="checkbox"/> Medications	<input type="checkbox"/> ROM exercises	<input type="checkbox"/> Blood pressure

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Client Diagnosis	<input type="checkbox"/> Stroke care	<input type="checkbox"/> Dementia care	<input type="checkbox"/> Heart disease
	<input type="checkbox"/> Alzheimers care	<input type="checkbox"/> Palliative care	<input type="checkbox"/> Brain injury clients
	<input type="checkbox"/> Diabetic clients	<input type="checkbox"/> Parkinson clients	<input type="checkbox"/> ALS clients
	<input type="checkbox"/> MS clients	<input type="checkbox"/> Hip replacement clients	<input type="checkbox"/> Cerebral Palsy

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## Cooking

How would you rate your cooking on a scale of 1- (poor) to 10 - (excellent)? \_\_\_\_\_

Have you cooked for an elderly client before?  Yes  No

What type of food? \_\_\_\_\_

Do you have experience with cooking special diets for clients?  Yes  No

What special diets? \_\_\_\_\_

Are you able to cook Chinese dishes?  Yes  No

Housekeeping - Please check duties in which you have had experience:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dusting                | <input type="checkbox"/> Washing floors      | <input type="checkbox"/> Vacuuming      |
| <input type="checkbox"/> Washing windows        | <input type="checkbox"/> Laundry             | <input type="checkbox"/> Cleaning stove |
| <input type="checkbox"/> Cleaning fridge        | <input type="checkbox"/> Cleaning cupboards  | <input type="checkbox"/> Ironing        |
| <input type="checkbox"/> Washing/drying clothes | <input type="checkbox"/> Changing bed linens |   |

How would you rate your housekeeping? \_\_\_\_\_

Are you comfortable doing housekeeping for a client? \_\_\_\_\_

References - List 3 work related references that we may contact as a reference for you. (Excluding family & close friends.)

Name	Phone number	Position/Company
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Have you had a criminal record search done within the last year?  Yes  No  
If so, please attach copy or mail into the office within two weeks of employment.

Have you ever been arrested?  Yes  No

Will you consent to having a police record check before being employed with us?  Yes  No

I understand that failing to provide accurate information or omission of facts on this form may disqualify me from consideration for employment with Classic Caregivers or subsequent termination if I am employed.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_