



[www.ultrahomecare.com](http://www.ultrahomecare.com)

4565 Ruffner Street Suite 210 San Diego, CA 92111

North San Diego: 760. 870. 4599  
San Diego: 858. 779. 1397  
South San Diego: 619. 866. 6098  
Fax: 858. 764. 2824

Dear Applicant,

Thank you for your interest in joining our caregiver staff with Ultra Home Care. In this packet you will find:

- 1) Application
- 2) References Sheet
- 3) Skills Checklist

**Please complete the paperwork listed above & fax back to 858-764-2824.** Please call us to confirm that we have received your application packet. Once we have received and reviewed your application, we will give you a call to set up an interview. There, you will meet with staff and management.

Before you are assigned to a case, we will have to run your background check and check your references.

If you have any questions prior to your interview appointment, please do not hesitate to call our office.

Once again, thank you for your interest in joining our staff here at Ultra Home Care. We look forward to hearing from you. Good luck!

Warm Regards,

*Ultra Home Care*



**PERSONAL INFORMATION**

Job Name: \_\_\_\_\_ Social Security: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Present Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: (if any) \_\_\_\_\_ Do you wish to work  Full Time  Part Time  Live In?

**Specify what hours you are available on each day. The amount of work we assign depends on your flexibility:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**What area would you prefer to work?** (Please circle all areas you would consider. The amount of work we can assign depends on your flexibility.) Areas are listed by alphabetical order.

- |                 |           |            |               |            |               |               |
|-----------------|-----------|------------|---------------|------------|---------------|---------------|
| Bonita          | Coronado  | Escondido  | Lakeside      | Poway      | Solana Beach  | NO PREFERENCE |
| Borrego Springs | Del Mar   | Fall Brook | Lemon Grove   | Ramona     | Spring Valley |               |
| Carlsbad        | El Cajon  | La Jolla   | National City | San Diego  | Vista         |               |
| Chula Vista     | Encinitas | La Mesa    | Oceanside     | San Marcos | Other: _____  |               |

Date Available for work: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Other Skills: \_\_\_\_\_

Languages spoken: \_\_\_\_\_

Professional Licenses: \_\_\_\_\_

**Education & Work History**

	Name, City, State	Degree / Certificate	Graduated?
Highschool:	_____	_____	Yes / No
College:	_____	_____	Yes / No
Nursing School:	_____	_____	Yes / No
Technical Training:	_____	_____	Yes / No

**WORK HISTORY:**

Include any information pertaining to patient care, starting with the most recent.

Company: \_\_\_\_\_ Starting Pay: \_\_\_\_\_  
 Title: \_\_\_\_\_ Ending Pay: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Date Started: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Date Ended: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Reason For Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Starting Pay: \_\_\_\_\_  
 Title: \_\_\_\_\_ Ending Pay: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Date Started: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Date Ended: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Reason For Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Starting Pay: \_\_\_\_\_  
 Title: \_\_\_\_\_ Ending Pay: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Date Started: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Date Ended: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Reason For Leaving: \_\_\_\_\_

May we call your former Companies?:  Yes  No

If no, please explain: \_\_\_\_\_

**QUESTIONNAIRE:**

Have you been fired in the last ten years? If yes, please explain:

\_\_\_\_\_

Have you ever been convicted, pled guilty or no contest, or forfeited bond on bail for any crime other than traffic violations?

\_\_\_\_\_

As a Companion/ Personal Attendant, you may be required to manually lift or transfer a patient. The average weight may be 150 lbs. Will you be able to do that? If no, please explain.

\_\_\_\_\_

Are you willing and able to drive for our clients using their car? \_\_\_\_\_

Do you have a current valid drivers license and valid insurance? \_\_\_\_\_ Drivers License #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that falsifying statements on this application shall be grounds for dismissal.

X \_\_\_\_\_  
 Name: (First Middle Initial Last)

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



Reference Sheet: Please list 3 to 5 **professional** references

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

References:

1) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ How long have you known this person: \_\_\_\_\_

2) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ How long have you known this person: \_\_\_\_\_

3) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ How long have you known this person: \_\_\_\_\_

4) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ How long have you known this person: \_\_\_\_\_

5) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ How long have you known this person: \_\_\_\_\_



### SKILLS CHECKLIST

Please check off the areas in which you have experience in.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alzheimers                        | <input type="checkbox"/> Aneurism                 | <input type="checkbox"/> Housekeeping  |
| <input type="checkbox"/> Dementia                          | <input type="checkbox"/> Wheelchair               | <input type="checkbox"/> Bed Bound Care  |
| <input type="checkbox"/> Diabetes ___ Insulin              | <input type="checkbox"/> Gait Belt                | <input type="checkbox"/> Oxygen  |
| <input type="checkbox"/> Congestive Heart Failure          | <input type="checkbox"/> Diapers                  | <input type="checkbox"/> COPD  |
| <input type="checkbox"/> Cancer<br>Type: _____<br>_____    | <input type="checkbox"/> Bed Pan                  | <input type="checkbox"/> ROM Exercises   |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Bedside Urinal / Commode | <input type="checkbox"/> Vital Signs   |
| <input type="checkbox"/> Multiple Sclerosis                | <input type="checkbox"/> Hoyer Lift               | Please Include any examples that display<br>your experience below:<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |
| <input type="checkbox"/> ALS                               | <input type="checkbox"/> G-Tube                   |  |
| <input type="checkbox"/> Parkinson's                       | <input type="checkbox"/> Tracheotomy              |  |
| <input type="checkbox"/> Hip Replacement                   | <input type="checkbox"/> PRN Meds                 |  |
| <input type="checkbox"/> Wounds                            | <input type="checkbox"/> Blood Pressure           |  |
| <input type="checkbox"/> Coumadin Related Issues           | <input type="checkbox"/> Cooking                  |  |
| <input type="checkbox"/> Stroke                            | <input type="checkbox"/> Low Salt Diet            |  |
| <input type="checkbox"/> Paralysis                         | <input type="checkbox"/> Low Sugar Diet           |  |
| <input type="checkbox"/> Swallowing or Speech Issues       | <input type="checkbox"/> Bathing                  |  |
| <input type="checkbox"/> Hospice                           | <input type="checkbox"/> Grooming                 |  |
| <input type="checkbox"/> Transfers ___ min ___ mod ___ max | <input type="checkbox"/> Toileting                |  |