

# Huntington Nannies Domestic Placement

## PERSONAL INFORMATION

Date of Application \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Are you a U.S. Citizen?  Yes  No

If no, can you legally accept employment?  Yes  No Card # \_\_\_\_\_

Do you have a Driver's License?  Yes  No State \_\_\_\_\_ License # \_\_\_\_\_

Do you have a car?  Yes  No Make \_\_\_\_\_ Model \_\_\_\_\_ Color \_\_\_\_\_ Yr. \_\_\_\_\_

State \_\_\_\_\_ License Plate \_\_\_\_\_

Do you have car insurance?  Yes  No Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Have you been in a car accident?  Yes  NO If yes, please explain \_\_\_\_\_

Marital Status (*check one*)  Single  Separated  Widowed  Married  Divorced

Do you have children?  Yes  No

If yes, do you need to bring your children with you?  Yes  No

Please list children (*name/age/date of birth*)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**EMERGENCY CONTACTS**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_

**JOB INTERESTS**

How did you hear about Huntington Nannies? \_\_\_\_\_

Have you worked or are currently working with another agency?  Yes  No

If yes, which agency (ies)? \_\_\_\_\_

What positions are you interested in? (*check all that apply*)

Full –Time (*over 30 hrs/wk*)  Part –Time (*under 30 hrs/wk*)  Live In  Live Out

Long –Term (*more than 3 months*)  Temporary/Summer (*less than 3 month*)

If temporary, list dates of availability \_\_\_\_\_

What hours are you available to work?

	From:	To:	Total Hours:
Monday	_____	_____	_____
Tuesday	_____	_____	_____
Wednesday	_____	_____	_____
Thursday	_____	_____	_____
Friday	_____	_____	_____
Saturday	_____	_____	_____
Sunday	_____	_____	_____

Are you willing to do a split shift (for example, 7:00 am – 8:30am, then 2:00pm – 7:00pm)?

Yes  No

Date available to start \_\_\_\_/\_\_\_\_/\_\_\_\_ Expected Salary Range \$\_\_\_\_\_

**Check the duties you are willing to do:**

- Run Errands
- Homework / Tutor Children
- Cooking                       Children                       Family
- Laundry                       Children                       Family
- Cleaning                       Light                       Heavy
- Drive Children               Own Car                       Family Car     Manual               Automatic
- Travel                       Weekend                       Extended
- Care for Pets               Yes                       No                      Please list exceptions\_\_\_\_\_
- Swim with Children

**Check all that apply:**

- Infant Care (newborn – 6 mos)               Have Experience               Interested               Not Interested
- 6 mos - 2 yrs                       Have Experience               Interested               Not Interested
- 2 yrs – 7 yrs                       Have Experience               Interested               Not Interested
- 8 yrs – 12 yrs                       Have Experience               Interested               Not Interested
- 12 yrs – over                       Have Experience               Interested               Not Interested
- Twins                       Have Experience               Interested               Not Interested

**Check all the items you have experience with and feel comfortable handling:**

- ADD               ADHD               Autism               Asthma               Blind               Cerebral Palsy
- Hearing Impaired               Medical Illness               Physical Disabilities               Emotional Disturbances
- Down Syndrome               Multiple Disabilities               Diabetes               Other \_\_\_\_\_

**EDUCATION**

(Include High schools, Colleges, Universities, and Degrees Earned)

School	State/City	Dates	Degree Studied	Degree Earned

What languages do you speak? Conversational\_\_\_\_\_ Fluent\_\_\_\_\_

List or describe classes you have taken (are taking) related to Education, Elementary Education, Child Care, Psychology, or anything else, that you feel will help you be a better child care provider\_\_\_\_\_

**OTHER INFORMATION**

What are your hobbies / special interests?

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What are your long term career / job goals?

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What are your thoughts on discipline? What is your preferred style of discipline?

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What activities would you do with children?

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Describe your family background?

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How many children/siblings were in your home when you were growing up? \_\_\_\_\_

Where do you fall in your family (for example, 1<sup>st</sup> of 5 children)? \_\_\_\_\_

Did you babysit your siblings growing up?  Yes  No

Did you babysit for neighbors/other families growing up?  Yes  No

Where did you grow up? (*state/city*) \_\_\_\_\_

Which age group do you relate to best and feel most comfortable with? (*check all that apply*)

Infants (newborn – 6 mos)     6 mos – 12 mos     1-2 yrs     3-4 yrs

5-8 yrs     9- 13 yrs

**CHILD CARE RELATED EXPERIENCE**

(List most recent reference first)

**EMPLOYER 1**

Employer \_\_\_\_\_ Date Started /Ended \_\_\_\_\_

Contact Name \_\_\_\_\_ May we contact?  Yes  No

Are you still employed?  Yes  No Reason for leaving? \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Work phone ( ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position/Title \_\_\_\_\_  Full- Time  Part- Time  Temp/Summer

Average hrs/wk \_\_\_\_\_  Live- Out  Live- In

Number of children \_\_\_\_\_

Child Information (name/age/gender) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Job Duties \_\_\_\_\_

**EMPLOYER 2**

Employer \_\_\_\_\_ Date Started /Ended \_\_\_\_\_

Contact Name \_\_\_\_\_ May we contact?  Yes  No

Are you still employed?  Yes  No Reason for leaving? \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Work phone ( ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position/Title \_\_\_\_\_  Full- Time  Part- Time  Temp/Summer

Average hrs/wk \_\_\_\_\_  Live- Out  Live- In

Number of children \_\_\_\_\_

Child Information (name/age/gender) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Job Duties \_\_\_\_\_

**EMPLOYER 3**

Employer \_\_\_\_\_ Date Started /Ended \_\_\_\_\_

Contact Name \_\_\_\_\_ May we contact?  Yes  No

Are you still employed?  Yes  No Reason for leaving? \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Work phone ( ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position/Title \_\_\_\_\_  Full- Time  Part- Time  Temp/Summer

Average hrs/wk \_\_\_\_\_  Live- Out  Live- In

Number of children \_\_\_\_\_

Child Information (name/age/gender) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Job Duties \_\_\_\_\_

**OTHER WORK HISTORY**

(List your most recent references first)

**EMPLOYER 1**

Employer \_\_\_\_\_ Date Started /Ended \_\_\_\_\_

Contact Name \_\_\_\_\_ May we contact?  Yes  No

Are you still employed?  Yes  No Reason for leaving? \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Work phone ( ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position/Title \_\_\_\_\_  Full- Time  Part- Time  Temp/Summer

Average hrs/wk \_\_\_\_\_  Live- Out  Live- In

Job Duties \_\_\_\_\_

**EMPLOYER 2**

Employer \_\_\_\_\_ Date Started /Ended \_\_\_\_\_

Contact Name \_\_\_\_\_ May we contact?  Yes  No

Are you still employed?  Yes  No Reason for leaving? \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Work phone ( ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position/Title \_\_\_\_\_  Full- Time  Part- Time  Temp/Summer

Average hrs/wk \_\_\_\_\_  Live- Out  Live- In

Job Duties \_\_\_\_\_

**EMPLOYER 3**

Employer \_\_\_\_\_ Date Started /Ended \_\_\_\_\_

Contact Name \_\_\_\_\_ May we contact?  Yes  No

Are you still employed?  Yes  No Reason for leaving? \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Work phone ( ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position/Title \_\_\_\_\_  Full- Time  Part- Time  Temp/Summer

Average hrs/wk \_\_\_\_\_  Live- Out  Live- In

Job Duties \_\_\_\_\_

**CHARACTER REFERENCES**

(Do not include work references or relatives)

Name	Address, City, State	Phone #
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

**HEALTH INFORMATION**

Do you have medical insurance?  Yes  No

Are you in good health?  Yes  No

Insurance Center \_\_\_\_\_ Physician's Name \_\_\_\_\_

**QUESTIONS**

**Yes**

**No**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Have you had a physical within the last 5 years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had the chicken pox?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies to animals or foods?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any physical, medical or mental disability which would prevent you from performing specific work? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any physical limitations?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you take prescribed medications?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you smoke? If yes, how often?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you drink? If yes, how often?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for a back injury?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you taking any type of medication? If yes, what?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any major operations/illnesses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been diagnosed with:   |                          |                          |
| a. Arthritis   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Diabetes  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hernia  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emotional problems  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Epilepsy or Convulsions   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fainting or Dizziness   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Frequent Headaches  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Cancer  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. High Blood Pressure   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Chest Pain or Pressure  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Heart Disease   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Chronic Coughs, Colds, or Sore Throats  | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Allergies, Asthma, Wheezing   | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Skin Disease  | <input type="checkbox"/> | <input type="checkbox"/> |