PH: (404) 990-3973
FX: (478) 746-5111

APPLICATION FOR MEDICATION AIDE TRAINING COURSE

"Village of Caregivers"
EXTENDED HEALTH SERVICES
4340 North Henry Blvd.
Suite 260
Stockbridge, GA 30281

COMPLETE ALL ITEMS. PLEASE PRINT IN INK. TODAYS DATE _____

NAME _____ S/S # _____
Last First Middle

Present Address: _____
Street Address, Apt # City State Zip Code

HOME PHONE: _____ CELL PHONE: _____

ARE YOU A U.S. CITIZEN OR AUTHORIZED TO WORK IN THE U.S. ON AN UNRESTRICTED BASIS? YES NO

DO YOU HAVE A VALID DRIVER'S LICENSE? YES _____ NO _____ CLASS/TYPE: _____ STATE: _____

ARE YOU AT LEAST 18 YEARS OF AGE? _____

HAVE YOU BEEN CONVICTED OF A CRIME OR PLED GUILTY OR NOLO CONTENDRE TO A CRIME?
YES _____ NO _____ IF YES, LIST COUNT, STATE, DATE AND DESCRIBE:

_____

_____

(Conviction will not necessarily disqualify a student for taking the course.)

IN CASE OF EMERGENCY NOTIFY:
NAME: _____ RELATIONSHIP: _____

PHONE: _____ ADDRESS: _____

HOW DID YOU LEARN OF PROGRAM? _____

DESCRIBE YOUR HEALTH CARE EXPERIENCE: IF ANY (Work history can be included): _____

_____

Why are you interested in this course? _____

_____

DAYS OF THE WEEK AVAILABLE FOR CLASS: MO TU WE TH FR SA (Circle all available)
HAVE YOU BEEN A CNA ON THE GEORGIA REGISTRY? YES NO (Circle)

ARE YOU CURRENTLY WORKING IN AN ASSISTED LIVING COMMUNITY? (IF YES, WHERE)_____

_____

Work History

EMPLOYER	TYPE OF BUSINESS	TELEPHONE NUMBER
ADDRESS (Street, City State Zip)		
DATE STARTED: (Month / Year)	STARTING SALARY	STARTING POSITION
RESIGNATION DATE: (Month/ Year)	SALARY WHEN RESIGNED	POSITION WHEN RESIGNED
NAME AND TITLE OF SUPERVISOR		

JOB DESCRIPTION AND RESPONSIBILITIES

_____

_____

REASON FOR LEAVING: _____

IF PRESENTLY EMPLOYED, MAY WE CONTACT YOUR EMPLOYER FOR REFERENCES? _____

-- EDUCATION --

NAME AND ADDRESS OF SCHOOL	GRADUATED?	MAJOR STUDY
HIGH SCHOOL		
BUSINESS OF TECHNICAL SCHOOL		
COLLEGE OR UNIVERSITY		
OTHER		
OTHER		

SPECIAL SKILLS: _____

_____

Professional and Personal References

NAME: _____ OCCUPATION: _____

ADDRESS: _____

CITY AND STATE: _____ PHONE: _____

NAME: _____ OCCUPATION: _____

ADDRESS: _____

CITY AND STATE: _____ PHONE: _____

Statement of Release

I understand that Extended Health Services (EHS) is committed to providing equal opportunity in all practices, including but not limited to selection, of all qualified applicants for class and training without regard to age, race, color, national origin, sex, religion, disability or any other category protected by law.

In making this application for training, I understand that EHS may investigate background and my criminal record as may be required by state and federal regulations. This inquiry includes information as to my character, general reputation, personal characteristics, and mode of living. I understand that I have a right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigative report.

I authorize former and current employers, work and personal references listed in the application, and any other individuals I may name to give EHS or its designee any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release such parties from all liability for any damages that may result from furnishing same to EHS.

NAME: _____ DATE: _____