PERSONAL ASSISTANT TRAINING

INTAKE FORM

Last Name_____ First Name _____ Middle _____

Street Address_____

City_____ State_____ Zip_____

Phone (Primary)_____ Phone (Secondary)_____

Email (optional)_____

Gender_____ Do you smoke? Yes____ No____

Are you willing to work for? Males_____ Females _____ Both_____

Are you willing to be an emergency or back-up PA? Yes____ No_____

Do you have reliable transportation? Yes____ No____

What **days and times** are you available to work? Please indicate below:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

What counties/areas are you willing to work in?

_____

What tasks are you **willing to perform**? (Check all that apply)

Bladder/Bowel care	Bathing	Grooming	Dressing	Shopping
Laundry	Appointment Assistance	Household Management	Hoyer Lift	Glucose Monitoring
Catheter care	Dressing Wounds	Eating	Transferring	Telephoning
Housework	Meal Preparation	Supervision	Registering Vitals	

Are you a CNA? Yes____ No____

What other Skills or Certifications do you have (including languages)?

_____

_____

_____

Do you have any work restrictions? (lifting, allergies,pets, etc.) Yes____ No____

If yes, please explain:

_____

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