



## NANNY EMPLOYMENT APPLICATION

Personal Information				Please print legibly
Last Name	First Name	Middle Initial	Date	
Full Street (Mailing) Address (including apartment number)		City	State	ZIP
Social Security Number	Day Telephone	Evening Telephone	Fax Number (if available)	
Available starting date	Hours available to work	Days available to work	Desired salary range	
18 years of age or older?	Do you smoke?	If no, do you object to smoking?	Are you legally eligible to work in the U.S.?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a driver's license?	Since When?	List state and license number		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you ever had a moving or driving related violation or traffic accident (include tickets)?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list specifics.				
Have you ever been arrested or convicted of a felony and/or a misdemeanor?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain.				
Have you ever been the subject of a substantiated complaint of child or sexual abuse?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain.				
Are you certified in First Aid?	Are you certified in CPR?	Do you swim?	Are you certified in lifesaving?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you willing to become certified in these programs?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please list which programs you are NOT willing to become certified in				
Are you comfortable caring for children when they are mildly ill?			Do you need health insurance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list any pets you would NOT be comfortable being around/living with.				
For Live-in Applicants only				
Have you ever lived away from home before?		If yes, how far away (in hours or miles), for how long and when?		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you ever been responsible for the payment of your own living expenses?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a checking account?	Do you have cooking skills?		Do you do your own laundry?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you plan on bringing a vehicle?		If yes, please list year, make and model		
<input type="checkbox"/> Yes <input type="checkbox"/> No				

Medical Information			
Do you have any medical condition that could affect your ability to care for children?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain.			
For each of the following, please indicate if you are willing to submit to, at no expense to you.			
Physical Examination	Drug screening	T.B. test	HIV test
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been immunized against the common childhood diseases?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, which ones have you NOT been immunized against?			
Do you have any diet restrictions?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain			
Do you have any current or history of emotional health problems?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain			
Have you ever been recommended to an alcohol or drug rehabilitation or mental institution?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain			
Educational Background			
Do you have a high school diploma/GED?		Please list name of high school	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list name of college (if attended)		Dates attended	Major
Degree/Certificate Received		Phone Number	
Please list any other special training you would like us to be aware of			
Employment History			
Current Employer (if a company, full company name)		Supervisor's Name / Phone Number (if different)	
Employer's full mailing address		City	State ZIP
Employer's Telephone Number	Position you held	Employed since	Ending salary
Reason for Leaving			May we contact?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

List ALL CHILDCARE References for the Past FIVE Years			
<b>Company/Family Name</b>		Date Employed From	To
Employer's full mailing address		City	State
Employer's Telephone Number	Position you held	Ending salary	May we contact?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving			
Describe your responsibilities in detail			
<b>Company/Family Name</b>		Date Employed From	To
Employer's full mailing address		City	State
Employer's Telephone Number	Position you held	Ending salary	May we contact?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving			
Describe your responsibilities in detail			
<b>Company/Family Name</b>		Date Employed From	To
Employer's full mailing address		City	State
Employer's Telephone Number	Position you held	Ending salary	May we contact?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving			
Describe your responsibilities in detail			

Personal, Character or Professional References			
PERSONAL, CHARACTER OR PROFESSIONAL REFERENCE 1			
Name		Relationship	
Phone Number		Length of time known	
PERSONAL, CHARACTER OR PROFESSIONAL REFERENCE 2			
Name		Relationship	
Phone Number		Length of time known	
Childcare Background/Information			
Ages of The Children You Have Cared For		Please List The Ages You Have the Most and Least Experience With	
Youngest	Oldest	Most	Least
Age you started caring for children		Did you care for your siblings?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had experience working with special needs children?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain			
Have you had to handle an emergency of any kind?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain			

I CERTIFY THAT I HAVE ANSWERED ALL THE QUESTIONS ON THIS APPLICATION ACCURATELY AND TO THE BEST OF MY KNOWLEDGE. I HAVE NOT WITHHELD ANY INFORMATION WHICH WOULD CAUSE THE INFORMATION GIVEN ABOVE TO BE MISLEADING. IN THE EVENT OF MY EMPLOYMENT AS A RESULT, IN FULL OR IN PART, FROM THE INFORMATION CONTAINED ON THIS APPLICATION, I UNDERSTAND THAT ANY INACCURATE OR MISLEADING INFORMATION IS GROUNDS FOR IMMEDIATE TERMINATION OF EMPLOYMENT.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date