



Nanny Employment Application

Personal Information				Please print legibly
Last Name		First Name		Middle Initial
Full Street (Mailing) Address (including apartment number)		City	State	ZIP
E-Mail Address		Mobile 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, do you object to smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you legally eligible to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No	Since When?	List state and license number		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you certified in CPR? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you swim? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you certified in lifesaving? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you need health insurance? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how far away (in hours or miles), for how long and when?		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have cooking skills? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you do your own laundry? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you plan on bringing a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list year, make and model			



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			
Are you agreeable to receiving an annual "flu shot"?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain			
Have received the Tdap vaccine or a Td booster within the last 10 years?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, 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
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				
Company/Family Name		Date Employed From		To
Employer's full mailing address		City	State	ZIP
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				
Company/Family Name		Date Employed From		To
Employer's full mailing address		City	State	ZIP
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				
Company/Family Name		Date Employed From		To
Employer's full mailing address		City	State	ZIP
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				
Company/Family Name		Date Employed From		To
Employer's full mailing address		City	State	ZIP
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