CARINGHANDS HOME HEALTH CARE INC.

Background Study Form

Date of Birth: Male Female Social Secutity #:

Last Name: Middle Name: First Name:

Address: APT: City:

State: Zip Code:

Phone: MN Driver's/State ID:

Race :

- African American/ Black
- Asian/ Pacific Islander
- Caucasian
- Hispanic/ Latin American
- Native American
- Unknown/Other

OTHER FIRST NAMES OR LAST NAMES YOU HAVE USED

First Name: Last Name: