# APPLICATION FOR EMPLOYMENT



All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural origin or handicap. All information provided herein will be kept confidential.

**PERSONAL**

| | | | |
|---|---|---|---|
| **Last Name** | **First** | **Middle** | **Date** |
| **Street Address** | | | **Home Phone** |
| **City, State, Zip Code** | | | **Business Phone** |
| **S.S. #** | | | **Date of Birth** |

Emergency contact (person not living with you)_____

Have you ever applied for employment with this Agency? _____Yes _____ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____ No

How did you learn of our organization? ____ Newspaper Ad ____Agency employee _____Other

Are you willing to work: _____Evenings? _____Weekends?

Position applying for: _____LVN _____RN _____Therapist (Specify)

# APPLICATION FOR EMPLOYMENT

**EDUCATION:**

| School Name | Location of School | Course of Study | Years of | Degree/Diploma |
|---|---|---|---|---|
| **College:** | | | | |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| **Vo-Tech or Trade:** | | | | |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| **High School:** | | | | |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| **Other:** | | | | |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

**Employment:**
**--List the last five years employment history, starting with the most recent employer**.

1. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

2. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

3. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____

## APPLICATION FOR EMPLOYMENT

Was your last name different from your present name during the above listed jobs?
Yes_____ No_____

If Yes, what was your name? _____

Are you currently employed? Yes _____ No _____

Do you have reliable transportation? Yes _____No _____

**PROFESSIONAL REFERENCES**
Persons who can furnish information about job performance

1. Name: _____Telephone:_____
Fax: _____
Address: _____

2. Name: _____Telephone:_____
Fax: _____
Address: _____

3. Name: _____Telephone:_____
Fax: _____
Address: _____

**GENERAL**
Have you ever been convicted of a crime in the past 5 years, barring employment in a Home Care and community support Agency? Yes _____No _____
Conviction will not necessarily disqualify an applicant from employment.
If yes, describe in full: _____
_____
_____
_____

Are you capable of performing the job set forth in the job description? Yes__No__

If you answered No, which job requirement can you not meet? _____
_____
_____
_____

# APPLICATION FOR EMPLOYMENT

**CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED**

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience**.**

_____

_____

_____

_____

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL

I Authorize complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to the Agency.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time**.**

**SIGNATURE**_____ **DATE:** _____

**INTERVIEW REVIEW**

Applicant Name:._____ Date_____

Days and Hours available M Tu W Th F Sa Su

## Review:

| | | | |
|---|---|---|---|
| Personality: | friendly | average | quiet |
| Verbal skills: | excellent | average | poor |
| Communicates: | clear | somewhat clear | not very clear |
| Flexibility: | very flexible | somewhat | not flexible |
| Skill level: | higher skilled | moderately skilled | lower skilled |
| Appearance: | professional | semi-professional | not professional |
| Good Candidate for employment: | | yes no | |

Overall Interview:_____

_____ _____

Interviewer Date

# APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

**To be filled out by applicant:**

Applicant Name**:**_____ Date of Application**:**_____

Previous Employer:_____ Contact Person:_____

Address:_____ Phone: ( ) _____

Fax: ( ) _____

**I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.**

Applicant's Signature:_____ Date: _____

**To be completed by previous employer:**

Date of employment: From: _____ To: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities: _____

_____

Reason for Leaving: _____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

**Reference check performed by_____**

# APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

**To be filled out by applicant:**

Applicant Name**:**_____ Date of Application**:**_____

Previous Employer:_____ Contact Person:_____

Address:_____ Phone: ( ) _____

Fax: ( ) _____

**I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.**

Applicant's Signature:_____ Date: _____

**To be completed by previous employer:**

Date of employment: From: _____ To: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities: _____

_____

Reason for Leaving: _____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

**Reference check performed by_____**

**ORIENTATION:** The following orientation topics will be used for all full-time, part-time and per-diem workers:

| **ORIENTATION PROGRAM** | |
|---|---|
| | Initial upon completion |
| Agency Mission, Vision and Plan | |
| Types of Care Provided by the Agency | |
| Policies and Procedures | |
| Personnel Policies and Job Descriptions | |
| Client Rights and Grievance Policy | |
| Ethics and Confidentiality of Patient Information | |
| HIPAA Compliance | |
| Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards) | |
| Emergency Preparedness Plan/Actions to Take in the Event of a Disaster | |
| Infection Control in the Home/Standard Precautions | |
| Identifying and Reporting Abuse, Neglect and Exploitation | |
| Medical Device/Hazards reporting | |
| Documentation - Record Keeping including OASIS | |
| Supervision and Evaluation | |
| Actions to Take in Unsafe Situations | |
| Patient Care Responsibilities | |
| Community Resources | |
| Safety Issues in the Home (Including Security and Guns in the Home) | |
| Understanding and coping with Alzheimer's Disease and Dementia | |
| Quality Assurance | |
| Fraud and Abuse, False Claims, False Statements, Whistle Blowing | |
| ID Badge Issuance | |
| Reviewed, understands and signed job description | |

| PRINT NAME: | TITLE |
|---|---|
| | |

| SIGNATURE | DATE |
|---|---|

**JOB ACCEPTANCE STATEMENT**

I have read, understand and agree to the terms specified in this job description for the position I presently hold. A copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Employee Signature_____ Date_____

# NOTICE TO EMPLOYEE

***Labor Code section 2810.5***

Effective January 1, 2012, California Labor Code section 2810.5(a) requires that the following information be provided to each employee at the time of hire in the language the employer normally uses to communicate employment-related information. Exceptions to this requirement are indicated on the next page.
This notice is available in other languages at www.dir.ca.gov/DLSE.

**EMPLOYEE**

Employee Name: _____ Hire Date: _____

**EMPLOYER**

Name of Employer: _____

(Check all that apply): □ Sole Proprietor X Corporation □ Limited Liability Company □ General Partnership

□ Other type of entity_____

□ Staffing agency (e.g., temp agency or PEO)

Other Name Employer is doing business as (if applicable): _____

Physical Address of Main Office : _____

Employer's Mailing Address: same as above

Employer's Telephone Number:_____

If the worksite employer uses any other business or entity to hire employees or administer wages or benefits, complete the information above for the worksite employer, complete the information below for the other business, and complete the remaining sections. If there is no other business or co-employer, or if the only other business is a recruiting service or a payroll processing service, skip the rest of this section, and complete the remaining sections.

Name of Other Business: _____

This other business is a:

□ Professional Employer Organization (PEO) or Employee Leasing Company or a Temporary Services Agency

□ Other: _____

Physical Address of Main Office: _____

_____

Mailing Address: _____

_____

Telephone Number: _____

_____

**WAGE INFORMATION**

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): □ Hour □ Shift □ Day □ Week □ Salary □ Piece rate □ Commission

□ Other (provide specifics): _____

Employment agreement is (check box): □ Oral □ Written

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

_____

Regular Pay Day: _____

**WORKERS' COMPENSATION**

Insurance Carrier's Name: _____

Address: _____

Telephone Number: _____

Policy No.: _____

□ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure:_____

**ACKNOWLEDGMENT OF RECEIPT**

| | |
|---|---|
| _____ | _____ |
| (PRINT NAME of Employer representative) | (PRINT NAME of Employee) |
| _____ | _____ |
| (SIGNATURE of Employer representative) | (SIGNATURE of Employee) |
| _____ | _____ |
| (Date provided to employee & signed by representative) | (Date received by employee & signed by employee) |

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.

This Notice is NOT required if (a) you are directly employed by the state or any political subdivision thereof, (b) you are an employee who is exempt from the payment of overtime wages by statute or wage order, or (c) you are covered by a collective bargaining agreement that expressly provides for wages, hours of work and working conditions, and provides for premium wage rates for all overtime worked.

The full text of Labor Code section 2810.5 may be found at www.leginfo.ca.gov/calaw.html. Check "Labor Code" and search for "2810.5" in quotes.

The employee's signature on this notice merely constitutes acknowledgement of receipt. In accordance with an employer's general recordkeeping requirements under the law, it is the employer's obligation to ensure that the employment and wage-related information provided on this notice is accurate and complete. Furthermore, the employee's signature acknowledging receipt of this notice does not constitute a voluntary written agreement as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.

## LEGAL AND ETHICAL RESPONSIBILITY

To All Employees:

PURPOSE DRIVEN HOME HEALTH acknowledges both legal and ethical responsibility to protect the privacy of the patients and the employees. Consequently, the undiscriminating or unauthorized review, use or disclosure of personal information, medical or otherwise, regarding any patient or employee is expressly prohibited.

Except when required in the regular course of business, the discussion, use, transmission or narration, in any form of any patient information which is obtained in the regular course of your employment is strictly forbidden.

Those individuals who also have access to employee information are expected to respect and treat the confidentiality of such information in the same manner as that of patient information.

Any violation of this policy shall constitute grounds for severe disciplinary action, including possible termination of the offending employee.

## SEXUAL HARASSMENT POLICY

Sexual harassment in employment violates the provisions of the *Fair Employment and Housing Act,* specifically *Government Code sections 12940(a), (j),* and *(k).*

### Definition of Sexual Harassment

The *Fair Employment and Housing Act* defines harassment because of sex as including sexual harassment, gender harassment and harassment based on pregnancy, childbirth, or related medical conditions. The Fair Employment and Housing Commission regulations define sexual harassment as unwanted sexual advances or visual, verbal or physical conduct of a sexual nature. This definition includes many forms of offensive behavior and includes harassment of a person of the same sex as the harasser. The following is a partial list:

- Unwanted sexual advances
- Offering employment benefits in exchange for sexual favors
- Making or threatening reprisals after a negative response to sexual advances
- Visual conduct, e.g., leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters
- Verbal conduct, e.g., making or using derogatory comments, epithets, slurs and jokes Verbal sexual advances or propositions
- Verbal abuse of a sexual nature, graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual, suggestive or obscene letters, notes or invitations
- Physical conduct, e.g. touching, assault, impeding or blocking movements

### Employers' Obligations

All employers have certain obligations under the law. Employers must:

- Take all reasonable steps to prevent discrimination and harassment from occurring.
- Develop and implement a sexual harassment prevention program.
- Post in the workplace a poster made available by the Department of Fair Employment and Housing.
- Distribute to all employees an information sheet on sexual harassment. An employer may either distribute this pamphlet (DFEH-185) or develop an equivalent document that meets the requirements of *Government Code section 12950(b)*. This pamphlet may be duplicated in any quantity. *However, this pamphlet is not to be used in place of a sexual harassment prevention policy which all employers are required to have.*

Initial here: _____

## Employer Liability

All employers are covered by the harassment section of the *Fair Employment and Housing Act*. If harassment occurs, an employer may be liable even if management was not aware of the harassment. An employer might avoid liability if the harasser is a rank and file employee and if the employer had no knowledge of the harassment and if there was a program to prevent harassment. If the harasser is a rank and file employee and the employer was aware of the harassment, liability may be avoided if the employer took immediate and appropriate corrective action to stop the harassment.

Employers are strictly liable for harassment by their employees. The law requires an entity to take "all reasonable steps to prevent harassment from occurring." If an employer has failed to take such preventive measures, that employer can be held liable for the harassment.

A victim may be entitled to damages even though no employment opportunity has been denied and there is no actual loss of pay or benefits.

## Typical Sexual Harassment Cases

The three most common types of sexual harassment complaints filed with the Department are those in which:

- An employee is fired or denied a job or an employment benefit because he/she refused to grant sexual favors or because he/she complained about harassment. Retaliation for complaining about harassment is illegal, even if it cannot be demonstrated that the harassment actually occurred. An employee quits because he/she can no longer tolerate an offensive work environment, referred to as a "constructive discharge." If it is proven that a reasonable person in the victim's position, under like conditions, would resign to escape the harassment, the employer may be held responsible for the resignation as if the employee had been discharged. An employee is exposed to an offensive work environment. Exposure to various kinds of behavior or to unwanted sexual advances alone may constitute harassment.

## Preventing Sexual Harassment

A program to eliminate sexual harassment from the workplace is not only required by law, but is the most practical way to avoid or limit liability if harassment should occur despite preventive efforts.

## Training of All Individuals in the Workplace

All employees should be made aware of the seriousness of violations of the sexual harassment policy. Supervisory personnel should be educated about their specific responsibilities. Rank and file employees must be cautioned against using peer pressure to discourage harassment victims from using the internal grievance procedure.

Initial here: _____

## Complaint Procedure

An employer should take immediate and appropriate action when he/she knows, or should have known, that sexual harassment has occurred. An employer must take effective action to stop any further harassment and to ameliorate any effects of the harassment. To those ends, the employer's policy should include provisions to:

- Fully inform the complainant of his/her rights and any obligations to secure those rights.
- Fully and effectively investigate. The investigation must be immediate, thorough, objective and complete. All persons with information regarding the matter should be interviewed. A determination must be made and the results communicated to the complainant, to the alleged harasser, and, as appropriate, to all others directly concerned.
- If proven, there must be prompt and effective remedial action. First, appropriate action must be taken against the harasser and communicated to the complainant. Second, steps must be taken to prevent any further harassment. Third, appropriate action must be taken to remedy the complainant's loss, if any.

## How the Law is Enforced

Employees or job applicants who believe that they have been sexually harassed may, within one year of the harassment, file a complaint of discrimination with the California Department of Fair Employment and Housing.

The Department serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If the Department finds evidence of sexual harassment and settlement efforts fail, the Department may file a formal accusation against the employer and the harasser the accusation will lead to either a public hearing before the Fair Employment and Housing Commission or a lawsuit filed on the complainant's behalf by the Department.

If the Commission finds that the harassment occurred, it can order remedies, not to exceed $150,000.00 in fines or damages for emotional distress from each employer or harasser charged. In addition, the Commission may order hiring or reinstatement, back pay, promotion and changes in the policies or practices of the involved employer.

For more information, contact the Department toll free at: (800) 884-1684 Sacramento area & out-of-state *(916)* 227-0551 TTY Number (800) 700-2320 *or* visit our website at: *www.dfeh.ca.gov*.

Initial here: _____

## CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both the Agency's and the employee's responsibility to ensure that every patient's health information is protected at all times. By signing below you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health Information will be provided to you upon hire.
I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Employee:_____ Date:_____

## PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.
- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Employee_____ Date:_____

# FIELD EMPLOYEE STANDARDS AND PROCEDURES

**Welcome! This Agency requires adherence to the following Standards and Procedures:**

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/client/family. This includes personal hygiene, jewelry, hair and makeup.

2. **Please do not smoke in the presence of a patient/client.**

3. Always wear your ID Badge. Licensed personnel must always carry their current nursing license and CPR care while on assignment.

4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR PATIENT DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**

5. If you have any problem, incident or accident on the job, do not discuss it with the patient/client, but call the Agency immediately.

6. If the patient/client asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.

7. Paraprofessional personnel (i.e.Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**

8. UNDER NO CIRCUMSTANCES are you to ask for, or accept any money from your patient/client or take home property that belongs to the patient client.

9. There shall not be any involvement with the patient/client's financial affairs (i.e. check writing).

10. You are expected to honor the confidentiality of any patient/ client information which is obtained in the regular course of your employment.

11. No personal telephone calls should be made or received by you while on assignment.

12. Please do not discuss your pay or any other personal affairs with the patient/client/family.

13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient/client contact us.

14. **It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule**. If the patient/client is unable to sign your note, a family member or responsible party may sign.

15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

16. Never leave your patient/client unattended.

Employee Signature_____ Date_____

# CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

The Agency requires that the Employee avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee agrees to refrain from prohibited competition with the Agency and to maintain the confidentiality of information regarding employees, clients and the Agency business.

The Employee will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any client or entity to discontinue any relationship with the Agency, solicit any client of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee is required to return all of the Agency's property including keys, client records, forms, manual, beeper, etc. to the Agency and will not retain copies. Failure to return a key will result in a $25.00 charge and failure to return a beeper will result in a $50.00 charge deducted from the paycheck.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. .suffered by the Agency. Employee will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

_____ _____

Employee Date

**REQUIRED HIPAA CONFIDENTIALY AGREEMENT**

**EMPLOYEE CONFIDENTIALITY AGREEMENT of PATIENT HEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS**

For good consideration and as an inducement for _____(employer) to employ _____(employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any patient health information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain.

The Employee agrees to not copy and to return all such Agency supplied Information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____.

_____

Agency

# EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the Policy.
I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meeting and inservice training. Home health aides are required to have 12 hours of inservice training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of client/ employee confidentiality is subject to civil and criminal penalties.
If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an " At Will" organization and may hire and fire at will.

Employee Signature_____ Date_____

**PERSONAL PROTECTIVE EQUIPMENT**
**FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT**

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- ☐ **Barrier Safety Goggles**
- ☐ **CPR Shield Face Barrier**
- ☐ **Fluid Resistant Gown**
- ☐ **Gloves**
- ☐ **Biohazard Bag**
- ☐ **Sharp Container**
- ☐ **3M Respirator**

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

**Signature/Title**_____ **Date**_____

**HEPATITIS VACCINE REQUIREMENT**

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

☐____request that I receive the Hepatitis vaccine

☐ refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

☐ provide written proof of immunity (attach)

☐ provide written proof of previous vaccination (attach)

☐ provide written proof of medical contraindication (attach)

Signature:_____ Date:_____

# TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____

Print Name

| | | YES | NO |
|---|---|---|---|
| 1. | Have you ever had a positive TB skin test or history of TB infection? If the answer is YES, please answer the following: | ____ | ____ |
| 2. | Have you ever had the BCG vaccine? | ____ | ____ |
| 3. | Do you have prolonged or recurrent fever? | ____ | ____ |
| 4. | Have you recently lost weight? | ____ | ____ |
| 5. | Do you have a chronic cough? | ____ | ____ |
| 6. | Do you cough up blood? | ____ | ____ |
| 7. | Do you have sweating at night? | ____ | ____ |

8. Do you have any of the following risk factors which may substantially Increase the risk of tuberculosis?

____ a. Silicosis (Lung Disease)

____ b. Gastrectomy

____ c. Intestinal Bypass

____ d. Weight 10% or more below ideal body weight?

____ e. Chronic Renal Disease

____ f. Diabetes Mellitus

____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy

____ h. Hematologic Disorder 1.e. leukemia or lymphoma

____ i. Exposure to HIV or AIDS

____ j. Other malignancies

_____ _____

Employee Signature Date

(The objective in filling up of this form is to avoid assignment which may be injurious to employee's health)

Name of Applicant: _____

Name of Physician: _____ Phone No. _____

Physician's Address: _____
Street Apartment No.

_____
City State Zip Code

I. If in the past 5 years you have suffered from any mental, physical or medical impairment which would prevent you from reasonably performing the job for which you have applied, please so state by answering the following questions:

| Have you ever in the past 5 years . . . | Yes | No | If "yes", please explain |
|---|---|---|---|
| 1. Been operated on, been a patient in a hospital, sanitarium or institution? | ☐ | ☐ | |
| 2. Been seriously injured? | ☐ | ☐ | |
| 3. Worked with radioactive materials? | ☐ | ☐ | |
| 4. Had convulsions? | ☐ | ☐ | |
| 5. Been rejected from or discharged from military service for health reasons? | ☐ | ☐ | |
| 6. Had a communicable disease? | ☐ | ☐ | |
| 7. Been receiving a pension for disability? | ☐ | ☐ | |

Have you ever had: Rubella ☐ Yes ☐ No Chicken Pox ☐ Yes ☐ No

II. Please indicate with a check mark if you have had any of the following:

| | | | |
|---|---|---|---|
| ☐ Severe headaches epilepsy/convulsions | ☐ Hernia or rupture | ☐ Allergy/wheezing/ asthma/arthritis | ☐ Kidney problems/ diseases |
| ☐ TB/any communicable disease | ☐ Skin allergies/disease | ☐ Bone problems | ☐ Menstrual difficulties |
| ☐ Chest pain/pressure | ☐ Alcohol/drug addition | ☐ Bowel problems | ☐ Hepatities |
| ☐ Heart problem | ☐ Vision impairment | ☐ Diabetes | ☐ Stomach ulcers |
| ☐ High blood pressure | ☐ Fainting/dizzy spells | ☐ Nervous breakdown | ☐ Chronic coughing |
| ☐ Back problems | ☐ Low blood pressure | ☐ Hearing difficulties | ☐ Venereal disease |
| ☐ Frequent colds | ☐ Speech impairment | ☐ Varicose veins | |

If you checked any of the above, please explain:

III. Medical History (past 10 years)

| | | | | |
|---|---|---|---|---|
| A. | Are you under the care of a physician? | ☐ Yes | ☐ No | If yes, please explain: _____ |
| B. | Are you taking medications? | ☐ Yes | ☐ No | If yes, please explain: _____ |
| C. | Have you had any serious accidents? | ☐ Yes | ☐ No | If yes, please explain: _____ |
| D. | Have you had any operations or hospitalizations for illness? | ☐ Yes | ☐ No | If yes, please explain: _____ |
| E. | If required by your position, would you be willing to have screening tests for drugs/alcohol done on your blood/urine as a condition of employment? | ☐ Yes | ☐ No | If yes, please explain: _____ |
| F. | Have you had a positive reading on a TB or PPD test? (Bi-annual PPD test is necessary for healthcare employment) | ☐ Yes | ☐ No | If yes, please explain: _____ |

**To be filled out by examining physician:**

**(May not submit if you can provide a copy of your current physical exam with TB Test)**

DO YOU HAVE OR HAVE YOU HAD ANY SIGNIFICANT OR RECURRENT PROBLEMS WITH THE FOLLOWING?

| | | | Please Elaborate |
|---|---|---|---|
| 1. Backache / joint or muscular pain | YES ☐ | NO ☐ | |
| 2. Hernia / rupture | YES ☐ | NO ☐ | |
| 3. Visual impairment | YES ☐ | NO ☐ | |
| 4. Perforated eardrum / discharge from ear | YES ☐ | NO ☐ | |
| 5. Recurrent indigestion | YES ☐ | NO ☐ | |
| 6. Jaundice / hepatitis / gall bladder disease | YES ☐ | NO ☐ | |
| 7. Changes in bowel habit / diarrhea | YES ☐ | NO ☐ | |
| 8. Blood in stool / piles, hemorrhoids | YES ☐ | NO ☐ | |
| 9. Shortness of breath /coughing up blood | YES ☐ | NO ☐ | |
| 10. Recurrent bronchitis / pneumonia | YES ☐ | NO ☐ | |
| 11. Blood in urine / kidney complications | YES ☐ | NO ☐ | |
| 12. Headaches / migraine / dizziness | YES ☐ | NO ☐ | |
| 13. Varicose veins | YES ☐ | NO ☐ | |
| 14. Skin trouble (e.g. dermatitis / eczema) | YES ☐ | NO ☐ | |
| 15. Surgical operations | YES ☐ | NO ☐ | |
| 16. Hospitalization | YES ☐ | NO ☐ | |
| 17. Fear of flying / fear of heights | YES ☐ | NO ☐ | |
| 18. Tropical disease / venereal disease | YES ☐ | NO ☐ | |
| 19. History of alcohol / drug abuse | YES ☐ | NO ☐ | |
| 20. Do you have any allergies? Please list. | YES ☐ | NO ☐ | |
| 21. Do you have any current illnesses? Please list. | YES ☐ | NO ☐ | |
| 22. Are you receiving any medication at present? Please list. | YES ☐ | NO ☐ | |
| 23. Have you attended a dentist in the last year? | YES ☐ | NO ☐ | |
| 24. Are you undergoing dental treatment? | YES ☐ | NO ☐ | |
| 25. Date of last tetanus booster. | YES ☐ | NO ☐ | |
| **FOR FEMALES ONLY – HAVE YOU EVER HAD?** | | | |
| 26. Abnormal smear / breast disease. | YES ☐ | NO ☐ | |
| 27. Gynecological problems e.g. pelvic infection. | YES ☐ | NO ☐ | |
| 28. Complications of pregnancy. | YES ☐ | NO ☐ | |
| 29. Please give date of last menstrual period. | YES ☐ | NO ☐ | |

| **EXAMINING PHYSICIAN'S COMMENTS** |
|---|
| |
| |
| |

TO BE COMPLETED BY EXAMINING PHYSICIAN:

| HEIGHT | WEIGHT | BMI | BP | PULSE | TB TEST DATE | RESULT AND DATE |
|---|---|---|---|---|---|---|
| | | | | | | |

| | | |
|---|---|---|
| 1. EYES/PUPILS | | |
| 2. EAR, NOSE & THROAT | | |
| 3. TEETH & MOUTH | | |
| 4. LUNGS / CHEST | | |
| 5. CARDIOVASCULAR | | |
| 6. ABDOMEN | | |
| 7. HERNIAL ORIFICES | | |
| 8. RECTAL | | |
| 9. GENITOUTINARY & TESTES | | |
| 10. MUSCULOSKELTAL | | |
| 11. SKIN | | |
| 12. VARICOSE VEINS | | |
| 13. NEUROLOGICAL | | |
| 14. BREASTS | | |
| 15. IDENTIFYING MARKS (E.G. TATTOOS/SCARS ETC.) | | |

I CERTIFY THAT (Applicant's Name)

_____

(Circle Response) IS FIT / NOT FIT FOR SERVICE.

DATE OF MEDICAL _____

PHYSICIAN'S SIGNATURE:_____

PHYSICIAN'S NAME: _____

**CRIMINAL HISTORY CHECK, EMPLOYEE MISCONDUCT REGISTRY**
**NURSE AIDE REGISTRY NOTIFICATION AND STATEMENT OF EMPLOYABILITY**

By execution of this document, I acknowledge that I have been informed by the Agency that a criminal history check will be performed on my name. I have informed that Agency of all names (for example, maiden name, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the criminal history check. I also understand that if I have been convicted of the following offenses, that I may not be employed by this Agency. I also understand that the Agency will search the Employee Misconduct Registry and the Nurse Aide Registry (if applicable) to determine whether any acts of abuse, neglect or exploitation have occurred and whether my name is designated on either registry. If my name is designated on either registry I understand the Agency must deny me employment.

Offenses which constitute a bar to employment and for which an administrative review is not available, are offenses under:

| | |
|---|---|
| Chapter 19, Penal Code | (Criminal homicide) |
| Chapter 20, Penal Code | (Kidnapping and unlawful restraint) |
| Chapter 21.11, Penal Code | (Indecency with a child) |
| Chapter 22.02, Penal Code | (aggravated assault) |
| Chapter 22.04, Penal Code | (injury to a child, elderly individual, or disabled individual) |
| Chapter 22.041,Penal Code | (abandoning or endangering a child) |
| Chapter 25.031 Penal Code | (Agreement to abduct from custody) |
| Chapter 25.06, Penal Code | (Solicitation of a child) |
| Chapter 25.11, Penal Code | (Sale or purchase of a child) |
| Chapter 28.08, Penal Code | (Arson) |
| Chapter 29.02, Penal Code | (Robbery) |
| Chapter 29.30, Penal Code | (Aggravated robbery)or |

A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice of an offense containing elements that are substantially similar to the elements of an offense listed under the above Subdivision.
A person convicted of an offense under Chapter 31, Penal Code (theft), that is punishable by a felony may not be employed in a position the duties of which involve direct contact with a consumer in a facility before the fifth anniversary of the date of the conviction. (This requirement only applies to those employees first employed by the facility or Agency on or after September 1, 2003).
A person convicted of an offense under section 22.01, Penal Code (assault),that is punishable as Class A misdemeanor or as a felony;
An offense under sec6tion 30.02, Penal Code burglary).
An offense under section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or as a felony; or an offense under section 32.45 Penal Code (securing execution of a document by deception), that is punishable as a Class A misdemeanor of a felony.

I understand that all information obtained by this Agency regarding any criminal history will remain confidential. By signing this form, I certify that the information on this form contains no willful misrepresentation and that the information is true and complete to the best of my knowledge.

| _____ | _____ | _____ |
|---|---|---|
| Applicant Signature | Printed Name | Date |