EMPLOYMENT APPLICATION

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**

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? ☐ Online Ad ☐ Agency employee ☐ Other

Are you willing to work: ☐ Evenings? ☐ Weekends?

Position applying for: _____

EDUCATION:

School Name	Location of School	Course of Study	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:_____

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: _____

Address: _____

2. Name: _____ Telephone: _____

Address: _____

3. Name: _____ Telephone: _____

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? _____

_____

_____

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**.**

DATE: _____ **SIGNATURE** _____

APPLICANT REFERENCE CHECK (1)

To be filled out by applicant:

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

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

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 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_____

EMPLOYEE EMERGENCY CONTACT INFORMATION

Employee Name: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

Next of kin: _____ Phone: _____

Relationship: _____ Address: _____

_____

*In case of emergency, please contact:

Name: _____ Phone: _____

Relationship: _____ Address: _____

_____

*Please notify this Agency immediately if any of the emergency contact information changes.

FIELD PRACTICES STATEMENT

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/family. This includes personal hygiene, jewelry, hair and makeup.
2. **Please do not smoke in the presence of a patient.**
3. Always wear your photo ID Badge.
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, but call the Agency immediately.
6. If the patient 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 or take home any property that belongs to the patient.
9. There shall not be any involvement with the patient's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient 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/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 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 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.

Employee Signature_____ Date_____

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. I agree to protect the Electronic Record and passwords provided to me as outlined in the HIPAA policy.

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: _____

HIPAA CONFIDENTIALITY AGREEMENT

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

For good consideration and as an inducement for LE CHOIX HOME CARE (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

STATEMENT OF GOOD HEALTH/FREE OF COMMUNICABLE DISEASE

Explanation and Instruction:

Our company policy requires all employees who have direct contact with patients in the home setting to submit a statement from an appropriately licensed health care professional, based on an exam performed within the last twelve months. The employee must show no apparent signs or symptoms of communicable disease.

Statement to be signed by a Physician or appropriately licensed Healthcare professional.

_____was examined by me on _____. He/She is in adequate health to perform home health duties and show no apparent signs or symptoms of communicable disease.

_____ _____
Professional Signature Date

_____

_____
Address

_____
Phone number

A PPD test was done in this office on_____ by_____.

and read on _____ by_____.

Rt. Forearm☐ Lt. forearm☐

Result: _____ If redness present, size/description _____

Manufacturer name:_____ Lot number:_____

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?	☐	☐
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

_____ _____
Reviewed by

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: _____