



# Application Package

Applicant's Name: \_\_\_\_\_



License #: \_\_\_\_\_ Application date: \_\_\_\_\_

Address: \_\_\_\_\_

City, St, ZC: \_\_\_\_\_

Phone: \_\_\_\_\_ Cel: \_\_\_\_\_ Bp: \_\_\_\_\_

Specialty (if any): \_\_\_\_\_

SS #: \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## EMPLOYEE'S LOG

Employee's Name: _____ Street Address: _____ City/State/Zip Code: _____ Job Title: _____	Bp: _____ Cell: _____ Soc. No: _____ Telephone: _____ Date of Hire: _____
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DESCRIPTION	YES	DESCRIPTION	YES
IRS from W-4 or W-9		SIGNED EMPLOYMENT APPLICATION	
INS Form I-9		SIGNED JOB DESCRIPTION	
HIPAA/Confidential Form		PROBATIONARY PERIOD	
COPY OF CHECK		EMPLOYMENT REFERENCES	
REVIEW-PERSONNEL POLICY [signed]		COMPLETED ORIENTATION [date]	
TRANSPORTATION RESPONSIBILITY		PROFESSIONAL LIABILITY SHEET	
TAX EXEMPT FORM		CONFIDENTIALITY STATEMENT [sig.]	
INDEPENDENT or CONTRACT AGREEMENT		HIV - AIDS Certificate [Mandatory]	
AFFIDAVIT OF GOOD MORAL CHARACTER		C.P.R. CARD [Mandatory]	
STATEMENT OF COMMITMENT		INFECTION CONTROL [Signed]	

DESCRIPTION	NUMBER	EXP. DATE	EXP. DATE	EXP. DATE	EXP. DATE	EXP. DATE
Professional License						
Certificate [CNA]						
Driver's License						
Prof. Liability Insurance [1 and 3 millions]						
Physical Exam, Free of Com. Disease, PPD/Mantoux test or X-Ray						
Automobile Liability Insurance [PIP and PD]						
H.H.A., 40 hours / C.N.A. 20 hrs.						
Form of Verification: RN/LPN/PT						

O.S.H.A. (Mandatory) YES ( ) NO ( )

Comments:

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# APPLICATION FOR EMPLOYMENT

## PRINT CLEARLY AND LEGIBLY

### SECTION I - Name/Address

Last:	First:	MI:
Address:		
City:	State:	Zip: Telephone:
Social Security #-		DOB:

### SECTION 2- Desired Employment

Position:	Date you can start:
Are you currently employed?: <input type="checkbox"/> yes <input type="checkbox"/> no If employed, may we inquire of your current employer?: <input type="checkbox"/> yes <input type="checkbox"/> no	
Have you applied to this agency before?: <input type="checkbox"/> yes <input type="checkbox"/> no If so, when:	

### SECTION 3 - Education

HIGH SCHOOL	Name & Location of School:
	Years Attended: Date Graduated: Degree:
UNIVERSITY/ COLLEGE UNDERGRADUATE	Name & Location of School:
	Years Attended: Date Graduated: Degree:
UNIVERSITY/ COLLEGE GRADUATE	Name & Location of School:
	Years Attended: Date Graduated: Degree:
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL	Name & Location of School:
	Years Attended: Date Graduated: Course study:

### SECTION 4- Employment History

Employer:	Job Title:
Address:	Duties:
Phone:	Salary:
Date From:	Date To: Reason for Leaving:

Employer:	Job Title:
Address:	Duties:
Phone:	Salary:
Date From:	Date To: Reason for Leaving:

Employer:	Job Title:
Address:	Duties:
Phone:	Salary:
Date From:	Date To: Reason for Leaving:

**SECTION 5- Personal References**

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

**SECTION 6- Physical Record**

Do you have any physical disabilities that would prevent you from performing the work for which you are applying?:  yes  no If so, please describe:

Have you ever been injured?  yes  no Provide Details:

**SECTION 7- Licenses/Certification**

TYPE	LICENSE / CERT. #	EXPIRATION DATE	STATE ISSUED

**SECTION 8- Additional Areas of Expertise**

Areas of specialized study, research or additional experience:

List the foreign languages you speak fluently: Read: Write:

U.S. Military Service: Separation Rank:

Present Membership in National Guard or Reserves:  YES  NO

**SECTION 9- Emergency Contact Information**

Name: Relation:

Address: Telephone:

Name: Relation:

Address: Telephone:

I voluntarily give to the Agency the right to make a thorough investigation of my past employment. I agree to cooperate in such an investigation. I understand that my employment will be based in part on the accuracy of the information provided on this application.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>AGENCY AUTHORIZED REPRESENTATIVE INTERVIEWER</b>		
HIRED? YES <input type="checkbox"/> NO <input type="checkbox"/>	SIGNATURE:	DATE:

Employee Name: \_\_\_\_\_ Position: \_\_\_\_\_

ITEM	DESCRIPTION	INITIALS
<p><b>EMPLOYEE ACKNOWLEDGMENT OF PROBATION</b></p>	<p>I UNDERSTAND THAT I AM ON PROBATION AS AN EMPLOYEE FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STARTED ON _____ FOR THE PURPOSE OF THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW". I UNDERSTAND IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE UNDER THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW" HE WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE DETERMINED FOR IN THE FUTURE. I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.</p>	
<p><b>NOTICE TO APPLICANTS</b></p>	<p>We comply with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability, to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. If required, all entering employees in the same job category will be subjected to the same medical questionnaire and/or examination and all information will be kept confidential and in separate files. We are an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, or martial status. We assure you that your opportunity for employment with us depends solely upon your qualifications. <b>PLEASE READ AND SIGN STATEMENTS BELOW</b> I understand that in accordance with Florida Statute 443.131 (3) (a) (2), if hired, I will be placed on a 90 day probationary period. I further understand that if I am terminated for unsatisfactory work performance within the 90 day probationary period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination. I understand and agree that all policies, procedures, and the Employee Handbook may be modified, amended, or deleted by my employer with or without notice to me of such amendment, modification or deletion; that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and that my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president. I understand that I may be required to undergo blood and/or urinalysis screening for drug or alcohol use as part of the pre-employment process. In addition, all employees are subject to blood and/or urinalysis screening for drug or alcohol use. I certify that all information given on this employment application, any resume that I submit to the company, and any related papers and answers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such information requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation of any derogatory information discovered as a result of this investigation may-subject-me-to-immediate-dismissal. I hereby release from liability all persons who provide information to my employer during the course of any such investigation.</p>	
<p><b>CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM</b></p>	<p>I have been formally instructed that any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency (except an needed to conduct the business of the day). I understand that no medical/criminal data are to be removed from the home health agency unless a "Release of Information" form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Agency to release my Physical/Background Information data to State/Federal surveyors at their request if needed for conduct the annual survey or any necessary investigation. I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.</p>	

Employee/Contractor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Position: \_\_\_\_\_

ITEM	DESCRIPTION	INITIALS
<p><b>CONFIDENTIALITY STATEMENT</b></p>	<p>I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF THE MEDICAL RECORDS AND UNDERSTAND THAT THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE, EITHER INSIDE OR OUTSIDE THE AGENCY (EXCEPT AN NEEDED TO CONDUCT THE BUSINESS OF THE DAY). I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE HOME HEALTH AGENCY UNLESS A "RELEASE OF INFORMATION" FORM HAS BEEN COMPLETED AND SIGNED BY THE PATIENT. IT IN MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL. I HAVE BEEN FORMALLY INSTRUCTED IN THE POLICIES AND PROCEDURES OF THIS HOME HEALTH AGENCY, ALSO INFORMED REGARDING THE AGENCY'S POLICY FOR HIPAA COMPLIANCE, AND I HAVE READ AND SIGNED A JOB DESCRIPTION FOR MY SPECIFIC CLASSIFICATION.</p>	
<p><b>PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY</b></p> <hr/> <p>SIGNATURE OF INDIVIDUAL MAKING PLEDGE</p> <hr/> <p>SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE</p>	<p>I, the undersigned, have read and understand the This Home Health Agency, (hereinafter "This Home Health Agency") policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation.</p> <p>I also acknowledge that I am aware of and understand the Policies of the This Home Health Agency, regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.</p> <p>In consideration of my employment or association with This Home Health Agency, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with This Home Health Agency, or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside This Home Health Agency, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and This Home Health Agency, policies governing proper release of information.</p> <p>I understand that my obligations outlined above will continue after my employment/contract/association/ appointment with This Home Health Agency, ends.</p> <p>I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with This Home Health Agency, or with any of the entities, which have an association with This Home Health Agency</p> <p>I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant state and federal legislation, and a report to my professional regulatory body.</p>	
<p><b>POLICY ON JOBS</b></p>	<p>As an employee of This Home Health Agency, I understand that the job I am being hired to perform belongs to This Home Health Agency, Inc. I also understand that it is illegal for me to transfer or attempt to transfer any case to another Agency or take ownership of any job that I am employed in.</p> <p>Should I act underhandedly and take over such a job so that I may be paid directly by the client, to the exclusion of my employer, or transfer any case to another Agency. I will be in violation of State, Federal and agency rules and will accordingly pay \$10,000.00 to This Home Health Agency</p>	

Employee/Contractor Signature: \_\_\_\_\_ Date: \_\_\_\_\_



DATE: \_\_\_\_\_



TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dear Sir or Madam,

\_\_\_\_\_ SS#: \_\_\_\_\_ is applying to our office as \_\_\_\_\_. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

\_\_\_\_\_  
APPLICANT SIGNATURE

To be completed by Previous Employer:

Position \_\_\_\_\_ Date from \_\_\_\_\_ to \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Would you rehire? Yes \_\_\_ No \_\_\_ If no please advise why: \_\_\_\_\_

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY. BELOW AVERAGE, OR COMMENTS.

Punctuality & Attendance \_\_\_\_\_

Appearance (Grooming) \_\_\_\_\_

Judgement \_\_\_\_\_

Performance \_\_\_\_\_

Ability to Perform \_\_\_\_\_

Organization of Time \_\_\_\_\_

Compatibility \_\_\_\_\_

Accepts Direction \_\_\_\_\_

Signed \_\_\_\_\_ Title \_\_\_\_\_ Ph \_\_\_\_\_

Print Name: \_\_\_\_\_ Thank you for your courtesy

DATE: \_\_\_\_\_

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Dear Sir or Madam,

\_\_\_\_\_ SS#: \_\_\_\_\_ is applying to our office as \_\_\_\_\_. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

\_\_\_\_\_  
APPLICANT SIGNATURE

To be completed by Previous Employer:

Position \_\_\_\_\_ Date from \_\_\_\_\_ to \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Would you rehire? Yes \_\_\_ No \_\_\_ If no please advise why: \_\_\_\_\_

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY. BELOW AVERAGE, OR COMMENTS.

Punctuality & Attendance \_\_\_\_\_

Appearance (Grooming) \_\_\_\_\_

Judgement \_\_\_\_\_

Performance \_\_\_\_\_

Ability to Perform \_\_\_\_\_

Organization of Time \_\_\_\_\_

Compatibility \_\_\_\_\_

Accepts Direction \_\_\_\_\_

Signed \_\_\_\_\_ Title \_\_\_\_\_ Ph \_\_\_\_\_

Print Name: \_\_\_\_\_ Thank you for your courtesy

# Form I-9, Employment Eligibility Verification

Department of Homeland Security  
U.S. Citizenship and Immigration Services

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen or national of the United States
- A lawful permanent resident (Alien #) A \_\_\_\_\_
- An alien authorized to work until \_\_\_\_\_  
(Alien # or Admission #) \_\_\_\_\_

Employee's Signature	Date (month/day/year)
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**Preparer and/or Translator Certification.** (To be completed and signed if (Section I is prepared by a person other than the employee) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #- _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #- _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

**Section 3. Updating and Reverification.** To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.		
Signature of Employer or Authorized Representative		Date (month/day/year)

## LISTS OF ACCEPTABLE DOCUMENTS

<b>LIST A</b> <b>Documents that Establish Both Identity and Employment Eligibility</b>	<b>LIST B</b> <b>Documents that Establish Identity</b>	<b>LIST C</b> <b>Documents that Establish Employment Eligibility</b>
	<b>OR</b>	<b>AND</b>
1. U.S. Passport (unexpired or expired)	1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address	1. U.S. Social Security card issued by the Social Security Administration <i>(other than a card stating it is not valid for employment)</i>
2. Permanent Resident Card or Alien Registration Receipt Card (Form 1-551)	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address	2. Certification of Birth Abroad issued by the Department of State <i>(Form FS-545 or Form DS-1350)</i>
3. An unexpired foreign passport with a temporary 1-551 stamp	3. School ID card with a photograph	3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form 1-766, 1-688, 1-688A, 1-688B)	4. Voter's registration card	4. Native American tribal document
	5. U.S. Military card or draft record	5. U.S. Citizen ID Card <i>(Form I-197)</i>
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form 1-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	6. Military dependent's ID card	6. ID Card for use of Resident Citizen in the United States <i>(Form I-179)</i>
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	7. Unexpired employment authorization document issued by DHS <i>(other than those listed under List A)</i>
	9. Driver's license issued by a Canadian government authority	
	<b>For persons under age 18 who are unable to present a document listed above:</b>	
	10. School record or report card	
	11. Clinic, doctor or hospital record	
	12. Day-care or nursery school record	

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**

Employee Name: \_\_\_\_\_



## OFFICE CLERK JOB DESCRIPTION

### **POSITION SCOPE:**

To ensure effective Office Filling/Secretarial needs for the services working with the company's personnel, and through liaison with other organizations and individuals also providing care to the patient/client

### **POSITION QUALIFICATIONS:**

Graduate of high school with a high school diploma or equivalent.

Evidence of knowledge of home care environment; Ability to work under stress, and to take rapid actions.

Verbal and written communication skills

Good organizational skills.

Computer skills/typing/filing.

### **PHYSICAL REQUIREMENTS:**

No physical requirement

Ability to deal effectively with stress and a great work load at times

### **PERFORMANCE, ABILITIES AND STANDARDS:**

Medical Records filling.

Basic Computer Data Entry/typing.

Institutes a set of check points to make sure that the services were provided/Customer Satisfaction Surveys.

Participates in facility activities directed to implementation of safety management program, security plan, utility plan, emergency preparedness plan, etc.

Is responsible for confidentiality issues. Ensure HIPAA guidelines and procedures are maintained.

Understands the nature and type of the patient/client population serviced,

The Office clerk will be aware of the responsibilities of all organizations and individuals involved in patient's/client's care/service including the coverage For the services rendered.

The Office clerk will participate in education conferences, meetings, in-services and training for policy and procedures modifications, emergency response and preparedness plan, organization planning, quality assurance and company activities improvement, etc.

The Office clerk gives accurate information to clients, clients' families, and other professionals involved in patient's care/service,

Complies with all applicable Policies and Procedures, Federal and State rules, regulations, and laws in effect.

Participates in personal growth and development.

Documents all communications in the Communication Notes from the patient's charts.

\_\_\_\_\_  
Employee

\_\_\_\_\_  
Date