Delta Homecare Services

APPLICATION FOR EMPLOYMENT

Position Applying for: ☐RN ☐LPN ☐HHA ☐GNA/CNA ☐CMA ☐OFFICE STAFF
Type of Employment: ☐FULL-TIME ☐PART-TIME ☐TEMPORARY ☐ON-CALL
Time of Availability: ☐MORNINGS ☐NIGHTS ☐WEEKENDS
Hours of Availability: _____

Basic Information

Name *(Last, First Middle Initial)*: _____
Date of Birth: _____ Social Security Number: _____-_____-_____
Address: _____
City/State: _____ Zip Code: _____
Home Telephone: _____ Mobile: _____ Other: _____
Desired Start Date of Employment: _____ Are you willing to travel? ☐Yes ☐No
Are you authorized to work in the United States on an unrestricted basis? ☐Yes ☐No
Do you possess a security clearance? ☐Yes ☐No

Personal Information

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married

In Case of an Emergency, Please Notify:

Name: _____ Relationship: _____
Home Telephone: _____ Alternative: _____

Educational History

Type of Degree Earned: ☐High School Diploma ☐G.E.D. ☐College ☐Grad. School
Additional Training: _____ Diploma/Degree? ☐Yes ☐No
Nursing School *(if applicable)*: _____
City/State: _____ Zip Code: _____
Dates Attended: _____ To: _____

I hereby certify that all information provided above is true and correct to the best of my knowledge. By signing below, I authorize Delta Homecare Services to investigate and verify the information.

Signature of Applicant: _____ Date: _____

For Office Use Only

Person Conducting Interview: _____ **Date:** _____
Title: _____
Comments:
_____
_____

Employment History

Company/Client's Name: ______________________________
Job Title: ______________________ Supervisor: ______________________
Address: ______________________________
City/State: ______________________ Zip Code: __________
Start Date: ______________________ End Date: ______________________
Starting Pay: __________ Ending Pay: __________
Duties Performed: ______________________________
____
Reason for Leaving: ______________________________
Comments: ______________________________
____

Company/Client's Name: ______________________________
Job Title: ______________________ Supervisor: ______________________
Address: ______________________________
City/State: ______________________ Zip Code: __________
Start Date: ______________________ End Date: ______________________
Starting Pay: __________ Ending Pay: __________
Duties Performed: ______________________________
____
Reason for Leaving: ______________________________
Comments: ______________________________
____

Company/Client's Name: ______________________________
Job Title: ______________________ Supervisor: ______________________
Address: ______________________________
City/State: ______________________ Zip Code: __________
Start Date: ______________________ End Date: ______________________
Starting Pay: __________ Ending Pay: __________
Duties Performed: ______________________________
____
Reason for Leaving: ______________________________
Comments: ______________________________
____

License Verification Form

Employee Name: ________________________________ Discipline: ________________

Social Security #: ______-_____-______

Maryland

License #: ______________________________________ Status: _______________

For Office Use Only

Verified By: ▢Automated System ▢Verbal Contact (*If verbal, complete the following. If not, skip.)*

Spoke With: _________________________________ Title: ______________________

Verified By: _______________________________________ Date: ________________

Title: ________________________________

Comments: ____

____

License #: ______________________________________ Status: _______________

For Office Use Only

Verified By: ▢Automated System ▢Verbal Contact (*If verbal, complete the following. If not, skip.)*

Spoke With: _________________________________ Title: ______________________

Verified By: _______________________________________ Date: ________________

Title: ________________________________

Comments: ____

____

License #: ______________________________________ Status: _______________

For Office Use Only

Verified By: ▢Automated System ▢Verbal Contact (*If verbal, complete the following. If not, skip.)*

Spoke With: _________________________________ Title: ______________________

Verified By: _______________________________________ Date: ________________

Title: ________________________________

Comments: ____

____

Name (Last Name): _______________________________________

Reference Form

The undersigned, having applied for a position with our company, hereby authorizes you to release any information necessary relating to employment. This hereby releases your organization unconditionally from all liability for damage whatsoever that might result from furnishing this information.

Section I: *(To be completed by Applicant)*

Name: _____

Company Name: _____ Position: _____

Supervisor's Name: _____ Telephone: _____

Dates Employed: _____-_____

I acknowledge filing an application with Delta Homecare Services and authorize the release of information from my former employer.

Applicant Signature: _____ Date: _____

Section II: *(Supervisor, please confirm information in Section I and complete Section II.)*

Is the Applicant's position title correct? ☐Yes ☐No _____
(if no, please correct information)

Are the dates of employment correct? ☐Yes ☐No _____
(if no, please correct information)

Is this employee eligible for rehire? ☐Yes ☐No or ☐Conditional

_____
(if no/conditional, please explain)

Section II: Evaluation of Performance

Job knowledge/Technical skills:	☐Excellent	☐Good	☐Fair	☐Poor
Quality of work:	☐Excellent	☐Good	☐Fair	☐Poor
Ability to work with others:	☐Excellent	☐Good	☐Fair	☐Poor
Initiative:	☐Excellent	☐Good	☐Fair	☐Poor
Punctuality/Attendance:	☐Excellent	☐Good	☐Fair	☐Poor

Additional Comments: _____

_____

Information Verified by: _____ Title: _____

Reference record completed by *(Authorized Representative)*: _____

Title: _____ Date: _____

Name (Last Name): _____

Reference Form

The undersigned, having applied for a position with our company, hereby authorizes you to release any information necessary relating to employment. This hereby releases your organization unconditionally from all liability for damage whatsoever that might result from furnishing this information.

Section I: *(To be completed by Applicant)*

Name: _____

Company's Name: _____ Position: _____

Supervisor's Name: _____ Telephone: _____

Dates Employed: _____-_____

I acknowledge filing an application with Delta Homecare Services and authorize the release of information from my former employer.

Applicant Signature: _____ Date: _____

Section II: *(Supervisor, please confirm information in Section I and complete Section II.)*

Is the Applicant's position title correct? ☐Yes ☐No _____
(if no, please correct information)

Are the dates of employment correct? ☐Yes ☐No _____
(if no, please correct information)

Is this employee eligible for rehire? ☐Yes ☐No ☐Conditional

_____
(if no or conditional, please explain)

Section II: Evaluation of Performance

Job knowledge/Technical skills:	☐Excellent	☐Good	☐Fair	☐Poor
Quality of work:	☐Excellent	☐Good	☐Fair	☐Poor
Ability to work with others:	☐Excellent	☐Good	☐Fair	☐Poor
Initiative:	☐Excellent	☐Good	☐Fair	☐Poor
Punctuality/Attendance:	☐Excellent	☐Good	☐Fair	☐Poor

Additional Comments: _____

_____

Information Verified by: _____ Title: _____

Reference record completed by *(Authorized Representative)*: _____

Title: _____ Date: _____

Name (Last Name): _____

PERMISSION FOR PPD TEST

I, _____, voluntarily take the PPD test intradermally as a screening
(Applicant's Name, Please Print)
method for tuberculosis. I understand that a PPD test must be administered and read annually. A chest X-Ray must be done every five years as a pre-requisite for employment at Delta Homecare Services I release Delta Homecare Services of any liability. I confirm that I have/have not had a PPD test within the last year; and I have no known allergy to the PPD test.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Delta Homecare Services Representative)

Date: _____

Name (Last Name): _____

EMPLOYEE ACKNOWLEDGEMENT OF HANDBOOK

I acknowledge receipt of Delta Homecare Services Employee Handbook. In consideration of my employment I agree to read and abide by the rules and the policies of this handbook. Since the information, policies, and benefits described in this booklet may be subject to change, I understand and agree that any such change can be made unilaterally by the company in its sole and absolute discretion, and that material changes will be made known to employees through the usual methods of communication within a reasonable period of time.

Employee Name_____Date_____/_____/_____

Employee Signature_____

Name (Last Name): _____

UNIVERSAL PRECAUTIONS

(OSHA BLOODBORNE PATHOGENS, SECTION 1910.1030 OF TITLE 29, CODE OF FEDERAL REGULATIONS)

I, _____, am aware and understand that due to my occupation, I am
(Applicant's Name, Please Print)
at risk for exposure to blood or other potentially infectious materials. Therefore, I have been given proper instruction on OSHA regulation and requirements. I also understand and I am aware of Universal Precautions and know that as a requirement of my job description I will practice Universal Precautions as described in my job description.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Delta Homecare Services Representative)

Date: _____

Name (Last Name): _____

IN-SERVICE REQUIREMENT

It is the policy of Delta Homecare Services at each licensed employee or independent contractor attends a minimum of four in-service hours per year. This is best accomplished by doing one (3) hour in-service every three (3) months, for a total of 12 hours per year.

Delta Homecare Services offers a variety of in-services throughout the year. You will be notified of scheduled in-services by memo in your paycheck. OSHA, Infection Control, and Tuberculosis are required annually. These courses must be home care focused. Should you attend an in-service elsewhere (i.e. hospital, nursing home, and/or other agencies), we will gladly accept a copy of your attendance record/certificate and will credit you with that in-service requirement.

By signing below, you acknowledge and understand that you must comply with the above requirement to remain in an "Active Status" with Delta Homecare Services.

Print Name: _____

Signature: _____

Date: _____

Name (Last Name): _____

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. It is strongly suggested that I be vaccinated for HBV. I understand that I may decline the vaccination and I also understand that not being vaccinated; I continue to at risk for acquiring and remain susceptible to HBV, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated with the HBV vaccine, I can receive the vaccination series at no charge to me.

Delta Homecare Services has explained to me that I continue to be at risk for HBV until such time that I am immunized.

Print Name: _____

Signature: _____

Date: _____

Authorized Signature: _____ Title: _____
(Delta Homecare Services Representative)

Date: _____

DRUG AND ALCOHOL POLICY

Informed Consent and Release of Liability

I authorize Delta Homecare Services or Client Company ("Company") to obtain a specimen of my urine for chemical analysis. I understand that this analysis is to determine or exclude the presence of alcohol, drugs or other substances, in accordance with the Substance Abuse and drug Testing Policy of Company. I understand that decisions regarding my continued employment may be made as a result of this analysis. I understand that test results will be divulged only to authorized personnel. I hereby consent to this test and release Company from any liability for decisions resulting from this test.

_____ _____
Employee/Applicant Signature Date

_____
Employee/Applicant Printed Name

Policy and Procedure Agreement

ALL STAFF:

I, _____ have read, understand and agree to abide by the policies
(please print)

and procedures set forth by Delta Homecare Services.

I also understand that I may view or copy any or all of Delta Homecare Services policy and procedure manual for review or retention.

I also agree to adhere to all local, state, and federal procedures regulated as precedent for the home health care industry for compliance in providing care to Agency clients as designated.

Employee Signature: _____ Date: _____

Administrative Signature: _____ Date: _____

EMPLOYMENT OFFER

Congratulations. We are pleased to inform you that you have been offered □part time □full time employment with Delta Homecare Services as a

□Registered Nurse □LPN □CNA □CMT responsible to provide services to Delta Homecare Services.

Duties and Responsibilities: During the period of this employment, employee/contractor shall perform His/her duties and responsibilities diligently and consistent with Delta Homecare Services Agency policies and procedures and practices in accordance with accepted professional practices. While providing services at clients work site, employee/contractor shall work under the supervision of Agency Director of Nursing and or Client and shall be required to abide by all the client's needs.

Compensation: Employee/contractor shall be compensated at regular per dime or hourly rate of $---------- .00. Your compensation shall be paid in by weekly remuneration and shall be in accordance with the company normal payroll cycle (biweekly).

Confidentiality: Except as authorized, employee/contractor shall not directly or indirectly publish or disclose any confidential information of the company neither shall employee abuse a client's information due to their privileged position.
General Conditions: This agreement may be terminated by either party upon written or verbal notice to other party. Upon termination, the employee/contractor shall prepare and submit final invoice for final services rendered.

In witness thereof, the parties hereto execute this agreement.

_____
Delta Homecare Services, Representative

Employee/Contractor Name _____ Date_____

CONFIDENTIALITY STATEMENT

Disclosure of confidential information gained through your employment by is stated as an act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient's illness, family, financial condition or personal peculiarities is strictly confidential. When a patient's history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Delta Homecare Services Representative)

Date: _____

EMPLOYEE CONFIDENTIALITY STATEMENT

I, _____, hereby agree and pledge that I will honor and respect the
(Applicant's Name, Please Print)
privacy and confidentiality of the agency, their clients and business associates. I will not divulge any information of any type obtained through my services as an employee of Delta Homecare Services. I agree not to discuss nor release any information obtained within the agency regarding any Delta Homecare Services clients, their medical record or any client's condition with any individual not directly associated with Delta Homecare Services, nor with Delta Homecare Services employees who are not directly associated with that client. I also agree that any information that is released regarding the client or client's record will only be done with proper authorization and/or in accordance with established agency policy for the release of the information: this includes, but is not limited to: the client's identity, description, medical condition, or addresses, the agency or their business associates, financial status or condition, or any and all commercial or private transactions of the agency.

My signature on this document indicates that I understand, and I am aware of, and agree to abide by the aforementioned policies and that any breach will have significant consequences which may include suspension or termination of employment and/or civil prosecution.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Delta Homecare Services Representative)

Date: _____