Love One
Home Healthcare

**APPLICATION FOR EMPLOYMENT**

**Please Print** Date: _____

**PERSONAL**

Name: _____ Soc. Sec. # _____ Date Of Birth ___/_____/_____

Address: _____ City_____State_____Zip code_____

Gender M ☐ F ☐ Home Phone ( ) _____ Cell Phone ( ) _____

Are you 18 years of age or over? Yes ☐ No ☐ Are you a U.S. citizen? Yes ☐ No ☐

If No, Are you legally eligible for employment in U.S.? Yes No

**EMERGENCY CONTACT**

In case of an emergency notify: Name: _____ Relationship_____

Address:_____ city_____state_____Zip code_____

Phone: ( ) _____ Cell ( ) _____

**EMPLOYMENT DESIRED**

Position: _____ Date you can start: ____/____/___ Salary desired: _____

Type of Employment Desired: Part-time ☐ Full-time ☐ PRN ☐ Day ☐ Evenings ☐ Nights ☐Live-in

Were you previously employed by us? Yes ☐ No ☐ If yes, when? ____/____/_____

**EDUCATION BACKGROUND**

| EDUCATION | Name and Location of School | Years Attended | Graduated Yes/No | Course/Major |
|---|---|---|---|---|
| High School | | | | |
| College | | | | |
| Other Education | | | | |

## EMPLOYMENT HISTORY

List your record of employment beginning with your present or most recent position.

Name of Employer _____ Phone ( ) _____ EXT _____

Address _____ City _____ State _____ Zip _____

Your Title _____ Supervisor Name _____ Title _____

Employment Dates From: _____ To: _____ Starting Salary: _____ Ending Salary _____

Work Performed

Reason for leaving _____

Name of Employer _____ Phone ( ) _____ EXT

Address _____ City _____ State _____ Zip _____

Your Title _____ Supervisor Name _____ Title _____

Employment Dates From: _____ To: _____ Starting Salary: _____ Ending Salary _____

Work Performed

Reason for leaving

Name of Employer _____ Phone ( ) _____ EXT _____

Address _____ City _____ State _____ Zip _____

Your Title _____ Supervisor Name _____ Title

Employment Dates From: _____ To: _____ Starting Salary: _____ Ending Salary

Work Performed

Reason for leaving

May we contact the employers listed above? Yes ☐ No ☐ if no, Explain

## REFERENCES

Three references required

1. Name _____ Relationship_____Ph.( ) _____
2. Name _____ Relationship_____Ph.( ) _____
3. Name _____ _____ Relationship_____Ph.( ) _____

## AUTHORIZATION

I authorize the Love One Home Healthcare Inc. to contact each former employer, firm or corporation. I authorize any of these persons to give all information concerning work-related items and I release all parties from liability for any damage that may result from furnishing same to you.

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 termination.

Applicant's Signature_____Date_____

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**DO NOT WRITE IN THE SPACE BELOW**

Interview by:_____ Date:_____

Hired: Yes_____ No _____ Position_____ Salary/Wage: _____

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CONSENT TO PERFORM CRIMINAL HISTORY BACKGROUND CHECK

Date:_____ Driver's Lic #_____ State Issued____

Last Name_____ First Name_____ Middle Initial_____

Address _____ City _____County _____ State _____Zip Code_____

Date of Birth___/___/___ Social Security _____ Male ☐ Female ☐

Previous Addresses _____

This authorization and consent for release of personal information acknowledges that

In connection with my employment at Love One Home Healthcare, I hereby authorize the Love One Home Healthcare to conduct a security background check on me. I understand that this security check will cover information such as criminal history, education and employment, eligibility, and professional licensure/certifications. I understand that this background check may include information from previous employers relating to my work experience. I hereby release Love One Home Healthcare as well as its employees from all liability resulting from the furnishing of this information Love One Home Healthcare. I certify that the statements made by me on this form are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I understand that any false statements made herein could void my consideration for employment, or could result in disciplinary action up to, and including termination.

The following are my responses to questions about my criminal record history (if any) with descriptions to any question with a YES answer:

(1) Have you ever been convicted or plead guilty before a court of any federal, state, or municipal criminal offense? (Excluding minor traffic violations) YES NO

If YES, please provide an explanation: _____

_____

(2). Have you ever received deferred adjudication or similar disposition for any federal, state or municipal criminal offense?

YES NO

If YES, Please provide an explanation: _____

_____

(3) Have you ever received probation or community supervision for any federal, state or municipal criminal offense?

YES NO

If YES, Please provide an explanation: _____

_____

(4) As of the date of this authorization, do you have any pending criminal charges against you?

YES NO

If YES, Please provide an explanation _____:

_____

_____

I hereby certify that all the information provided in this authorization is true, correct and complete. I understand that if any information proves to be incorrect or incomplete that might be grounds for cancellation of any and all offers of employment.

Applicant Name (Print) _____Signature_____Date_____/

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# DRUG/ALCOHOL TEST CONSENT AND RELEASE FORM

I hereby consent to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis, as shall be determined by Love One Home Healthcare Inc. in order to meet with their policy regarding the selection of applicants for employment.

I further authorize and give full permission to have the Company and/or its authorized agents and physicians to send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company. I further agree to and hereby authorize the release of the results of said tests to the Company.

I understand that it is the current use of illegal drugs that would prohibit me from being employed at this Company.

I further agree to hold harmless the Company and its agents and physicians from any liability arising in whole or part, out of the collection of specimens, testing, and use of the information from said testing in connection with the Company's consideration of my application of employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

APPLICANT: Print Name: _____ S.S. #: _____

Signature: _____ Date: _____

WITNESS: Print Name: _____ Signature: _____

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**Confidentiality Statement**

All patient Protected Health Information (PHI—which includes patient medical and financial information), employee records, financial and operating data of the practice, and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

- Employees discussing or revealing PHI or other confidential information to friends or family members.
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the practice to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

**Employee Confidentiality Agreement**

I hereby acknowledge, by my signature below, that I understand that the PHI, other confidential records, and data to which I have knowledge and access in the course of my employment with Love One Home Healthcare is to be kept confidential, and this confidentiality is a condition of my employment. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand that my duty to maintain confidentiality continues even after I am no longer employed.

I am familiar with the guidelines in place at Love One Home Healthcare pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of Love One Home Healthcare is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of Love One Home Healthcare is grounds for disciplinary action, up to and including immediate dismissal.

Print Name_____ Date_____

Signature of Employee_____ Supervisor _____


**Physical Examination Form**

**To be filled by the Physician**

**Employee Information**

Name: _____Date:_____

Address: _____

City:_____ State:_____ Zip:_____
Weight ____ Hgt ____ Allergies_____

Medical Information

I have examined the above parson; he/she is in sound health to perform the duty of patient care provider.

- ☐ Does not have signs and symptoms of communicable disease such as tuberculosis.
- ☐ Does not have Physical disability or any form of handicap, which could impact his/ her ability performing patient care services.
- ☐ Does not have any chronic conditions that will affect his /her ability to work as patient care provider.

Recommendations: _____

_____

_____

Physician Signature _____Date_____

Physician Name _____

Office Address _____

_____

Telephone Number. _____

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**HEPATITIS B VACCINE CONSENT FORM**

Employee Name _____SS# _____ Title_____

I _____ understand that due to occupational exposure to blood or other Potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, if I decline a hepatitis B vaccination at this time and 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 vaccination series at no charge to me.

I understand that adverse reactions are rare; the most common being local irritation at the injection site. The vaccine cannot transmit the disease; however, the vaccine is contra-indicated during pregnancy. I am not pregnant .

With this understanding, I choose

☐ To be vaccinated ☐ Not to be vaccinated.

☐ I have been vaccinated within the last 5 years at another place of employment and do not need current vaccination.

Employee Signature _____ Date_____

Witness _____ Date _____

1st Dose (Date _____) lot# _____ Exp_____ ☐ RT Deltoid ☐LT Deltoid RN Signature _____

2nd Dose (Date _____) lot# _____Exp_____ ☐ RT Deltoid ☐LT Deltoid RN Signature _____

3rd Dose (Date _____) lot# _____ Exp_____ ☐ RT Deltoid ☐LT Deltoid RN Signature _____

Blood work Results (Date _____) RN Signature _____

(Date _____) RN Signature _____