OUR-REHOBOTH CARE INC.

APPLICATION FOR EMPLOYMENT

Position Applying for: ☐RN ☐LPN ☐HHA ☐GNA ☐CNA ☐OFFICE STAFF ☐DSP
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
EMAIL ADDRESS: _____

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 OUR-REHOBOTH CARE INC. to investigate and verify the information.

Signature of Applicant: _____ Date: _____

OUR-REHOBOTH CARE INC.

For Office Use Only

Person Conducting Interview: _____ **Date:** _____

Employment History

1) 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: _____

_____

2) *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: _____

_____

OUR-REHOBOTH CARE INC.

*Please attach additional sheet if you have more information to provide…

I certify that the information on this employment application is true and complete to the best of my knowledge, I understand that any misrepresentation, willful omission, false or misleading information is grounds for rejection of this application form, refusal to hire, withdrawal of an offer of Employment, or immediate discharge whenever discovered. P&J CARE is authorized to conduct investigations, including verification of prior employment history and education. I also understand that employment is dependent upon receipt of acceptable employment history and satisfactory completion of a pre-employment health screening which will include illicit drug or alcohol testing and provision of documents required by the immigration reform and control Act of 1986. P&J Care Inc does not discriminate against any qualified person because of age, race, color, religion, sex, national origin, disability or sexual orientation. By signing this application, I acknowledge that an offer of employment at P&J Care Inc should not be interpreted as an offer of continued or permanent employment.

Name (Last Name): _____

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: _____

_____

District of Columbia

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: _____

_____

OUR-REHOBOTH CARE INC.

Others

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: _____

_____

OUR-REHOBOTH CARE INC.

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 OUR-REHOBOTH CARE INC. 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)

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: _____

OUR-REHOBOTH CARE INC.

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 OUR-REHOBOTH CARE INC. 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)

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: _____

OUR-REHOBOTH CARE INC.

CONFIDENTIALITY STATEMENT

Disclosure of confidential information gained through your employment by OUR-REHOBOTH CARE INC. 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 people 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: _____
(OUR-REHOBOTH CARE INC. Representative)

Date: _____

OUR-REHOBOTH CARE INC.

EMPLOYEE CONFIDENTIALITY STATEMENT

I, _____, hereby agree and pledge that I will honor and respect
(Applicant's Name, Please Print)
the 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 OUR-REHOBOTH CARE INC. I agree not to discuss nor release any information obtained within the agency regarding any OUR-REHOBOTH CARE INC. clients, their medical record or any client's condition with any individual not directly associated with OUR-REHOBOTH CARE INC., nor with OUR-REHOBOTH CARE INC. 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: _____
(OUR-REHOBOTH CARE INC. Representative)

Date: _____

OUR-REHOBOTH CARE INC.

PERMISSION FOR PPD TEST

I, _____, voluntarily take the PPD test intradermally as a
(Applicant's Name, Please Print)
screening 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 OUR-REHOBOTH CARE INC..

I release OUR-REHOBOTH CARE INC. 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: _____
(OUR-REHOBOTH CARE INC. Representative)

Date: _____

OUR-REHOBOTH CARE INC.

DECLINATION OF MANTOUX

I, _____, have submitted or will submit documentation of a PPD
(Applicant's Name, Please Print)
test and results of said test. If an employee has a known history of having had a Positive Tuberculin test the Mantoux method, he/she may decline the Mantoux test. He/she must agree to give the agency documentation of a negative chest X-Ray within the past 12 months.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(OUR-REHOBOTH CARE INC. Representative)

Date: _____

OUR-REHOBOTH CARE INC.

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
(Applicant's Name, Please Print)
am 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: _____
(OUR-REHOBOTH CARE INC. Representative)

Date: _____

OUR-REHOBOTH CARE INC.

IN-SERVICE REQUIREMENT

It is the policy of OUR-REHOBOTH CARE INC. that 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.

OUR-REHOBOTH CARE INC. 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 OUR-REHOBOTH CARE INC.

Print Name: _____

Signature: _____

Date: _____

OUR-REHOBOTH CARE INC.

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.

OUR-REHOBOTH CARE INC. 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: _____
(OUR-REHOBOTH CARE INC. Representative)

Title: _____

Date: _____

OUR-REHOBOTH CARE INC.

DRUG AND ALCOHOL POLICY AGREEMENT

It is the policy of OUR-REHOBOTH CARE INC. . that all its employees be free of the influence of alcohol and drugs. All employees must be fit for the duty physically and mentally, as is necessary to perform work in a safe and competent manner.

Possession, trading, manufacture and sale of illegal drugs or alcohol on the job are considered therefore, a violation of this policy.

Also, it is a violation of this policy to work under the influence of illegal drugs or alcohol.

Violations of this policy are subject to disciplinary action up to and including termination.

ACKNOLEDGEMENT

I, ---------- certify that I am not under the influence of drugs or alcohol, nor will I use or possess in anyway controlled substances (marijuana, heroin, cocaine, crack, hash etc). I understand that these examples do not cover all controlled substances. Failure to comply with this agreement may result in termination of my employment with OUR-REHOBOTH CARE INC.. I have been briefed and fully understand OUR-REHOBOTH CARE INC. . OUR-REHOBOTH CARE INC. drug and alcohol policy and I agree to fully comply with the provisions herein.

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Employee Signature Date

OUR-REHOBOTH CARE INC.

REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONALS

The basic requirements for all employees and volunteers providing direct services are as follows:

- Be at least eighteen (18) years old or older
- Obtain an annual physical documentation from a physician or other health professional that he or she is free from tuberculosis
- Hepatitis B vaccination
- High school diploma or general education development (GED) certificate
- First Aid and CPR Certificate
- Credentials such as CAN, HHA, or other related certificates (optional)
- Complete pre-service and in-service training as described in DDS policy
- Have the ability to communicate with the person whom services are provided
- Be able to read, write, and speak the English language
- Participate in competency based training needed to address the unique support needs of the person, as detailed in his or her ISP
- Possess a social security card
- Possess a Drivers License or official ID
- A criminal background check