# APPLICATION FOR EMPLOYMENT

**An Equal Opportunity Employer**

AHCS, in accordance with applicable state and federal laws, does not discriminate on the basis of age, race, gender, religion, national origin, marital status, or physical or mental disabilities, military status or sexual orientation.

I,________________________________authorize the release of my personnel records, including background screening, DMV checks, and physical / medical clearance results to AHCS.

## PERSONAL INFORMATION (Please Print)

LAST NAME/ MIDDLE INITIAL/ FIRST NAME

☐ ☐

GENDER Male-Female RACE:Asian, Alaskan Native, American Indian, Black, Hispanic, Pacific Islander, White

SOCIAL SECURITY # DRIVER'S LICENSE # D.O.B

HOME ADDRESS CITY STATE ZIP

(____)______________________(_______)__________________ ______________________________

HOME PHONE # MOBILE PHONE # E-MAIL ADDRESS

## EMPLOYMENT DESIRED

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

PT - PTA - OT - OTA- ST RN- LPN-CNA-HHA

Position Date you can start

☐ Full-time ☐ Part-time ☐ Per Diem ☐ Sub-Contractor/1099

## EDUCATION

High School City Years Attended Did You Graduate? Degree

College City Years Attended Did You Graduate? Degree

Post Graduate City Years Attended Degree Conferred

## MILITARY SERVICE RECORD

Branch of Service Type of Discharge & Date Rank at Discharge

## BACKGROUND

Have you ever been convicted of a felony or misdemeanor? If yes please explain

______________________________________________

______________________________________________

## EMPLOYMENT VERIFICATION

**ARE YOU LEGALLLY ENTITLED TO WORK IN THE UNITED STATES? ☐ Yes ☐ No**

ARE YOU PRESENTLY EMPLOYED? ☐ Yes ☐ No

IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? ☐ Yes ☐ No

## WORK EXPERIENCE

**1.** ______________________________________________

Name of Present or Last Employer, Phone & Fax Number City State

______________________________________________

Start Date (Mo/Yr) Departure Date (Mo/Yr) Postition Held:

______________________________________________

Job Title Name of Supervisor

☐ Yes ☐ No

______________________________________________

Were you fired? Explain reasons/circumstances for changing or wanting to change jobs

**2.** ______________________________________________

Name of Prior Employer, Phone & Fax Number City State

______________________________________________

Start Date (Mo/Yr) Departure Date (Mo/Yr) Postition Held:

______________________________________________

Job Title Name of Supervisor

☐ Yes ☐ No

______________________________________________

Were you fired? Explain reasons/circumstances for changing or wanting to change jobs

**3.** ______________________________________________

Name of Prior Employer, Phone & Fax Number City State

______________________________________________

Start Date (Mo/Yr) Departure Date (Mo/Yr) Postition Held:

______________________________________________

Job Title Name of Supervisor

☐ Yes ☐ No

______________________________________________

Were you fired? Explain reasons/circumstances for changing or wanting to change jobs

# REFERENCES

**LIST THE NAMES OF TWO PERSONS, NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST TWO YEARS.**

**1**. ______________________________________________________________________
NAME TITLE

______________________________________________________________________
ADDRESS PHONE YEARS KNOWN

**2.**______________________________________________________________________
NAME TITLE

______________________________________________________________________
ADDRESS PHONE YEARS KNOWN

# EMERGENCY NOTIFICATION

In case of emergency notify:

Name________________________________Number____________________________________

Address_________________________________________________________________________

# EMPLOYEE REFERENCE FORM

**TO BE COMPLETED BY APPLICANT:**

**Last Name:** **First Name:**

**Company/Facility Name:**

**Phone & Fax Number:** **E-Mail**

**Position Held:**

**Dates of Employment:** **Start Date:** **End Date:**

I have applied for employment with Advanced Healthcare Services Inc. I hereby request and authorize you to furnish the listed employer with any information regarding my employment record. I do hereby release the addressed entity and all individuals concerned from any claims, suits, and liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the giving of such information.

☐ By checking this box I understand that an electronic signature shall have the same force and effect as a written signature, even if sent to Advanced Health Care Services from a foreign e-mail address.

Signature of Applicant:________________________________________Date:______________________

Printed Name: ____________________________________

**TO BE COMPLETED BY EVALUATOR**:

Dates of Employment are correct? ☐ YES

☐ NO Corrected Dates:

☐ By checking this box I understand that an electronic signature shall have the same force and effect as a written signature, even if sent to Advanced Health Care Services from a foreign e-mail address.

Signature of HR/Evaluator:____________________________________Date:___________________

Printed Name: ____________________________________

# EMPLOYEE REFERENCE FORM

**TO BE COMPLETED BY APPLICANT:**

**Last Name:** **First Name:**

**Company/Facility Name:**

**Phone & Fax Number** **E-Mail**

**Position Held:**

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Signature of Applicant:________________________________________Date:______________________

Printed Name: ____________________________________

**TO BE COMPLETED BY EVALUATOR**:

Dates of Employment are correct? ☐ YES

☐ NO Corrected Dates:

☐ By checking this box I understand that an electronic signature shall have the same force and effect as a written signature, even if sent to Advanced Health Care Services from a foreign e-mail address.

Signature of HR/Evaluator:____________________________________Date:___________________

Printed Name: ____________________________________

**PLEASE READ CAREFULLY BEFORE SIGNING**

I CERTIFY THAT ALL STATEMENTS MADE BY ME ON THIS APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE AHCS:

TO MAKE A THOROUGH INVESTIGATION OF MY PREVIOUS EMPLOYMENT HISTORY AND ALL OTHER FACTS STATED ON MY APPLICATION FOR EMPLOYMENT/CONTRACTOR. I UNDERSTAND THAT A COMPLETE BACKGROUND SCREENING WILL BE CONDUCTED AS A PREREQUISITE FOR EMPLOYMENT TO INCLUDE LICENSE/CERTIFICATION VERIFICATION, CRIMINAL BACKGROUND CHECK, AND ABUSE SCREENING IN ORDER TO DETERMINE WHETHER THE MINIMUM STANDARDS OF GOOD MORAL CHARACTERFOR HOMEHEALTH AGENCY PERSONNEL HAVE BEEN STATISFIED. SUBSEQUENTLY, BACKGROUND/LICENSE FAILURES COULD RESULT IN TERMINATION OF EMPLOYMENT IF FOUND TO BE IN NONCOMPLIANCE WITH THE MINIMAL STANDARDS OF GOOD MORAL CHARACTER. I HEREBY RELEASE FROM LIABILITY OR RESPONSIBILITY ALL INDIVIDUALS, BUSINESS ESTABLISHMENTS, EMPLOYERS, EDUCATIONAL INSTITUTIONS AND/OR AGENCIES SUPPLYING SUCH INFORMATION.

IF I AM EMPLOYED, I AGREE TO ABIDE BY THE POLICIES AND RULES OUTLINED BY THE EMPLOYER. MY EMPLOYMENT/CONTRACTOR AND COMPENSATION CAN BE TERMIATED, WITH OR WITHOUT CAUSE, AND WITHOUT NOTICE AT ANY TIME, AT THE OPTION OF EITHER EMPLOYER OR MYSELF. I ALSO UNDERSTAND THAT I MAY NOT WORK EITHER DIRECTLY OR INDIRECTLY AT ANY FACILITY OR BRANCH OF ANY CORPORATE ENTITY THAT I HAVE WORKED THROUGH MY EMPLOYMENT AGREEMENT WITH AHCS FOR A PERIOD OF 1 YEAR AFTER MY LAST PAYCHECK WITH AHCS. I UNDERSTAND THAT NO EMPLOYEE OR A REPRESENTATIVE OF EMPLOYER, OTHER THAN THE MANAGEMENT, HAS THE AUTHORITY TO ENTER INTO ANY AGREEMENT OR CONTRACT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OF TIME OR TO MAKE ANY EMPLOYMENT AGREEMENT OR CONTRACT CONTRARY TO THE FORGOING.

**CONFIDENTIALITY STATEMENT**

I have been formally instructed in maintaining patient and agency confidentiality. I have been advised that, except as needed to conduct the business, medical and all other information may not be discussed with anyone inside or outside of the office. It is understood that materials, forms, and manuals are the exclusive property of the agency, in addition to business practices and personnel information which is kept confidential. I understand that any breach of this policy is cause for dismissal.

I understand that my electronic signature on this application has the same legal effect as an original hardcopy document signed. I declare I have read and fully understand the foregoing application and the facts stated in it are true and seek employment under these conditions. I understand that falsification of any material information on this application may result in administrative action, or criminal penalty.

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Signature of Applicant:_______________________________________________ Date:_________________

Printed Name:_______________________________________________________

HEPATITIS B

Hepatitis B is an inflammation of the liver. Hepatitis B virus (or HBV) presents a risk to health care workers. The course of acute hepatitis can be mild and completely without outward symptoms, or it can be severe, prolonged and possibly fatal. Health care workers can be exposed to HBV from contaminated needle punctures or blood spills on broke skin or mucous membranes. Other body fluids such as bloody urine, bloody wound drainage or semen may also be infectious.

Recombinant Hepatitis B Vaccine is for protection against HBV. Three doses of the vaccine are required. The initial dose, a second dose a month later and a third dose five months later. A booster dose may be needed five to seven years for continued protection.

By signing this document I acknowledge that:

1. I have willfully chosen to refuse inoculation of Hepatitis B.
2. I understand and accept my potential for exposure to the disease, and I fully understand the effects of the disease. This includes, but is not limited to, the effects of the disease itself, any and all side effects from the disease and/ or treatment for said disease, and any and all psychological or mental damage, and any pain and suffering that I, or my family, may suffer as a direct or indirect result of Hepatitis B and/ or any accompanying complications.
3. I hold harmless, Advanced Health Care Services, its agents, affiliates, and employees and any other facility which shall cover both acute and non-acute care settings, its agents, affiliates and employees from any and all damages that I or my family may suffer as a direct or indirectly consequence of contracting HBV.

I hereby declare that I have read, reviewed and understand the aforementioned conditions, and I agree with them in their entirety.

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Signature of Applicant:_______________________________________________ Date:_________________

Printed Name:_______________________________________________________

I have received my copy of Advanced Health Care Services (AHCS) Employment/Contactor Manual which includes Payroll Procedures, Time Sheet Policy, HIPPAA Compliance, Job Descriptions, HR Policies, Drug Testing, Background Authorization, Receipt of Contractor Status, General employment/contactor guidelines, and Policies between me and my employer AHCS. It is my responsibility to read and understand the matters set forth in this manual. It is a guide to AHCS's policies and procedures. I understand that no statement contained in this manual creates any guarantee of continued employment/contractor or creates any obligation, contractual or otherwise, on the part of the company. I will rely on any promises, statements or representations to the contrary only if they are in writing and signed by an authorized member of the company's management.
I understand and acknowledge that the company has the right, without prior notice, to modify, amend or terminate policies, practices, benefit plans, and other institutional programs within the limits and requirements imposed by law.

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Signature of Applicant:_______________________________________________ Date:_________________

Printed Name:______________________________________________________

WITNESS________________________________DATE_________