Application for Employment

Name: _____
Last First Middle

Address: _____
Street City State Zip+4

Phone # _____ Cell# _____ E-mail_____

Position applied for _____ Date of Application _____

Best time to call you is … _____ May we contact you at work? _____
If yes, work # and best time to call _____

What is your desired hourly rate of pay? _____ per _____

Drivers license # _____ State _____

Have you ever plead "guilty" or "no contest" to, or been convicted of a crime? _____
If yes, provide date(s) and details _____
_____

Emergency Contact Name: _____ Relation to you_____
Phone #: _____

Applicant Statement

I certify that all information provided in order to apply for or secure employment is true, complete and correct.

I expressly authorize, without reservation, the employer, its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume or job interview. I hereby waive any and all rights and claims that I may have regarding the employer, its agents, employees or representatives, for seeking, gathering and using truthful and non-defamatory information, in a lawful manner, in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that this employer does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or eliminating any applicant from consideration of employment on a basis prohibited by applicable local, state or federal law.

I understand that this application remains current for 90 days.

If I am hired, I understand that I am free to resign at any time, with or without cause and with or without prior notice, and the employer reserves the same right to terminate my employment with or without cause and with or without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment.

I also understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete and I-9 Form in this regard.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (i) eliminate me from further consideration for employment, or (ii) may result in my immediate dismissal from the employer's service whenever it is discovered.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANT STATEMENT

I certify that I have read, fully understand and accept all terms of the foregoing Applicant Statement.

_____ _____
Signature of Applicant Date

island
HOME CARE AGENCY, INC.
DRUG & SURGICAL PHONE: (631) 289-6223 FAX: (631) 289-7473

Discipline:_____ New:☐ Reactivating:☐

Name: _____ Date: _____

Address:_____

_____

Email: _____

Contact Phone numbers:

Home: _____ Cell:_____ Fax:_____

How did you hear of Island Home Care Agency?

Friend Referral:_____ Ad Referral: _____

What towns will you travel to? _____

_____

What Hours are you available? _____

What days are you available?_____

_____

Can you work weekends?_____

Will you treat pediatric patients? _____

In addition to this application packet, we will also need the following documents:

__ Profession License (copy)
__ State drivers license (copy)
__ Social Security card (copy)
__ Physical (within one year current, signed by MD)
__ PPD (within one year current)
__ Titer levels: Rubella and Rubeola
__ Auto Insurance Card (all employees)
__ CPR Certification Card (all employees)
__ Your NPI number and Your Private Provider # (if applicable)

island HOME CARE AGENCY, inc. DRUG & SURGICAL

ANNUAL EMPLOYEE PHYSICAL

PART 1: TO BE COMPLETED BY EMPLOYEE:

NAME: _____ **DATE:** _____

ADDRESS: _____

PHONE: _____ **DOB:** _____

****

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE:

1. Do you require glasses? _____ Hearing aid? _____
2. Have you ever been treated for any disease entity/injury that hampers your ability to function for extended periods? _____
3. Are you presently being treated for any disorders of a chronic or recurring nature (Congenital defect, nervous/mental disorder or other condition) that might hamper job performance? _____
4. Do you have any history of back injury? _____
5. Have you ever been treated for back injury? _____
6. Are you presently being seen by a chiropractor or physician for a back problem? _____.

If yes, please give Name, address and phone number: _____

_____

HEIGHT _____ **WEIGHT** _____

****

MEDICATIONS (*please list all medications prescribed, that you take on a continuing basis)*

_____ _____

_____ _____

_____ _____

ALLERGIES: _____ **SYMPTOMS**: _____

_____ _____

HABITUAL/ADDICTION:

Alcohol _____ Depressants _____ Stimulants _____ Narcotics _____

If yes, please explain: _____

FAMILY HISTORY/HEREDITARY DISEASES:

Coronary Artery Disease _____ Hypertension _____ Cancer _____ Diabetes _____

Renal Disease _____ Alcoholism _____ Sickle Cell Anemia _____ Other _____

****

I have received the Employee Handbook of Island Home Care Agency's Policies and Procedures for in home patient care; including but not limited to;

A. HIV Confidentiality.
B. Standard Precautions.
C. Occupational Infection Risk Reduction and Hepatitis B immunization for Healthcare workers.
D. Identification of patient abuse/neglect.
E. Emergency Disaster Preparedness
F. Identifying a Clandestine Methamphetamine Laboratory in the home

I have read and understand the aforementioned policies.

I am free from any habituation to alcohol, depressants, stimulants, narcotics or any other substances that may alter my behavior.

ALL OF THE QUESTIONS ANSWERED BY ME AND INFORMATION GIVEN BY ME HAVE BEEN ANSWERED AND OFFERED TRUTHFULLY TO THE BEST OF MY KNOWLEDGE. [ ] YES [ ] NO

Employee Signature: _____ ***Date:*** _____

(over)

****

Part II: TO BE COMPLETED BY QUALIFIED EXAMINING CLINICIAN *

*Island Home Care policy at present is mandatory first physical must be done by a physician/nurse practitioner within one year prior to date of hire. All following physicals can be done by a Registered Nurse Clinician and are to be done annually. Employee physical must be within the regulations as specified by the New York State Department of Health: DOHM 86-47 and 86-51, DOHM 81-51, DOHM 86-39, as set forth in 10NYCRR Section 400.10 and DOHM 87-47 and DOHM 88-1. Updates on immunizations will be done according to Department of Health Requirements, Mantoux and lab values.

****

GENERAL PHYSICAL FINDINGS:

Blood Pressure: _____ Pulse: _____ Respirations:_____Heart: _____

Lungs:_____ GI_____ GU_____ Neuromuscular _____

****

IMMUNIZATION TITRES:

	DATE	TITRE	RESULTS
MUMPS	_____	_____	_____
MEASLES	_____	_____	_____
RUBELLA	_____	_____	_____

Employee is free from fever, cough, runny nose, conjunctivitis, , Koplik spots [small bluish white spots surrounded by a reddish area] on the gums or in buccal cavity, or descending rash which fades in the same order it appeared after approximately 5 days.
_____[initial]

****

TUBERCULOSIS:

LOT # _____ DATE GIVEN _____ DATE READ _____RESULTS_____

FOLLOW UP FOR ANY POSITIVE RESULTS:

CXR: DATE: _____ RESULTS: _____

TB SCREENING:

1. HAVE A COUGH FOR > 3 WEEKS _____ 2. LOSS OF APPETITE:_____ 3. UNEXPLAINED WT LOSS:_____

4. NIGHT SWEATS: _____ 5. BLOODY SPUTUM:_____ 6. HOARSENESS:__ 7. FEVER: _____

8. FATIGUE: _____ 9. CHEST PAIN:_____

****

THIS PERSON [ ] IS [ ] IS NOT CAPABLE OF PERFORMING DUTIES.

FOLLOW UP RECOMMENDATION WITH REASON(S) (IF APPLICABLE) : _____

_____

_____

QUALIFIED CLINICIAN'S* NAME: _____LICENSE:_____

SIGNATURE: _____DATE:_____

HR/phys/8/09gtl

island
HOME CARE AGENCY, INC.
DRUG & SURGICAL

REFERENCE REQUEST

Applicant's Name: ____

Position Held: ____

Dates______________________________To______________________________

I hereby release from liability the person completing this form, and authorize them to release all information regarding my relationship with them.

Name of Employer: ____

Applicant's Signature______________________________Date______________________

The above named person has applied to us for employment stating that he/she was previously in your employ. Please verify the above information and provide us with the information listed below. Thank You.

Is Above Employment Information Correct? Yes _______________No _______________

Would You Rehire? Yes _________________ No _______________________

	POOR	FAIR	VERY GOOD	EXCELLENT
Dependability/Attendance				
Cooperation				
Quality Of Work				
Initiative				
Accepts Supervision				

Does employee have history of back injury or chronic back problems? Yes_____________ No_________

Has employee put in for a disability claim due to back injury, to your knowledge? Yes________ No_________

Reason for leaving ____

Comments____

____

____

Signature______________________________Date______________________

Title____

Thank You!

Hr/reference/0692JLDL

island
HOME CARE AGENCY, INC.

REFERENCE REQUEST

Applicant's Name: _____

Position Held: _____

Dates_____To_____

I hereby release from liability the person completing this form, and authorize them to release all information regarding my relationship with them.

Name of Employer: _____Contact Phone #_____

Applicant's Signature_____Date_____

The above named person has applied to us for employment stating that he/she was previously in your employ. Please verify the above information and provide us with the information listed below. Thank You.

Is Above Employment Information Correct? Yes _____**No** _____

Would You Rehire? Yes _____ **No** _____

	POOR	**FAIR**	**VERY GOOD**	**EXCELLENT**
Dependability/Attendance				
Cooperation				
Quality Of Work				
Initiative				
Accepts Supervision				

Does employee have history of back injury or chronic back problems? Yes_____ No_____

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Reason for leaving _____

Comments_____

_____

_____

Signature_____Date_____

Title_____

Thank You!

Hr/reference/0692JLDL

193 Montauk Hwy • PO Box 244 • Speonk, NY 11972 • 631-289-6223 Fax 631-289-7473

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