PNC Palliative Hospice LLC

APPLICATION FOR EMPLOYMENT

NAME: ________________________________ DATE: ______________

OTHER NAME USED IN EMPLOYMENT: ______________________________

REFERENCES SENT 1__________ 2__________ RECEIVED 1________ 2________

POSITION DESIRED: ______________________________________

STATE LICENSE #: ____________________ EXPIRATION DATE: ____________

LAST NAME: ____________ MIDDLE: ____________ FIRST: ______________

STREET ADDRESS: ______________________________________

CITY: ______________ State: ___________ ZIP CODE: ______________

HOME PHONE: ______________________________________

BUSINESS PHONE: ______________________________________

AVAILABLE: FULL TIME: ________ PART TIME: ________ CONTRACT: __________

SHIFTS WILLING TO WORK: DAY: ______ EVENING: ______ WEEKEND: _______

ARE YOU LEGALLY ELIGIBLE TO WORK IN THE USA: YES: ________ NO: _______

IF ON A VISA, WHAT TYPE? ______________________________________

SOCIAL SECURITY #: ______________________________________

DRIVERS LICENSE #: ______________________________________

EXPIRATION DATES: Health Care: _______________ CPR Card: _______________

ACLS CERTIFICATION DATE: ______________________________________

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES: _______ NO: _______

Conviction of a crime is not an automatic bar to employment, other factors such as the nature and date of the crime will be taken into consideration.

IF YES, GIVE DATE AND DETAILS: ______________________________________

____

____

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EDUCATION

Type of School:	Name and Location	Major	Degrees Obtained & Date:
High School			
College			
Other Education or Special Training			
Other Education or Special Training			

WORK EXPERIENCE

Date:	EMPLOYER & FULL ADDRESS LAST OR CURRENT	TYOE OF BUSINESS	POSITION HELD		REASON FOR JOB CHANGE
From:			Position	Work Phone:	
To:			Superior & Title	Starting Pay:	
				Final Pay:	

DESCRIBE DUTIES/RESPONSIBILITIES:____

Date:	EMPLOYER & FULL ADDRESS LAST OR CURRENT	TYOE OF BUSINESS	POSITION HELD		REASON FOR JOB CHANGE
From:			Position	Work Phone:	
To:			Superior & Title	Starting Pay:	
				Final Pay:	

Date:	EMPLOYER & FULL ADDRESS LAST OR CURRENT	TYOE OF BUSINESS	POSITION HELD		REASON FOR JOB CHANGE
From:			Position	Work Phone:	
To:			Superior & Title	Starting Pay:	
				Final Pay:	

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I certify that the information on this application is correct and I understand that any misrepresentation or omission of any information will result in my disqualification from consideration for employment or, if employed, my dismissal. I understand that this is not a contract, offer, or promise of employment and that if hired, I can be terminated at will, with or without cause, with or without notice, at any time and for any reason, at the option of either **PNC PALLIATIVE HOSPICE LLC.** or myself. I further understand that no supervisor, manager, official of representative **PNC PALLIATIVE HOSPICE LLC.** and its related entities has the authority to enter into an employment contract or make any agreement, orally or writing, contrary to the forgiving.
I have read, understand, and agree to this statement _________ (please initial here).

PNC PALLIATIVE HOSPICE LLC. in considering my application for employment may verify the information set forth on this application, related papers or oral interviews and obtains additional background information relating to my background. I authorize all persons, schools, companies, corporations, law enforcement agencies and doctors to supply any information concerning my background that they may have whether or not it is on their records. I hereby release them and their company from all liability for divulging it. A photographic copy of this authorization shall be as valid as the original. If any of my given information is found to be false or misleading. I understand that I will be subject to dismissal at any time during the period of my employment without liability for wages or salary except such as may have been earned at date of such termination and I agree to hold **PNC PALLIATIVE HOSPICE LLC.** and persons named herein blameless in that event.

I have read, understand and agree to the statement (please initial here). __________

PNC PALLIATIVE HOSPICE LLC. is an equal opportunity employer and does not discriminate in its recruiting in its recruiting, selecting and hiring procedures because of race, color, gender, religion, national origin, age, sexual orientation or disability status nor does it discriminate with regard to Veteran status.

Date: ____________________________ Signed: ____________________________________

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INTERVIEW REVIEW

Applicant Name: ______________________________ Date: _______________

Days and Hours available: M Tu W T F Sa Su

REVIEW:

Personality:	friendly	average	quite
Verbal Skills:	excellent	average	poor
Communicates:	clear	somewhat clear	not very clear
Flexibility:	very flexible	somewhat	not flexible
Skill level:	higher skilled	moderately skilled	lower skilled
Appearance:	professional	semi-professional	not professional

Good Candidate for employment: yes no

Overall Interview:

____

____

____

Interviewer: ______________________________ Date: _______________

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ORIENTATION STATEMENT

This is to verify that I have read, understand, and will comply with all applicable agency policies and procedures.

Employee/ Volunteer Signature	Title	Date

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ORIENTATION

The following orientation will be used for all full-time, part-time and per-diem workers.

TOPIC	**Initil Below**
Agency Mission, Vision and Plan	
Types of Care Provided by the Agency	
Policies and Procedures	
Personnel Policies and Job Descriptions	
Client Rights and Grievance Policy	
Ethics and Confidentiality of Patient Information	
Supervision and Evaluation	
Home Safety (Bathroom, Electrical, Environment, Fire and Hazards)	
Safety Issues in the Home (Including security and Guns in the Home)	
Emergency Preparedness Plan/Actions to Take in the Event of Disaster	
Actions to Take in Unsafe Situations	
Infection control in the Home/Standard Precautions	
Patient Care Responsibilities	
Understanding and coping with Alzheimer's Disease and Dementia	
Identifying and Reporting Abuse, Neglect and Exploitation	
Fraud and Abuse	
False Claims, False Statements and Whistle blowing	
Community Resources	
Quality Assurance	
Documentation- Record keeping including OASIS	
Hazardous Device Reporting	
Reviewed, understands and signed job description	
ID Badge issued	

Print Name: ______________________ Title: ______________________

Signature: ______________________ Date: ______________________

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REFERENCE CHECK FORM

____1ST ____2ND

TO: ____

____

____

Name of Application: ______________________________ (SS#) ______________
applied for employment with our company. Please assist us in making a decision regarding employment that will best benefit this applicant and our organization by providing the requested information below.

Sincerely, ______________________________ Date: ______________

I voluntarily give **PNC PALLIATIVE HOSPICE LLC.** the right to investigate my past and /or present employment and release from all liability or responsibility by all persons, companies, or organizations supplying information.

Applicant Signature: ____

Employment Dates: ____

Eligible for rehire? Yes __________ No__________

Position Held: ____

Final Salary $ ____

Reason for termination/separation: ______________________________

Please rate this individual on the basis of his/her employment with you:

Quality of work __ Exceptional __Satisfactory __Unsatisfactory

Quantity of Work __ Exceptional __ Satisfactory __Unsatisfactory

Ability __ Exceptional __Satisfactory __Unsatisfactory

Attendance __Exceptional __Satisfactory __Unsatisfactory

Reference Information Provided By: ______________________ Job Title: ______________

Verified by: Phone: ______________ Mail: ______________

Verified By: ______________________________ Job Title: ______________

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RECEIPT OF PERSONAL PROTECTIVE EQUIPMENT (OSHA KIT) FORM

I have received the following Personal Protective Equipment (PPE):

_____ Gloves

_____ Gown

_____ Goggles/ Protective Eye Wear

_____ Resuscitation Device

_____ Biohazard Bag

OTHER: ____

____

_____ I decline issuance of PPE equipment as I already have this equipment.

PLEASE NOTE:
REPLACEMENT OF THE ABOVE ARE AVAILABLE AT THE AGENCY OFFICE. I HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE PERSONAL PROTECTIVE EQUIPMENT AND UNDERSTAND THAT IF I TERMINATE MY EMPLOYMENT OR IT IS TERMINATED THAT ALL UNUSED ITEMS MUST BE RETURNED TO THE AGENCY PRIOR TO THE ISSUANCE OF MY LAST PAYCHECK OR A FEE OF $20.00 WILL BE DEDUCTED FROM MY LAST PAYCHECK.

____
EMPLOYEE/VOLUNTERR SIGNATURE AND DATE

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CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION AND CLIENT'S MEDICAL RECORDS

The agency will respect the patient's rights to confidentiality of personal and medical information in accordance with applicable state, federal, and HIPAA regulations. All employees will be provided with information during orientation regarding respect for the patient's privacy and confidentiality of information obtained by the employee during the provision of services and through contact with the client's medical record. Medical records will be secured at the Agency's office in file cabinets. In the event of agency closure, see Agency Closure policy. All office and field-based employees will maintain confidentiality of medical information and records. Access to medical records will be limited to the minimum amount necessary to accomplish the stated purpose according to professional judgement. Records will not be removed from the office. The patient's or designated legal representative's written consent will be required for the release of information as indicated in HIPAA privacy guidelines.

A patient data sheet may be kept in the patient's home for the purpose of communication between all health care providers and family and for quick reference on patient status. Example of items listed might include vital signs, glucose levels, and concerns or problems. The patient and/or authorized family members will be educated by the skilled nurse or therapist upon admission, regarding the confidentiality, any patient protected health information transported to and from patient's homes must be safeguarded according to the agency's policies see transporting of Notes and Other Protected Health Information Policy.

If a patient transfers to another hospice agency or healthcare setting, a transfer form will be utilized per policy, Prior to beginning employment, personnel will be requested to sign an "Agreement of Confidentiality" attesting to their understanding of and agreement to maintenance of confidentiality of all protected health information and other privacy and security requirements required by HIPAA.

AGREEMENT OF CONFIDENTIALITY

I, ______________________________ understand that in the performance of my duties, I may have contact with sensitive and confidential information about patients' receiving services from the Agency. I will respect each patient's right to privacy and will hold in confidence any privacy or medical information of which I may become knowledgeable of in carrying out my assigned duties.

I further understand that should I fail to honor confidential information about patients, other employees, or the agency, such breach of confidentiality may be cause for my termination of employment with the agency and potentially, expose me to fines and other sanctions defined in the enforcement section of the HIPAA regulations.

Signed: ____ Date: ________________________

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EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the policy.
I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the Term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all service provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meeting and in-service training. Home health aides are required to have 12 hours of in-service training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services as required by law. Information may be used in statistical or other summary form or for clinical purpose only if the identity of the individual is not disclosed. I understand the violation of client/ employee confidentiality is subject to civil and criminal penalties.
If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company in an "At Will" organization and may hire and fire at will.

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Employee Signature: ______________________________ Date: ________________

JOB ACCEPTANCE STATEMENT

I have read, understood and agree to the terms specified in the job description for the position I presently hold. A copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Employee Signature: ______________________________ Date: ____________________

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NOTICE REGARDING WORKER'S COMPENSATION

This is to notify you that our agency does not provide Worker's Compensation insurance. Please sign below indicating that you have read this information.

Employee Signature: ______________________________ Date: ________________

Witness Signature: ______________________________ Date: ________________

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TB TARGETED MEDICAL QUESTIONNAIRE

To be completed by employee/volunteer:

Name: ______________________________ SSN: ____________________ (Please Print)

		YES	NO
1.	Have you ever had a positive TB skin test, or history? Of TB infection?	____	____

If the answer is yes, please answer the following:

		YES	NO
2.	Have you ever had the BCG vaccine?	____	____
3.	Do you have prolonged or recurrent fever?	____	____
4.	Have you recently lost weight?	____	____
5.	Do you have a chronic cough?	____	____
6.	Do you cough up blood?	____	____
7.	Do you have sweating at night?	____	____
8.	Do you have any of the following risk factors, which may Substantially increase the risk of tuberculosis?	____	____

_____a. Silicosis (Lung Disease)
_____b. Gastrectomy
_____c. Intestinal Bypass
_____d. Weight 10% or more below ideal body weight
_____e. Chronic Renal Failure
_____f. Diabetes Mellitus
_____g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy
_____h. Hematologic disorder (i.e. leukemia or lymphoma)
_____i. Exposure to HIV or aids
_____j. Other malignancies

Employee/Volunteer Signature: ______________________________ Date: ____________

To be completed by the Nurse:

Date PPD applied: ______________________ By: ____________________
Date PPD Read: ______________________ By: ____________________
Result: ______________________________ mm Induration
CXR Indicated? ____________________
Date of CXR: ________________ Result: ____________________
Signature of Nurse: ______________________________ Date: ____________

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Hepatitis B Vaccine Consent Form

Hepatitis B infection is caused by the Hepatitis B virus, which causes death in 1% to 2% of patients. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carriers od the virus. Most of these people have no symptoms, but can continue to transmit the disease to other. The healthcare provider is at an increased risk for acquiring this infection.

Hepatitis B vaccine (recombinant) is available and requires three injections for adequate response, although some persons may not develop immunity even after three doses. The duration of immunity is unknown at this time. The vaccine has been tested extensively for safety and efficiency in large-scale clinical trials with human subjects.

Engirex-B is a non-infectious recombinant DNA Hepatitis B vaccine. It contains purified surface antigen of the virus obtained by culturing a genetically engineered yeast cell, which carries the surface antigen gene of the Hepatitis B virus. The Product contains no more than 5% yeast protein.

The Vaccine side effects are very low. Tenderness and redness of the injection sire and low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. I should not take this vaccine if pregnant or nursing because effects at this time are unknown. I further understand that I should not take this vaccine if active infection is present, an allergy to this compound is known, or if hypersensitive to yeast.

****

I have read the above statement, and have had the opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccine. I understand that as an exposure prone health- care worker. I am being offered this vaccine at no charge to me. I understand I must have three doses of the vaccine to confer immunity, however, as with all medical treatment, these is no guarantee that I will become immune or that I will not experience side effects from the vaccine. I request that the vaccine be given to me.

____

Printed Name Employee/Volunteer   Signature of Employee   Title

____

Date signed   Witness

I realize it is my responsibility to return in one (1) and six (6) months after my first dose to complete my vaccination series.

Date Vaccinated	Lot#	Site	Initials	Next Dose Due Week Of	Signature of recipient
1.					
2.					
3.					

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Hepatitis B Vaccine Refusal Form

Hepatitis B infection is caused by the Hepatitis B virus, which causes death in 1% to 2% of patients. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carries of the virus. Most of these people have no symptoms, but can continue to transmit the disease to other. The healthcare provider is at an increased risk for acquiring this infection.

Hepatitis B vaccine (recombinant) is available and requires three injections for adequate response, although some persons may not develop immunity even after three doses. The duration of immunity is unknown at this time. The vaccine has been tested extensively for safety and efficiency in large-scale clinical trials with human subjects.

Engirex-B is a non-infectious recombinant DNA Hepatitis B vaccine. It contains purified surface antigen of the virus obtained by culturing a genetically engineered yeast cell, which carries the surface antigen gene of the Hepatitis B virus. The Product contains no more than 5% yeast protein.

The Vaccine side effects are very low. Tenderness and redness of the injection sire and low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. I should not take this vaccine if pregnant or nursing because effects at this time are unknown. I further understand that I should not take this vaccine if active infection is present, an allergy to this compound is known, or if hypersensitive to yeast.

****

I have had the opportunity to ask questions about the risks and benefits of the vaccine.

I have read the above statement, and have had the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis vaccination at this time. I understand that by declining this vaccine I continue to be at increased risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or body fluids and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ I have previously received a complete series of Hepatitis B vaccine.

Dates: ____________________ ____________________ ____________________

______________________________________ ______________________________________
Printed Name of Employee/ Volunteer Signature

______________________________________ ______________________________________
Date Signed Title

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NURSE AIDE REGISTRY (NAR) AND EMPLOYEE MISCONDUCT REGISTRY (EMR) DOCUMENTATION

Employee Name: ______________________________

The agency must search the nurse aide registry (NAR) and the employee misconduct registry (EMR) when hiring/rehiring and on an annual basis thereafter, for all hospice employees who have direct patient contact or access to patient records. The agency must use the DADS' Employability Status Search website listed below http://www.dads.state.tx.us/providers/employability/esearch.cfm, to verify the applicant is not listed with a finding concerning abuse, neglect, or exploitation or mistreatment of a client of an agency or a facility, or misappropriation of a client's property as required by the Texas Health and Safety Code § 253.008.

A person listed in the EMR will not be offered employment at this agency.

As required by Texas Health and Safety Code § 253.008, the agency shall immediately terminate a person's employment is the agency becomes aware an employee is designated in the NAR or the EMR with:

- A finding concerning abuse, neglect, or exploitation or mistreatment of a client of an agency or a facility, or misappropriation of a client's property; or
- Whose criminal history check reveals conviction of a crime that bars employment or that agency determines is contraindication to employment.

The NAR and the EMR report was verified by Using DADS' Employability Status Search website at http://www.dads.state.tx.us/providers/employability/esearch.cfm ___ Initial ___ Annual

____ No reports were on file.

____ See attached reports

Comments: ______________________________

____

____

Employee Signature: ______________________________ Date: ______________

Supervisor Signature: ______________________________ Date: ______________

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