

ALLIED HOME CARE PERSONNEL FILE REQUIREMENTS

NAME _____

_____ Resume or CV (Curriculum Vitae)

_____ Copy of applicable professional license, certification, registration

_____ Copy of Drivers License

_____ Copy of Social Security Card

_____ Copy of Proof of Auto Insurance

_____ Signed License verification

_____ Signed (2) work-related references

_____ Mantoux skin test (completed no more than thirty days before direct contact)

_____ Copy of pre-employment physical exam (completed 180 days before pt care)

_____ Signed Hepatitis B Vaccine Statement

_____ Signed Health Status Statement

REFERENCE CARD

Because we care so much about pleasing our clients, we are asking you to help...

The applicant named below has applied for a position with Home Based Rehab and has listed you as a previous employer. We would appreciate your assistance in verifying this applicant's employment and in evaluating his/her job performance so that we can maintain our high standards. All information provided will be held in strict confidence. Thank you.

1. Does the information below correspond with your records? Yes No If No, please give correct information:

2. Would you rehire this employee? Yes No If No, please explain.

3. FOR SKILLED PERSONNEL – If applicable

I certify that the applicant has had experience in:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> TPN | <input type="checkbox"/> IV Chemotherapy | <input type="checkbox"/> IV Antibiotic Therapy | <input type="checkbox"/> Blood Draw – Peripheral/Central |
| <input type="checkbox"/> Hickman/Broviac/Ports | <input type="checkbox"/> Urokinase | <input type="checkbox"/> PICC Insertion | <input type="checkbox"/> Mechanical Ventilators |
| <input type="checkbox"/> IV Pain Management/CADD Pumps | <input type="checkbox"/> Peripheral IV Insertion | | |

4. FOR PARAPROFESSIONAL PERSONNEL – If Applicable

I certify that the applicant has had experience in the following under RN supervision:

- Home Health Aide Skills and/or Personal Care Aide Skills

5. EVALUATION:

| Criteria | Excellent | Good | Average | Poor | Criteria | Excellent | Good | Average | Poor |
|-----------------|-----------|------|---------|------|---------------------|-----------|------|---------|------|
| Attendance | | | | | Job Knowledge | | | | |
| Punctuality | | | | | Accepts Supervision | | | | |
| Depend-ability | | | | | Approp. Attire | | | | |
| Quality of Work | | | | | Caring Demeanor | | | | |

6. **COMMENTS:** _____

Name of Institution/Company or Patient

Signature Title Date

BELOW TO BE COMPLETED BY APPLICANT

Applicant Name (Print) Social Security Number

Previous Employer Full Address

From To

Dates of Employment Approx. # of Hrs Per Week Position(s) Held

Reason For Leaving Wage Rate

I hereby authorize you to disclose all and any information concerning my employment with your firm to BEST HOME CARE. I understand this is in accordance with all applicable Federal and State laws.

Signature of Applicant Date

HEPATITIS B VACCINE STATEMENT

DECLINATION

Employee Name (Please Print)

Social Security Number

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. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If 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.

Employee Signature

Date

CONSENT

Name of Person to Receive Vaccine (Please Print)

Social Security Number

I have read the Fact Sheets “Bloodborne Facts: Hepatitis B Vaccination-Protection For You” and Hepatitis B Virus Vaccine”. I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccination. I understand that I must have three doses of vaccine to confer immunity; however, as with any medical treatment, there is no guarantee that I will become immune and/or will not experience an adverse side effect from the vaccine. I voluntarily agree and consent to be vaccinated with the Hepatitis B vaccine and hold ALLIED HOME CARE, its employees, and agents harmless for any adverse effect from such vaccination.

Signature of Employee

Date

LICENSE VERIFICATION

| | |
|--------------------------------------|--|
| E M P L O Y E E | Name: _____ |
| | License/Certification Number: _____ |
| | Maiden Name: _____ |
| | Authorization: I hereby authorize the State to verify and provide information regarding my professional license/certification to ALLIED HOME CARE. |
| | Signature: _____ Date: _____ |

| | |
|--|---|
| B O A R D O F N U R S I N G | The above name and license /certification number is correct: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | The above license/certification is current: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | The above license/certification has legal action pending: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If yes, please explain: _____ _____ |
| | Name of authorized State Licensing Agency/Department: _____ _____ |
| | Authorized Representative Signature _____ Date _____ |

ALLIED HOME CARE
Medical Coordinator Signature

HEALTH INFORMATION STATEMENT

PERSONAL HISTORY: *(TO BE COMPLETED BY EMPLOYEE)*

Have you had or do you have any of the following conditions? (Check all that apply)

| | |
|--------------------------|-------------------------|
| 1. Arthritis | 11. Hepatitis |
| 2. Asthma | 12. Hernia |
| 3. Back Trouble | 13. High Blood Pressure |
| 4. Convulsions | 14. Low Blood Pressure |
| 5. Diabetes | 15. Mental Illness |
| 6. Difficulty Hearing | 16. Rheumatic Fever |
| 7. Difficulty Seeing | 17. Severe Headaches |
| 8. Fainting/Dizzy Spells | 18. Stomach Ulcers |
| 9. Goiter | 19. Venereal Disease |
| 10. Heart Trouble | 20. C.O.P.D. |

Please explain any condition(s) circled:

History of accidents, fractures, illness, operations:

Are you now taking medications prescribed by a physician? Yes No

If YES, what: _____

Have you ever had an illness caused by any type of work? Yes No

If YES, please explain _____

Comments: _____

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS ASSESSMENT IS NOT FOR DIAGNOSIS / TREATMENT, NOR DOES IT REPLACE MY ANNUAL PHYSICIAN'S MEDICAL EXAMINATION.

Employee Signature

Date