

APPLICATION

AllCare Health Services



Please complete this application as completely and accurately as possible

PERSONAL INFORMATION

Name: Last First Middle

Address

City State Zip Code

Are you over the age of 18? YES NO

Are you a US Citizen? YES NO If no, do you have the legal right and necessary documents to work in the US? YES NO (Identify and employment eligibility will be verified as required by law.)

Today's Date _____

Social Security Number _____

Home Telephone Number _____

Cell Phone Number _____

Nursing License Number _____

E-mail address: _____

GENERAL INFORMATION

Position desired _____ Part time Full time Shift Preference _____

Salary Requirement _____ Date available for work _____

Do you possess a valid driver's license? YES NO Driver's License Number _____

Do you have your own reliable transportation? YES NO

Have you applied at AllCare Health Services before? YES NO If so, when? _____

How were you referred to us? Classified adv. Where did you see the adv.? _____

MediQuest employee Please give us their name _____

Other Please tell us _____

QUALIFICATIONS & EXPERIENCE

Education: Did you graduate? _____

High School _____ YES NO _____

College _____ YES NO _____

Nursing School _____ YES NO _____

Technical Training _____ YES NO _____

Languages spoken in addition to English _____

Can you perform all of the job-related functions of the position(s) for which you are applying?
 YES NO If NO, please explain: _____

Do you have your CPR certification? YES NO Expiration date: _____

Why do you want to work for AllCare Health Services?

PAST & PRESENT EMPLOYERS

Current Employer:

Name _____ Phone _____
Address _____ Position _____
_____ Date Started _____
May we contact? YES NO Salary _____ Supervisor _____

Past Employers:

Name _____ Phone _____
Address _____ Position _____
_____ Salary _____
May we contact? Yes No Supervisor _____
Date started _____ Date ended _____ Reason for leaving _____

Name _____ Phone _____
Address _____ Position _____
_____ Salary _____
May we contact? Yes No Supervisor _____
Date started _____ Date ended _____ Reason for leaving _____

REFERENCES (Give work or medical related references. Do not list relatives or personal friends.)

Name _____ Phone _____
Address _____ How I know _____
_____ Years acquainted _____

Name _____ Phone _____
Address _____ How I know _____
_____ Years acquainted _____

Name _____ Phone _____
Address _____ How I know _____
_____ Years acquainted _____

CRIMINAL BACKGROUND INQUIRY

Have you ever been convicted of a crime, other than a minor traffic offense, or pled no contest to a crime ?

Yes No If Yes, please explain. _____

(You will not be denied employment solely because of a conviction record, unless the offense is related to the work for which you have applied.)

EMERGENCY CONTACT

Name _____ Home Phone _____ Work phone _____
Address _____ Relationship to you _____

"I certify that the facts contained in this application are true and complete and to the best of my knowledge and I understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information that they may have, personal or otherwise, and release all parties from all liability for damage that may result from furnishings same to you."

Signature _____ Date _____

AllCare Health Services

Caregivers Confidentiality

This confidentiality agreement is made by and between

AllCare Health Services (employer) and _____ (myself).

No contract regarding the length of employment is created by this agreement. Employee and Employer agree to execute and be bound by this agreement as follows.

Employee acknowledges that:

Employer's business is both highly specialized and competitive. While employee is employed and at all times following the voluntary termination of his or her employment for any reason, the employee shall not discuss or disclose confidential information regarding clients.

The care of our clients is by its very nature personal. Our Home Care staff must hold absolutely confidential any and all information about our clients: address, problems, health issues, financial status, relationships, etc.. Divulging information about our clients during and after employment is considered a gross violation of our company policy and we will take disciplinary action.

(Employee Signature)

(Date)

(AllCare Representative)

(Date)

AllCare Health Services



Agreement to Standards

I, _____ understand that This Agency is a temporary employment service and cannot guarantee any number of hours in any given week. Even if I work a full week, I cannot expect the same number of hours in the following weeks or months. I have been fully advised that after I am employed, I will be terminated if I violate any of the following standards:

1. Verbal and/or physical abuse of any client or employer.
2. Accept an assignment and not notify This Agency that I will not be going to work or not appearing for work on a current assignment without notifying this agency.
3. Excessive lateness or absenteeism; that is, more than two (2) times within a one-month period.
4. Sleep on assignment, unless assignment is a Sleep-Over or a Live-In.
5. Violation of the Confidentiality Policy.
6. Misrepresent reference sources.
7. Misrepresent time worked on an assignment.
8. Take any object or money that belongs to a client of this agency, accept money or gifts from clients, or make long-distance phone calls without permission.
9. Work directly for a client whose services originated with this agency.
10. Use of alcohol or drugs of any kind before or during work schedule.
11. Refusal to comply with assigned duties or dress code on assignment; unsatisfactory job performance.
12. Appear for work accompanied by any other person, ie. take children to work with you.
13. Leave an assignment before scheduled time unless approved by the supervisor.
14. Lack of cooperation.
15. Violation of "Policies for Caregivers" in the Employee Policy Handbook.
16. If I am currently not working on an assignment for This agency I will call this agency each week with the times I am available for assignment. I understand that if I do not call with my availability each week, I will be considered voluntarily unavailable for assignment effective the day following my last assignment.

I hereby agree that, for a period of 90 days after termination of my employment for any reason, I will not accept employment, directly or indirectly, by or from any client of this agency for whom I performed services while working for this agency.

I hereby acknowledge that I understand this agency's *Agreement to Standards*, and I received a copy of This agency's *Agreement to Standards* which states grounds for termination.

Employee: _____ Witness: _____

Date: _____

**FLU VACCINE
CONSENT FORM**

I, _____, have been provided with information regarding flu vaccine. I acknowledge that if I consent to a flu vaccine this agency would not be responsible for providing the vaccine. I understand that there is no guarantee that I will experience an adverse side effect from the vaccine. I will hold harmless this agency in the event I have an adverse reaction.

FOR WOMEN

I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the vaccine is not known on a developing fetus.

Signature of Recipient

Date

Social Security Number

Signature of Witness

Date

**FLU VACCINE
DECLINE TO ACCEPT FORM**

I have been provided information the flu vaccine. I do not wish to receive the flu vaccine at this time and hold harmless this agency. However, I reserve the right receive the vaccine at a future date.

Signature of Employee

Date

Social Security Number

Signature of Witness

Date

Authorization for Direct Deposit

This authorizes AllCare Health Services (the “Company”) to send credit entries (and appropriate debit and adjustments entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the “Account”). This authorizes the financial institution holding the Account to post all such entries.

Account # 1

ACCOUNT TYPE (e.g. Checking or Savings)

EMPLOYEE BANK NAME

BRANCH

CITY, STATE

ROUTING NUMBER

ACCOUNT NUMBER

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

SIGNATURE

PRINTED NAME

SOCIAL SECURITY NUMBER

DATE

Availability Sheet

Name: _____

Phone: _____

CNA: YES NO

SSN: _____

DOB: ____-____-____

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday