CHECKLIST

Amazing Home Healthcare

Name_____

Phone Number_____ **Date**_____

**********Do not write below this line**********

	Item	Checked	Expiration
1.	Application	☐	
2.	Character Reference Check Form	☐	
3.	CJIS Results Background Check (BCHC)	☐	
4.	RN License	☐	
5.	LPN	☐	
6.	MedTech	☐	
7.	CNA	☐	
8.	GNA	☐	
9.	Proof of Age (Driver's License, State ID, Passport)	☐	
10.	Copy of Social Security Card	☐	
11.	CPR	☐	
12.	First Aid	☐	
13.	Physical Test/PPD Test	☐	
14.	HB Vaccination Form	☐	
15.	MAS Form for Medication Providers	☐	
16.	Skills Assessment/Demonstration	☐	
17.	Tax Documentation	☐	
18.	Verification of Prior Employment	☐	
19.	Contract	☐	
20.	I-9 Form	☐	
21.	Confidential Agreement	☐	
22.	Resume	☐	
		☐	

Verified By (Office Staff)_____

Date_____

APPLICATION FOR EMPLOYMENT

AMAZING HOME HEALTH CARE **is An Equal Opportunity Employer**

We do not discriminate on the basis of age over 40, race, sex, color, religion, national origin, disability, or any other applicable status protected by state or local law. It is our intention that all qualified applicant be given equal opportunity and that selection decisions be based on job-related factors.

Each question should be fully and accurately answered. No action can be taken on this application until all questions have been answered. Use blank paper if you do not have enough room on this application. PLEASE PRINT, except for signature on back of application. In reading and answering the following questions, be aware that none of the questions are intended to imply illegal preferences or discrimination based upon non-job-related information.

Job Applied For (PCP, RN, Secretary, CNA, etc.) _____ Today's Date _____/_____/_____

Are you seeking: Full-time ☐ Part-time ☐ Temporary ☐ employment? When could you start work? _____

_____ _____ _____ (_____) _____-_____

Last Name First Name Middle Initial Telephone Number

_____ _____ _____ _____

Present Street Address City State Zip Code

Are you 18 year of age or older? Yes ☐ No ☐ (If you are hired you may be required to submit proof of age.)

Social Security # _____-_____-_____ If hired, can you furnish proof you are eligible to work in the U.S.? Yes ☐ No ☐

Have you ever applied here before? . . . . . Yes ☐ No ☐ If yes, when? _____

Were you ever employed here? . . . . . Yes ☐ No ☐ If yes, when? _____

Have you ever been convicted of any law violation (except a minor traffic violation)? . . . . . Yes ☐ No ☐

If yes, give details: _____
(A "Yes" answer does not automatically disqualify you from employment, since the nature of the offense, date, and the job for which you are applying will also be considered.)

Are you now or do you expect to be engaged in any other business or employment? . . . . . Yes ☐ No ☐

If yes, please explain: _____

For Driving Jobs Only: Do you have a valid driver's license? . . . . . Yes ☐ No ☐

Driver's License Number _____ State of License: _____ Class of License _____
Have you had your driver's license suspended or revoked in the last 3 years? . . . . . Yes ☐ No ☐

If yes, give details: _____

List professional, trade, business or civic activities and offices held. (Exclude labor organizations and memberships which reveal age over 40, race, sex, color, religion, national origin, disability or other protected status.) _____

LIST NAME AND ADDRESS OF SCHOOLS	# of Years Completed	Diploma/ Degree/ Certificate	Subjects Studied
High School or GED _____	_____	_____	_____
College or University _____	_____	_____	_____
Vocational or Technical _____	_____	_____	_____

What skills or additional training do you have that are related to the job for which you are applying? _____

_____

What machines or equipment can you operate that are related to the job for which you are applying? _____

_____

Initials: _____

List names of employers in consecutive order with present or last employer listed first. Account for all periods of time including military service and any periods of unemployment. If self-employed, give firm name and supply business references. **PLEASE GIVE MONTH AND YEAR.**

NAME OF EMPLOYER	JOB TITLE AND DUTIES	
ADDRESS	DATES OF EMPLOYMENT: FROM TO	
CITY, STATE, ZIP CODE	PAY: START $ FINAL $	
SUPERVISOR	TELEPHONE	REASON FOR LEAVING
NAME OF EMPLOYER	JOB TITLE AND DUTIES	
ADDRESS	DATES OF EMPLOYMENT: FROM TO	
CITY, STATE, ZIP CODE	PAY: START $ FINAL $	
SUPERVISOR	TELEPHONE	REASON FOR LEAVING
NAME OF EMPLOYER	JOB TITLE AND DUTIES	
ADDRESS	DATES OF EMPLOYMENT: FROM TO	
CITY, STATE, ZIP CODE	PAY: START $ FINAL $	
SUPERVISOR	TELEPHONE	REASON FOR LEAVING
NAME OF EMPLOYER	JOB TITLE AND DUTIES	
ADDRESS	DATES OF EMPLOYMENT: FROM TO	
CITY, STATE, ZIP CODE	PAY: START $ FINAL $	
SUPERVISOR	TELEPHONE	REASON FOR LEAVING

Have you worked or attended school under any other name?. . . . . Yes ☐ No ☐

If yes, give names :____

Are you presently employed? . . . . Yes ☐ No ☐

If yes, may we contact your present employer? . . . . Yes ☐ No ☐

Have you ever been fired from a job or asked to resign? . . . . Yes ☐ No ☐

If yes, please explain :____

Give three references, not relatives or former employers.

Name	**Address**	**Phone**
____________________	____________________________	(_____)______-_________
____________________	____________________________	(_____)______-_________
____________________	____________________________	(_____)______-_________

PLEASE READ EACH STATEMENT CAREFULLY BEFORE SIGNING

In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment. I give Amazing Home Health Care permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by Amazing Home Health Care with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, Amazing Home Health Care may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Amazing Home Health Care, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information. In consideration of my employment and of my being considered for employment by Amazing Home Health Care, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either Amazing Home Health Care or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of Amazing Home Health Care, at any time, can constitute a contract of employment. No representative or agent of Amazing Home Care has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing. I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results. I understand that Amazing Home Care is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies Amazing Home Health Care against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

Signature ____ Date ______/_________/__________

This application for employment will remain active for a limited time. Ask the organization representative for details.

EMPLOYEE AVAILABILITY

Please provide the following information on your availability to work for Amazing Home Care.

Type of Transportation you have / will use for home visits: _____

Do you have any allergies that would affect your work at AHHC? □ No. □ Yes.
If yes, please list here: _____

Do you have a problem working with a client who smokes? □ No. □ Yes

How many hours are you willing to work per week? _____

Locations willing to work (circle those that apply, and/or write in additional locations):

Baltimore Baltimore City	**Montgomery**		**Prince George**	**Other**

Please Check (X) the Day and Time of Week You <u>Are Available</u>

	SUN	MON	TUE	WED	THUR	FRI	SAT
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
Overnight							

Initials: _____

HEPATITIS Vaccination Consent Form

By signing this form, employees/contractors acknowledges the following:

1. Due to occupational exposure to blood or potentially infectious materials, employees/contractors may be at risk of acquiring Hepatitis B Virus (HBV) infection.

2. Although Amazing Home Health Care, LLC recommends that employees/contractors obtain the Hepatitis B vaccination series, it is not required; and

3. If employees/contractors so choose, Amazing Home Health Care, LLC will provide employees with Hepatitis B vaccination series at no cost upon hire or in the future should employee/contractor continue to have occupational exposure to blood or other potentially infectious materials.

Please INITIAL the appropriate space:

_____ I have received the Hepatitis B vaccination

_____I have not received the Hepatitis B vaccination and do not wish to receive it. I understand that I continue to be at risk of acquiring Hepatitis B, a serious disease.

_____I would like to obtain the Hepatitis B vaccination series at no cost to me. I agree to obtain the first shot of the series within 10 working days from my request, document the shot on the company Hepatitis B vaccination confirmation form and return it to my office manager within 15 calendar days of request.

_____I had previously requested to obtain the Hepatitis B vaccination series and have changed my mind. I elect to _____ not receive the vaccination_____ not to continue the series.

_____ _____

Employee /Contractor Name

Employee/Contractor Signature

_____ _____

Employee/Contractor Title

Today's Date

ATHC TELEPHONE REFERENCE CHECK FORM - # 1

EMPLOYMENT INFORMATION: ***To be completed by Applicant***

*Name of first Professional Reference To Be Contacted*_____ *Title*_____

*Company Name*_____ *Phone (_____)_____-_____*

Reason for leaving this company: _____

I authorize the company I worked for and/or the individual listed above to release information about me to Amazing Home Care.

_____ _____/_____/_____

Applicant Signature *Date*

*****FOR OFFICE USE ONLY***

EMPLOYMENT VERIFICATION*: **To be completed by employer***

*What was his/her position?*_____ *What were the dates of his/her employment?*_____

What was your relationship to him/her? (e.g., supervisor, co-worker, etc) _____

*What were his/her strengths as an employee?*_____

_____

*How would you rate his/her overall performance?*_____

*If you had an opening today for the same job, would you hire him/her? Why/why not?*_____

_____

Was he/she _____ dependable? *_____ work well with other?* *_____ exhibit initiative?*

*If we were to extend an employment offer, what suggestions would you give us to help contribute toward _____'s success on the job?*_____

_____

Is there anything else you think would be helpful for us to know about _____ in making our hiring decision?

_____

Name of Interviewer:_____ Date:_____/_____/_____

(Form to be filed in employee file. Write any additional information or comments on a separate sheet of paper)*.*

Skills Assessment

Please indicate to us what skills you are competent enough to perform. This means the ability to perform procedures safely, correctly, effectively and professionally. Scale 1-4, where one means least competency and 4 means highest competency.

Task	Have you ever done this before? Please Circle Yes or No	Are you competent performing? Please circle the number	Comments
Bathing	Yes No	1 2 3 4	
Personal Hygiene (i.e. Hair, Oral, Nail and Skin Care)	Yes No	1 2 3 4	
Toileting (i.e. Bladder, Bowel, Bed Pan, Routines etc	Yes No	1 2 3 4	
Dressing & Changing Clothes	Yes No	1 2 3 4	
Mobility & Transfers	Yes No	1 2 3 4	
Eating & Drinking	Yes No	1 2 3 4	
Meal Preparation	Yes No	1 2 3 4	
Light House Keeping	Yes No	1 2 3 4	
Grocery Shopping	Yes No	1 2 3 4	
Transportation/Travelling in the Community	Yes No	1 2 3 4	
Laundry	Yes No	1 2 3 4	
Handling Money	Yes No	1 2 3 4	
Using Telephone	Yes No	1 2 3 4	
Reading specific items	Yes No	1 2 3 4	
Wash Equipment	Yes No	1 2 3 4	
Other:	Yes No	1 2 3 4	

_____ _____

Last Name First Name

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:			
Date of birth:	SSN:	Gender: ☐ Male ☐ Female *(Please check)*	
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*			
Place of Birth:		Citizenship:	
Current address:			
City:		State:	ZIP Code: -
Daytime Phone:	Evening Phone:	Driver's License #:	

AGENCY INFORMATION

Agency Authorization #: 2200000891	
ORI # (if required):	Reason fingerprinted? Pre-Employment
Position Applied for: Caregiver/CNA/LPN/RN/Other	

Request Type: *(Choose one ONLY)*

- ☑ Adult Dependent Care
- ☐ Attorney/Client
- ☐ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: Amazing Home Health Care

Address: 7531 Elioak Terrace

City, State, Zip code: **Gaithersburg, MD 20878**