Extended Hands AL&HC

We reach you where you are

Mailing Address: 921 Town Centre Blvd Ste # 1065 | Clayton, NC 27520
Phone: (919) 585-4904 | (919) 585-5103 FAX

EMPLOYMENT APPLICATION

PLEASE READ CAREFULLY AND PRINT IN INK OR TYPE. Extended Hands Assisted Living & Home Care LLC is an equal opportunity employer and we do not and will not discriminate on the basis of race, religion, national origin, sex, age, marital status, color, creed, sexual orientation, or disability. Information provided on this application will not be used for any discriminatory purpose.

Name (Last): First: Middle:

Address: ZIP:

Home Telephone: Cell Telephone:

Email Address:

Position Applying for: When are you available to start work?

Live-in: ☐ Hourly: ☐ Overnight: ☐ Anytime: ☐ Weekend: ☐ Flexible: ☐

Location desired:

Do you have your own transportation? Health restrictions, if any:

Are you a veteran or military spouse? Yes ☐ No ☐

REFERENCES:

Please list 4 professional references (**not relatives**). Give name and current phone number and relationship to you.
[Example: teacher, co-worker, landlord, doctor, pastor, rabbi, manager/supervisor, business owner, roommate, etc.]

NAME	CURRENT PHONE	RELATIONSHIP
1.		
2.		
3.		
4.		

How did you hear about Extended Hands?

List previous jobs starting with most recent. If you need more room attach another sheet or write on back. It is important to list duties and/or experiences related to home care, nursing or any specific therapy you are qualified for.

EMPLOYER: SUPERVISOR: PHONE:

ADDRESS: ZIP:

FROM: TO: POSITION:

DUTIES:

REASON FOR LEAVING:

MAY WE CONTACT THEM? ☐ Yes ☐ No

****

EMPLOYER: SUPERVISOR: PHONE:

ADDRESS: ZIP:

FROM: TO: POSITION:

DUTIES:

REASON FOR LEAVING:

MAY WE CONTACT THEM? ☐ Yes ☐ No

****

EMPLOYER: SUPERVISOR: PHONE:

ADDRESS: ZIP:

FROM: TO: POSITION:

DUTIES:

REASON FOR LEAVING:

MAY WE CONTACT THEM? ☐ Yes ☐ No

****

EDUCATION:

High School: Did you graduate? ☐ Yes ☐ No Highest grade completed:

Technical/Trade School Location: Major:

College:

Location: Major:

Other Education:

Location: Major:

Certificates:

Professional memberships, certificates or licenses:

Length of experience:

SALARY REQUIREMENTS :

I declare the above information is true and correct and understand that any misrepresentation or omission of facts will be grounds for immediate dismissal. I also understand my employment will be contingent upon receipt of proof of eligibility to work, verification of birth, criminal background check and / or any other pertinent information required by Extended Hands Assisted Living & Home Care LLC to satisfy Federal and State regulations. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision, including checking references of previous employers. I understand the State of North Carolina is an employment "at will" state and the employer can fire any employee for any reason at any time as long as that reason is not illegal.

I understand this application will be kept active for 90 days only.

Signed: Date:

EXTENDED HANDS ASSISTED LIVING & HOME CARE LLC

Mark **only** the skills you can confidently and accurately perform today:

- ☐ Dressing and undressing Client
- ☐ Meal preparation and feeding
- ☐ Bathing (bed and tub/shower)
- ☐ Monitoring vital signs
- ☐ Read all charting and follow care plan
- ☐ Accurate charting
- ☐ Report any changes to Nurse Manager
- ☐ Be familiar with and practice Universal Precautions
- ☐ Be familiar with and follow OSHA regulations and guidelines
- ☐ Be familiar with emergency policies and numbers and be prepared to act when necessary
- ☐ Perform personal hygiene and grooming
- ☐ General housekeeping tasks
- ☐ Assist Client with walking
- ☐ Transfers (bed to chair, chair to walker)
- ☐ Use of bedpans and urinals
- ☐ Care and maintenance of Foley catheter
- ☐ Diabetic blood glucose monitoring
- ☐ Use of oxygen / nebulizer
- ☐ Proper use of Hoyer Lift
- ☐ Medication reminders

Disclosure and Authorization for Background Investigation

I hereby authorize Extended Hands Assisted Living & Home Care LLC (hereinafter referred to as The Company), and the North Carolina Department of Human Services, as directed by The Company, to obtain a consumer report and / or an investigative consumer report for employment purposes. I understand this report may include inquiries regarding my educational background; work history; court records; including criminal as permitted by law; driving history; workers compensation history; immigration status; general reputation; performance; experience; and references obtained from professional and personal associates and other qualities pertinent to my qualifications, for employment, including reasons for termination of past employment. I further understand and agree that a consumer report may be obtained at any time, and any number of times, as The Company in its sole discretion determines is necessary before, during, or after my employment.

Medical and workerôs compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA), and / or any other applicable state laws. The Fair Credit Reporting Act gives you specific rights. If we rely on the report for an adverse action, before taking the adverse action we will give you a pre-adverse action disclosure that includes a copy of the report.

By my signature below, I hereby authorize all previous employers, educational institutions, consumer reporting agencies, and other persons or entities having information about me to provide such information to The Company or other entity, including the North Carolina Department of Human Services, that obtains information for the company. I further fully release The Company, its employees, officers, directors, agents, successors and assigns, and all
other parties involved in this background investigation, including but not limited to the North Carolina Department of Human Services, and its employees, officers, directors and agents, and including all consumer reporting agencies, and those companies or individuals who provide information to the North Carolina Department of Human Services or The Company concerning me, from any claims or actions for any liability whatsoever related to the process or results of the background investigation.

My signature allows a photocopy or fax copy of this authorization to be as valid as the original.

Please **print** the following information:

Name (Last): First: Middle:

Other names you have used :

Home Address:

City: State: Zip:

Social Security Number: Date of Birth:

Driverôs License Number: State:

Signature: Todayôs Date:

DHR-ESB3004
02/01/09

Department of Health and Human Services
Criminal Record Check
Consent Form

RELEASE:

I authorize the North Carolina Department of Justice through the State Bureau of Investigation, Division of Criminal Information to perform a name and/or fingerprint search of the State's criminal history record file and/or the Federal Bureau of Investigation for a national criminal history record check in connection with my suitability to perform work for the Department of Health and Human Services pursuant to N.C.G.S. 114-19.6, N.C.G.S. 114-19.2, N.C.G.S. 143B-146.16 and N.C.G.S.115C-332. In addition, I authorize the North Carolina Department of Health and Human Services to conduct a name check through use of the Administrative Office of the Courts (AOC) data system.

I understand that the North Carolina State Bureau of Investigation, Division of Criminal Information, the Administrative Office of the Courts, DHHS and their officials and employees shall not be held legally accountable in any way for providing this information to DHHS and I hereby release said agencies and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that DHHS cannot release the results of the criminal history record check to me.

I understand failure to consent is just cause to deny or terminate employment and a criminal history may serve as a basis to deny or terminate employment.

Signed _____ Date _____

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I understand that the North Carolina State Bureau of Investigation, Division of Criminal Information, the Administrative Office of the Courts, Extended Hands Assisted Living & Home Care and their officials and employees shall not be held legally accountable in any way for providing this information to Extended Hands Assisted Living & Home Care and I hereby release said agencies and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that Agency cannot release the results of the criminal history record check to me.

I understand that failure to consent is just caused to deny or terminate employment, and a criminal history may serve as a basis to deny or terminate employment.

Signed _____ Date _____

Extended Hands Assisted Living & Home Care LLC

Hepatitis B Vaccination Acceptance or Declination Form

Instructions:

Complete the Employee/ Volunteer/Intern information below. Determine whether or not you wish to receive the vaccine at no charge. Check either the "Acceptance" or "Declination" section and forward it to the agency Compliance Office at admin@extendedhandsassistedlivinghomecare.com

Name: _____ **Agency/Facility Location:**_____

Supervisor: _____ **Date:** _____

I am an: Employee: ☐ Volunteer or Intern: ☐

Please Check One of the Following:

☐ **I Accept the Hepatitis B Vaccination**

I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I acknowledge that I have been provided information on the hepatitis B vaccine (CDC for HpB Vaccinations), including information on its effectiveness, safety, method of administration and the benefits of being vaccinated. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to myself.

I understand that I am responsible for scheduling and keeping my appointments to receive the Hepatitis B vaccine in accordance with the recommended series (three vaccination series; second vaccine one month after first vaccine; and third vaccine within five months of second vaccine). ***See Appendix I below for the process to secure your vaccination.***

☐ **I Decline the Hepatitis B Vaccination**

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM) I may be at risk of acquiring hepatitis B virus (HBV) infection I acknowledge that I have been provided information on the hepatitis B vaccine, including information on its effectiveness, safety, method of administration and the benefits of being vaccinated. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to myself. However, I decline the hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Please check one of the following if you are declining:

☐ I am declining because I have previously completed the hepatitis B vaccination series.

☐ I am declining because I choose not to have the hepatitis B vaccination series. I am also aware that I may change my mind at a later date.

_____

Employee/Volunteer/Intern Signature Date

Appendix I

1. If you have checked the "I Accept the Hepatitis B Vaccination," please contact Extended Hands Assisted Living & Health Care LLC's Office to schedule your appointment.

2. After you receive proof of vaccination, present it to your supervisor and the Administrative Office.

REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ Date of Birth _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____
_____
_____