NAME:**EXHIBIT A - Employment Application**

❑RN ❑ LVN/LPN ❑ Therapist ❑Other

Date References Sent: 1 2 3 4

❑ Phone ❑ Mail ❑Phone ❑Mail ❑Phone ❑Mail ❑Phone ❑Mail

Date References Received: 1 2 3 4

❑ Phone ❑ Mail ❑Phone ❑Mail ❑Phone ❑Mail ❑Phone ❑Mail

PERSONAL

Name Preferred Name Social Security # Date

Street Address

City State Zip

Home Phone Number Alternative Phone Number Work Phone Number

License No. State Other Licenses (States)

What other home care/nursing services are you registered with

Transportation Do you have a valid Driver's License? ❑Yes ❑No

How did you learn about Empowering Care?

All persons shall have the opportunity to be considered for employment without regard to their race, color, religion, national origin or ancestry, age, disability, sex, marital status, liability for service in the armed forces of the United States, citizenship, or any other characteristic protected by law.

EDUCATION

SCHOOL NAME AND CITY	YEARS ATTENDED	GRADUATED	DEGREE AWARDED
Vocational/Technical		❑ Yes ❑ No	
Hospital		❑ Yes ❑ No	
College/University		❑ Yes ❑ No	
Post Graduate		❑ Yes ❑ No	
Additional Education		❑ Yes ❑ No	

PROFESSIONAL REFERENCES (List the names of two Licensed Nurses; exclude relatives or former employers.)

Name	Address	Telephone Number

WORK HISTORY (Please list in order, present or last employer first.)

1. Name Phone	2. Name Phone
Address	Address
Job Title Salary	Job Title Salary
Your work name if different	Your work name if different
Dates Worked: From To Hrs/Wk	Dates Worked: From To Hrs/Wk
Supervisor Shift	Supervisor Shift
Duties	Duties
Reason for leaving	Reason for leaving
3. Name Phone	4. Name Phone
Address	Address
Job Title . Salary	Job Title Salary
Your work name if	Your work name if

different	different
Dates Worked: From To Hrs/Wk	Dates Worked: From To Hrs/Wk
Supervisor Shift	Supervisor Shift
Duties	Duties
Reason for leaving	Reason for leaving

Please explain any gaps in employment

EXPERIENCE (Please check areas of experience and skills in appropriate blocks. Do not include school experiences.)

AREA	EXPER IN LAST 3 YEARS	CERT	AREA	EXPER IN LAST 3 YEARS	CERT	AREA	EXPER IN LAST 3 YEARS	CERT	AREA	EXPER IN LAST 3 YEARS	CERT
AIDS			IV Therapy			Nursing Home			Recovery Room		
Bums			Labor & Delivery			OB/Gyn			Rehabilitation		
CCU			Medical Floor			Oncology			Surgical Floor		
Charge			Medicare Home Care			Operating Room			Telemetry		
Dialysis			Medications			Orthopedics			Total Patient Care		
Doctor's Office			Neonatal CCU			Pediatrics			Urology		
Emerg Room			Newborn			Pediatric ICU			Ventilators		
Home Care			Neurological			Preemie Nursery			Other (Describe)		
ICU			Nursery			Private Duty in Facility					
Industrial Nursing			NICU			Psychiatric					

EXPERIENCE (Please check areas of experience and skills in appropriate blocks. Do not include school experience.) (Continued)

SKILL	EXPER IN LAST 3 YEARS	CERT	SKILL	EXPER IN LAST 3 YEARS	CERT	SKILL	EXPER IN LAST 3 YEARS	CERT	SKILL	EXPER IN LAST 3 YEARS	CERT
Assessments			Hickman			Landmark Catheters			Suprapubic Catheter		
Blood Admin			Heal Conduit			NG Tube Feeding			TPN/Lipids		
Blood Draws			N Chemo Admin			Ostomy Management			Trach Care		
Epidural			IV Pumps			Peripheral IV Starts			Tube Feeding Pump		
G-Tube/ G-Button Feeding			Types			PICC			Types		
Groshong						Port-A-Cath					

First day available for work Amount of work wanted per week

Please complete the Supplemental Employment Questionnaire.

ACKNOWLEDGEMENT (Please read carefully and sign)

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 the Company permission to use any information in this application to enable it and its agents to verify the information contained in this application, and I authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by the Company 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 with the Company, Empowering Care may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release the Company, its agents, and all affiliated entities, as well as any person or institution that provides the Company with 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 Empowering Care I agree to abide by all Company rules and regulations, which I understand are subject to change by the Company 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. I understand that either the Company 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 the Company, at any time, can constitute a contract of employment. No representative or agent of the Company other than the Director of Human Resources, by either written or mutually signed agreement, has the authority to enter into any agreement for employment for any specific period or to make any agreement contrary to the foregoing.

In addition, I understand that the Company and all compensation and benefit plan administrators have the maximum discretion permitted by law to administer, interpret, modify, discontinue, enhance or otherwise administer, interpret or change all policies, procedures, benefits or other terms and conditions of employment.

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 applicable laws.** If I receive an offer of employment at the request of the Company and if one is given, I agree that my continued employment may be contingent on the results.

I agree, in consideration of your employing me that I will not seek or accept employment, either directly or indirectly in any capacity from any client to whom I have been assigned, for at least thirty (30) working days after the last day of that assignment. I also agree that I will not solicit these clients on my behalf nor on behalf of any future employer(s). I further understand that I cannot be paid until I present a time slip signed by both the client and me to the Empowering Care office.

I understand that Empowering Care does not provide auto insurance coverage for me and that I am not to transport patients in my automobile, nor am Ito drive patients in the patient's automobile without written consent from the Empowering Care office.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature Date

EXHIBIT B—Supplemental Employment Questionnaire

SAMPLE—

NAME:

LAST FIRST MIDDLE

In reference to question #1, to be considered "qualified" under the Americans with Disabilities Act, an applicant must be able to perform the essential functions of the job, with or without reasonable accommodation. "Reasonable Accommodation" is a modification or adjustment to a job, the work environment, or the way things usually are done that enables a qualified individual with a disability to enjoy equal employment opportunity. After reviewing the attached job description:

1. Can you perform the essential functions of the position for which you have applied, with or without accommodation by the Company?
   Yes No

   If you answered "No", please identify what job functions you cannot perform, with or without an accommodation by the Company.

2. Are you currently engaged in any illegal use of drugs which would prevent you from safely performing the essential functions of Your job? Yes No

   If yes, please explain:

3. Have you ever been convicted of a crime? Yes No

   If yes, please explain:

4. Have you ever been employed by Empowering Care? Yes No

   If yes, state which offices and dates:

- Has your license or certification ever been under investigation or had disciplinary action taken against it? Yes No

  If yes, please explain:

- Is your license or certification currently being investigated or having disciplinary action taken against it?
  Yes No

  If yes, please explain:

*** A** yes **answer to either question will not necessarily disqualify me for a position with Empowering Care**

Notice to Applicants: We will comply with the Texas Human Resources Code (106.001) to submit applicant information to the Dept. of Human Services for the purpose of investigating your criminal conviction history, if any exists, prior to making an offer of permanent employment. Any offer of temporary employment, and continued employment, is contingent upon satisfactory completion of this criminal conviction investigation.

I certify that the information herein is complete and true and correct and that any material omission or misrepresentation shall be enough cause for dismissal.

SIGNATURE: DATE:

EXHIBIT C—License or Certification Verification Form

LICENSE \ CERTIFICATE VERIFICATION FORM

❑ Certificate ❑ License ❑ Registration

Classification: ❑ RN ❑ LPN/LVN ❑ PT ❑ OT ❑ ST ❑ MSW

❑ PTA ❑ OTA ❑HHA ❑CAN ❑PCA ❑ PCW

Name: Other Name:

Social Security Number:

License Number: State: Expiration Date:

How was the license obtained? ❑ Examination ❑ Reciprocity ❑ Other

Visually Verified by:

Client Service Staff Date

Supervising RN Date

VERBAL VERIFICATION

Name of State Agency:

Person Giving Verification

Name Title Date

Confirmation # (required by California)

Pending Investigation ❑ Yes ❑ No Restrictions ❑Yes ❑ No

Comments:

Signature:

Empowering Care Representative/ Title Date

NOTE: WHEN VERBAL VERIFICATION IS UNAVAILABLE THE -REQUEST FOR LICENSURE VERIFICATION" SECTION OF THIS FORM MUST BE COMPLETED BY THE STATE.

REQUEST FOR LICENSURE VERIFICATION

The above-named person has applied to Empowering Care for employment. Please verify the following information about the applicant, complete this portion of the form and return it in the envelope provided, as soon as possible.

STATE AGENCY COMPLETES

Pending Investigations ❑ Yes ❑ No Restrictions ❑ Yes ❑ No

If YES Explain

Signature:

Title Date

Thank you for your cooperation.

Sincerely yours,

Date

Exhibit D—Skills Checklist: Licensed

SKILLS CHECKLIST: LICENSED

Name: Office:
Classification: Date:

Skill	P	O	NE	Skill	P	O	NE
Special Therapeutic Nursing Care				**Line Therapy**			
Administration of Rectal Suppositories	☐	☐	☐	Administration of Medications through Groshong Catheter	☐	☐	☐
Application of a Leg Bag	☐	☐	☐	Application of Extension Tubing to Hickman or Broviac Catheter	☐	☐	☐
Application of Polyurethane Dressing for Partial Thickness Wounds	☐	☐	☐	Blood Administration	☐	☐	☐
Application of Transparent Wound Dressings	☐	☐	☐	Cap change for Hickman or Broviac Catheter	☐	☐	☐
Application of Unna's Boot	☐	☐	☐	Central Line Dressing Change	☐	☐	☐
Arteriovenous Fistula & Shunt Dressing Change	☐	☐	☐	Dressing Change to Groshong Catheter Site	☐	☐	☐
Assessment & Management of Open Wounds	☐	☐	☐	Hickman or Broviac Catheter Irrigation	☐	☐	☐
Blood Glucose Testing Devices	☐	☐	☐	Home Antibiotic Therapy	☐	☐	☐
Care of Patient with Gastrostomy Tube	☐	☐	☐	Home Chemotherapy Administration	☐	☐	☐
Catheter Care	☐	☐	☐	Injection Cap Change to Groshong Catheter	☐	☐	☐
Catheterization	☐	☐	☐	Intravenous Therapy	☐	☐	☐
Catheterization for Residual Urine	☐	☐	☐	Irrigation of a Heparin Lock	☐	☐	☐
Cleansing Enema	☐	☐	☐	Irrigation of Groshong Catheter	☐	☐	☐
Colostomy Irrigation	☐	☐	☐	IV Gamma Globulin Administration	☐	☐	☐
Condom Catheter Application	☐	☐	☐	Medication Administration via Epidural Catheter	☐	☐	☐
Continuous Bladder Irrigation	☐	☐	☐	Obtaining Blood Specimens from a Hickman or Broviac Catheter	☐	☐	☐
Dry Sterile Dressing	☐	☐	☐	PICC Lines	☐	☐	☐

Enteral Feeding	☐	☐	☐	Port-A-Cath System	☐	☐	☐
Fleets Enema	☐	☐	☐	Refill of Infused Pump	☐	☐	☐
Insertion of a Rectal Tube	☐	☐	☐	Total Parenteral Nutrition and Lipids	☐	☐	☐
Insertion of Gastrostomy Tube	☐	☐	☐	Use of a Groshong Catheter	☐	☐	☐
Insertion of Suprapubic Catheter	☐	☐	☐	Withdrawal of Blood samples from Groshong Catheter	☐	☐	☐
Intermittent Bladder Irrigation or Installation	☐	☐	☐	**Eyes, Ears, Nose**	☐	☐	☐
Manual Removal of Fecal Impaction	☐	☐	☐	Instillation of Ear Drops	☐	☐	☐
Nasogastric Tube Placement	☐	☐	☐	Instillation of Eye Drips	☐	☐	☐
Oil Retention Enema	☐	☐	☐	Instillation of Nose Drops	☐	☐	☐
Oral and Nasopharyngeal Suction	☐	☐	☐	Irrigation of the Ear	☐	☐	☐
Ostomy Care	☐	☐	☐	Irrigation of the Eye	☐	☐	☐
Patency Assessment of Arteriovenous Fistul	☐	☐	☐	**Orthopedic Care**			
Seizure Precautions	☐	☐	☐	Application of Arm Sling	☐	☐	☐
Specific Gravity	☐	☐	☐	Care of Patient Following Total Hip Replacement	☐	☐	☐
Sterile Scrub Sponges	☐	☐	☐	Care of Patient Following Total Knee Replacement	☐	☐	☐
Suprapubic Catheter Care	☐	☐	☐	Care of Patient in Traction	☐	☐	☐
Suctioning the Tracheostomy Tube	☐	☐	☐	Stump Wrapping			
Suture Removal	☐	☐	☐	Use of Arm or Leg Splint			
Tracheostomy Care.	☐	☐	☐				
Vaginal Irrigation	☐	☐	☐				
Vaginal pack Removal	☐	☐	☐				
Wet Sterile Dressing	☐	☐	☐				
Wound Irrigation	☐	☐	☐				

P = Proficient O = Observed NE=No Experience

Skill	**P**	**O**	**NE**	**Skill**	**P**	**O**	**NE**
Medications				**Miscellaneous**			
Abdominal Subcutaneous Injection of Heparin	☐	☐	☐	Bedside Commode	☐	☐	☐
Administration of Medications via Nasogastric or Gastrointestinal Tube	☐	☐	☐	Bladder Training	☐	☐	☐
Administration of Potassium via IV Infusion	☐	☐	☐	Bowel Training	☐	☐	☐

Aerosolized Pentamidine for Treatment and Prophylaxis	☐	☐	☐	Care of Patient w/ Angina Pectoris	☐	☐	☐
Intermittent Intravenous Medication	☐	☐	☐	Care of Patient w/ Artificial Pacemaker	☐	☐	☐
Intramuscular Injections	☐	☐	☐	Care of Patient w/ Congestive Heart Failure	☐	☐	☐
Intramuscular Medication Compatibility	☐	☐	☐	Care of Patient w/ Hearing Impairment	☐	☐	☐
Medication Errors	☐	☐	☐	Care of Patient w/ Plaster Cast	☐	☐	☐
Subcutaneous Injections	☐	☐	☐	Care of Patient w/ Visual Impairment	☐	☐	☐
Z-Track Intramuscular Injection	☐	☐	☐	Care of the Diabetic Patient	☐	☐	☐
Diagnostic Tests				Care of the Hemodialysis Patient	☐	☐	☐
Collection of Clean Catch Midstream Urine Specimen	☐	☐	☐	Care of the Patient with Hypertension	☐	☐	☐
Collection of Culture Specimen from Wound or Orifice	☐	☐	☐	Care of the Patient with Acute Myocardial Infarction	☐	☐	☐
Collection of Sterile Urine Specimen from A Foley Catheter	☐	☐	☐	Collection of a Random Urine Specimen	☐	☐	☐
Collection of Urine Specimen from Urostomy	☐	☐	☐	Collection of a Sputum Specimen	☐	☐	☐
Gastric Analysis	☐	☐	☐	Collection of a Stool Specimen	☐	☐	☐
Intermittent Self-Catheterization Using a Clean Technique	☐	☐	☐	Patient Safety	☐	☐	☐
Specific Gravity	☐	☐	☐	Perineal Care Procedure	☐	☐	☐
Testing for Occult Blood in Feces	☐	☐	☐	Prevention and Care of Decubitus Ulcers	☐	☐	☐
Urine Testing for Glucose and Ketones	☐	☐	☐	Prevention of Pressure Ulcers	☐	☐	☐
Venipuncture for Blood Specimens	☐	☐	☐	Solutions for Dilutions, Reconstitution, and Irrigation	☐	☐	☐
Oxygen Therapies in the Home				Storage of Pharmaceuticals or Other Chemicals	☐	☐	☐
Home Respiratory Therapy Program—Arterial Blood Gas Samples	☐	☐	☐	Teaching Self-Injection of Insulin	☐	☐	☐
Intermittent Positive Pressure Breathing Therapy	☐	☐	☐	**Universal Precautions**	☐	☐	☐
Oxygen Safety	☐	☐	☐	Home Management of Soiled Linen	☐	☐	☐
Oxygen Therapy	☐	☐	☐	Other			
Postural Drainage	☐	☐	☐		☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

EXHIBIT F Reference Check Form

EXHIBIT E-Reference Check Form

One of your associates or former employees has applied for employment with Empowering Care and has authorized this request for information about employment and performance. Information you provide will be held in strict confidence. Please complete and return this addressed reply from at your earliest convenience

Branch Director Date

I hereby authorize the release of all information requested on this form.

Applicant Date

Verifying Employer

Applicant's Name Classification: SS #

Name Used While Employed

Employment Dates: From to Position

Check if telephone reference ❑ and sign below.

Are the Employment Dates Correct? Yes ❑ No ❑

Type of Reference: ❑ Employment ❑ Personal ❑ Education

Correct Employment Dates Eligible for Rehire? Yes❑ No❑

Reason for Leaving

Please Evaluate the Applicant on the Following:

				Excellent	Good	Average	Poor	Not Known
Performance	❑	❑	❑	❑	❑			
Attendance	❑	❑	❑	❑	❑			
Cooperation	❑	❑	❑	❑	❑			
Personal Appearance		❑	❑	❑	❑	❑		
Judgment	❑	❑	❑	❑	❑			
Initiative	❑	❑	❑	❑	❑			

Comments:

Name Title

Signature Date

Representative Date

EXHIBIT F-Staffing Orientation Verification Form

Basic Orientation

- ❑ I. Mission Statement/Philosophy/Code of Ethics
- ❑ 2. Empowering Care Website/Employee Comer
- ❑ 3. CPR & Health Statement/TB Requirements
- ❑ 4. Current licensure/Certification Requirements
- ❑ 5. Skills Verification
- ❑ 6. Office Organization
- ❑ 7. Scheduling and Cancellation Procedures
- ❑ 8. Time slips/Signup sheets
- ❑ 9. Overtime
- ❑ 10. Meal Periods
- ❑ 11. Weekly pay/Daily pay/Bank cards
- ❑ 12. Taxes
- ❑ 13. ID Badge
- ❑ 14. Dress Code
- ❑ 15. Telephone Numbers
- ❑ 16. Smoking
- ❑ 17. Evaluations
- ❑ 18. Transfers
- ❑ 19. Handguns and Weapons
- ❑ 20. Counseling/Disciplinary Action
- ❑ 21. Safety
- ❑ 22. Workers Compensation Mission Statement
- ❑ 23. Reporting a work-related injury or illness
- ❑ 24. Injury Treatment Protocol
- ❑ 25 Post Injury Drug Testing
- ❑ 26 Transitional Duty
- ❑ 27 Professional Liability Insurance
- ❑ 28 Unemployment Insurance
- ❑ 29 Educational Assistance Program
- ❑ 30 Medical/Dental/Vision/Life/Dependent Life
- ❑ 31 Hospitalization/Short Term Disability
- ❑ 32 Long Term Care
- ❑ 33. 401(k) Plan
- ❑ 34. Grievance Policy and Procedures
- ❑ 35. Complaints/Harassment
- ❑ 36. Liability Incident Report
- ❑ 37. Suspected Client Abuse, Neglect and Exploitation
- ❑ 38. Ethics/Confidentiality/Patient Rights
- ❑ 39 Drug Administration Policy
- ❑ 40 Documentation Guidelines
- ❑ 41 Private Duty in Medical Facilities
- ❑ 42 Advance Directives
- ❑ 43 Restraints
- ❑ 44. Equal Employment Opportunity (EEO)
- ❑ 45 Family Medical Leave Act (FMLA)
- ❑ 46 Military Leave
- ❑ 47 Americans with Disabilities Act (ADA)
- ❑ 48 False Claims Act

- ❑ I have participated in Empowering Care orientation, which explained the above topics, and was offered a copy of Empowering Care orientation handbook contents. I understand that if I do not ask for a paper copy of the employee handbook, that I may also access it online by going to (insert Company website), login to employee corner, click on the "Resources" tab and click on "Employee Staffing Handbook". I may use this as reference to employment related rights and rules in the future. I have also been given the opportunity to ask and receive answers to my questions regarding the standards and policies.
- ❑ I have received and understand my job description and qualifications for this position of m(Initial)
- ❑ Empowering Care safety mission is that every employee is provided a safe and healthful environment. A critical

component of employee safety is aiding our employee through the workers' compensation process if they become injured.

Empowering Care carries Workers' Compensation insurance to ensure that any employee legitimately injured on the job will receive appropriate and timely medical, indemnity, and other benefits to which he/she is entitled. Our focus is to take care of our people as well as control our workers' compensations costs.

- ❑ I understand that I am an employee of Empowering Care and only Empowering Care or I can terminate my employment. When an assignment ends, I understand that I am to report to Empowering Care for my next job assignment.
- ❑ I agree to complete any job assignment I accept. I agree that if I do not complete the assignment or fail to promptly notify (insert Company name) of my inability to complete an assignment, or if I do not report for an assignment, then Empowering Care may assume I have voluntarily quit, and I will not be eligible for unemployment benefits.

- ❑ Empowering Care has my permission to allow agencies or facilities to review or receive copies of the confidential information in my personnel folder as necessary to meet survey or regulatory compliance including: Application, License or Certifications, Results of Criminal Background Checks, Drug Screens, Health Statements, TB Screening, Immunizations, References, Skills Testing, Competency Testing and Performance Evaluations.
- ❑ I have been issued a (insert Company name) I.D. badge and will be responsible for its safekeeping and return to (insert Company name) upon separation of my employment from (insert Company name). I understand I.D. Badges are property of (insert Company name) and are to be returned upon termination of my employment.
  (Initial)

All employees have the right to not participate in aspects of patient care or treatment that are in direct conflict with cultural values or religious beliefs. Do you have any conflicts that should be addressed at this time? ❑ Yes ❑ No

(Print) Name of Employee (Print) Name of Clinical Director/Branch Director/Branch Manager

Employee Signature Signature of Clinical Director/Branch Director/Branch Manager

EMPLOYEE ACKNOWLEDGMENT
OF
OSHA TRAINING

I have been instructed and understand the OSHA standards for:

____Bloodborne Pathogens and Other Potentially Infection Materials.

____Prevention of Tuberculosis and Transmission of Tuberculosis.

____The Right to Know/Hazard Communication Program (MSDS).

____Needlestick Safety and Prevention.

____Workplace Violence.

I have been given the opportunity to have my questions answered regarding these standards and agree to follow these standards in all instances of occupational exposure as an Empowering Care employee.

I understand where and how to obtain and use personal protective equipment which I need in order to implement these standards.

Print Employee Name

Employee Signature Social Security Number Date

Signature of Trainer Date

EXHIBIT H—Employee Health Form

Employee Name (Print Please)

EMPLOYEE HEALTH FORM

❑ **STATEMENT OF SATISFACTORY HEALTH (I x IF THIS SECTION IS TO BE COMPLETED)**

_____, is found to be in good health without evidence of communicable disease and free of work restrictions on this date. Date of last physical exam: _____

Date of 1st Mantoux: Results: MM Date: Signature/Title:
Date of 2'd Mantoux: Results: MM Date: Signature/Title:
Date of Chest X-ray: Results:

❑ Repeat Chest X-ray required on / / ❑ Other:

❑ Repeat Chest X-ray with development of symptoms

Signed: Date:
Physician or Licensed Nurse Practitioner or PA

❑ **EMPLOYEE HEALTH HISTORY ([X] IF THIS SECTION IS TO BE COMPLETED) DATE:**