PAMCO Care, LLC.
7610 Lucas Court
Gainesville, VA20155

Application for Employment

Referred by: _____

Name: _____ **SSN:** _____

Address: _____
City **State** **Zip Code**

Home#: ( ) _____ **Cell#:** ( ) _____ **Email:** _____

Position: _____ Date Available: ____/____/____

Status Desired: ☐Full-Time ☐Part-Time ☐Relief ☐Any Available

Region in which you desire to work: ☐**Manassas** ☐**Gainesville**

Have you ever applied for a position with PAMCO CARE, LLC. Before? ☐Yes ☐No

For vehicle insurance purposes: Are you 21 years old or older? ☐Yes ☐No

Are you currently serving, or have you served in the US Military? ☐Yes ☐No

Educational Background:	Name/Location	Did you graduate?	Degree?
High School		□ Yes □No	□Yes GED? □Yes □No □ No
College		□ Yes □No	□Associate □ Other Degree: □Bachelor

Employment History:

Employment: Begin with the most recent	Dates of Employment/ Salary & Reason for Leaving	Your Job Title/ Supervisor's Name	Brief Description of Duties
		Your Title:	
		Supervisor:	
Phone			

		Your Title:	
		Supervisor:	
Phone:			
		Your Title:	
		Supervisor:	
Phone:			
		Your Title:	
		Supervisor:	
Phone:			

These positions will require tasks such as lifting, running, kneeling or performing CPR during emergencies, as well as having the ability to complete all required documentation according to standards and to pass all required tests; all areas that are considered "essential job functions". You may also be required to use authorized physical intervention techniques during episodes of aggressive client behavior. Do you have any limitations that may affect your ability to perform these tasks? ☐Yes ☐No (If yes, please explain.)

_____

_____

_____

Have you ever been convicted of any crime other than a traffic violation? □Yes□ No (If yes, please explain.) Include offense, note if a misdemeanor or felony and date of conviction.

_____

_____

_____

This position will require that we are able to contact you in the event of emergency or shift change. Do you have a current, active telephone Number? _____

If I am hired at PAMCO Care in a direct care role:

- I understand that the needs of the individual we support and programs come first; therefore I may be assigned a different shift or location to meet those needs.
- I will provide the information and release required to complete CPS/APS and criminal history checks.
- I will submit verification of vehicle insurance coverage within the first thirty days of employment.
- I will obtain and submit the results of tuberculosis (TB) test within the first thirty days of my employment.
- I understand that I will be required to have a vehicle available to use on a regular basis, during all shifts worked

- I understand that during the course of my employment I must meet all of the standards of HHS-OIG as a non-excluded provider.
- I understand that I must complete/pass all required training and maintain current certifications in CPR/First Aid.
- I understand and agree that my employment is for no specific period of time, and that I may be terminated without any previous notice.

I understand and agree that the information contained in this application may be verified and that falsification of any information is cause for dismissal.

Signature:._____ **Date:** _____

PAMCO Care – Personnel References

Please provide 5-6 Professional References*:

- Name/Phone Number/Email: _____
- Name/Phone Number/Email: _____
- Name/Phone Number/Email: _____
- Name/Phone Number/Email: _____
- Name/Phone Number/Email: _____
- Name/Phone Number/Email: _____

*Please notify all references PAMCO Care may contact them for a reference check

I, _____, authorize PAMCO Care to contact my references to investigate my past employment and professional activities. I also agree to release from liability all persons and companies providing this information.

I understand and acknowledge that any offer of employment is conditional upon PAMCO Care being completely satisfied with the information provided as a result of this reference check.

_____	_____
Applicant name	Applicant signature

Department of Behavioral Health and Developmental Services (DBHDS)

AUTHORITY FOR RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize any investigator or duly accredited representative of the Department of Behavioral Health and Developmental Services (DBHDS) bearing this release, or a copy thereof, to obtain any information from law enforcement/criminal justice agencies and report the results of such search to the agencies, facilities, or individual(s) authorized to receive same. I hereby direct you to release such information upon request of the bearer. I understand that the information released is for official use by DBHDS and may be disclosed to such third parties as indicated below in the fulfillment of official responsibilities.

I hereby release any individual, including records custodians, from any and all liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or any attempts to comply with this authorization. Should there be any questions as to the validity of this release, you may contact me as indicated below.

Signature (Full Name): _____

Print Name (Full Name): _____

Other Names Currently or Previously Used (Maiden, Former Married, Religious, etc.): _____

Current Address: _____

_____

Telephone Number: (____) _____ **Date:** _____

Release to: PAMCO Care, LLC - 2214

(Licensed Provider Name and Provider Number)

NOTE: Providers – Please do not send to DBHDS, only retain for your records.

Attachment #3

Disclosure Statement
for
Licensed Private Provider Employees

A criminal history background investigation is required by law (§ 37.2-416 (B,(i)), *Code of Virginia*) on each individual who was not an employee or service provider at the facility prior to July 1, 1999. (Please type or print clearly.)

Licensed Provider Business Name	**Licensed Provider Number (3 or 4 digit)**
PAMCO Care, LLC	2214
Applicant's Name (Last, First, Middle)	**Applicant's Social Security Number** ☐ **No SSN #**
Applicant's Mailing Address (Street, City, State, Zip)	**Applicant's Phone Number (Area Code + Number)**

In Virginia or any other location:
Have you ever been or are the subject of a founded complaint of child abuse or neglect?
☐ **No** ☐ **Yes:** **If yes, please list all cases and explain.**

Have you ever been <u>convicted</u>* of or are you the <u>subject of pending charges</u> for <u>any offense</u>, including moving traffic violations, but excluding offenses committed before your eighteenth birthday which were finally adjudicated in a juvenile court or under a youth offender law?
☐ **No** ☐ **Yes:** **If yes, please list all cases and explain.**

Convictions include <u>all</u> adult convictions <u>as well as</u> Virginia juvenile adjudication's for the following, Capital Murder, First and Second Degree Murder, Lynching, or Aggravated Malicious Wounding, if you were age fourteen (14) to eighteen (18) when charged.

***If convicted of misdemeanor assault & battery, were any of these convictions committed while employed in a direct consumer care position?**
☐ **No** ☐ **Yes**

I hereby certify that all entries on this disclosure statement are true and complete. I agree and understand that: (1) any falsification of the information provided, regardless of the time of discovery, may result in termination of my services as an employee; and (2) the information on this disclosure statement is subject to verification.

_____ _____
Signature of Applicant **Date**

VIRGINIA DEPARTMENT OF HEALTH
REPORT OF TUBERCULOSIS SCREENING

Name_____ Date of Birth_____ Date_____

TO WHOM IT MAY CONCERN: The above individual has been evaluated by: _____
(PLEASE PRINT name of health department, facility or clinician)

TB Screening and/or Testing Conclusions

I. No Symptoms nor Other Risks Identified on TB Risk Assessment

☐ A tuberculin skin test (TST) or blood test (IGRA) is not indicated at this time due to the absence of symptoms suggestive of active TB, no risk factors identified for infection or for developing active TB if infected, and has no known recent contact with active TB. Health care workers employed in a low risk facility according to CDC "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005" do not need testing.

☐ The individual has a history of TB infection. Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active TB.

If neither applies, go to section II.
If in a health-care setting that *requires* a test for TB infection but no symptoms are present, go to section III.
If one of these two statements applies, select the appropriate statement and skip to Section V and select statement 'A'.

II. Symptoms Consistent with Potential Tuberculosis are Present

Call the local health department to refer the person for further TB evaluation immediately. This notification is necessary even when the individual prefers to pursue an evaluation privately. Proceed to Section V and select statement 'B.'
If there are no symptoms consistent with TB, go to Section III.

III. Testing for TB Infection – Choose TST or IGRA

Tuberculin Skin Test (TST): (record both tests if a 2-step TST was required)
Date given: _____ Date read: _____ Results: _____mm Interpretation: ☐ negative ☐ positive
Date given: _____ Date read: _____ Results: _____mm Interpretation: ☐ negative ☐ positive

Interferon Gamma Release Assay (TB infection blood test):
Date drawn: _____ Test done: ☐ T-Spot TB ☐ Quantiferon TB Gold
Result: ☐ negative ☐ positive ☐ indeterminate ☐ borderline ☐ invalid

If test above is negative, proceed to Section V and select statement 'A'. If either test for TB infection is positive, proceed to Section IV,

IV. Chest X-Ray to Evaluate for Potential TB Disease

Date of chest x-ray: _____ Location of chest x-ray: _____
Interpretation:
☐ no evidence of active tuberculosis
☐ chest x-ray abnormal, active tuberculosis to be ruled out

V. TB Screening/Testing Conclusion

☐ A. Based on the TB Screening and/or further testing, the individual listed above is free of communicable tuberculosis in a communicable form.

☐ B. Active tuberculosis cannot be ruled out in the individual listed above. The individual has been referred to their physician and the local health department for further evaluation.

Signature _____ Date _____ Phone _____
(Clinician with prescriptive authority or health department official)

Address _____

_____