

FOR EMPLOYER USE ONLY:

1. Copy of HHA competency certificate or proof of required testing (if applicable)
2. Job description - signed and dated
3. Two signed reference letters
4. Copy of driver's license - marked "copy" (where allowed by law)
5. Copy of CPR certification
6. Signed basic employee policies and procedures
7. Date of TB test and/or other as required by Federal or State Law
8. Withholding tax forms (W-4)
9. Documentation of in-service/continuing education or special training
10. Required testing (answer sheets)
11. Proof of automobile liability insurance - marked "copy" (not required)
12. I-9 Documents
13. _____

INSERVICE PROGRAMS:

Photo I.D. Badge

Comments / additions _____

Birthdate (month and day only) _____ / _____

Application for Employment

Federal and State laws prohibit discrimination in employment because of sex, race, color, religion, national origin, age, disability, veteran status, and citizenship status. We are an equal opportunity employer. Applicants may request accommodations needed to apply for work.

Personal _____ Date: _____

Name _____ Social Security #: _____

Is any additional information relative to change of name necessary to enable us to check references or prior employers? Yes No

If Yes, explain _____

Present Address _____

Home Phone Number _____ Alternate Phone Number _____

In case of emergency, please notify _____ Phone Number _____

Classification: Nurse Aide / Assistant Home Health Aide Companion/Homemaker Live-In

Are you State Certified? Yes No Certificate Number _____ Expiration Date _____

If hired, on what date will you be available to start work? _____

Do you have the right to work and remain in the United States? Yes No

You may not work for Priority Healthcare Services of Tennessee, Inc. unless you can present satisfactory proof of your identity and legal ability to work in the United States.

Are you fluent in reading, writing, and/or speaking any of the following languages:
 Spanish French Portuguese Russian Vietnamese Chinese Other _____

Do you know sign language: Yes No Type _____

A job description listing the activities of the position for which you are applying is part of this application.

Will you accept assignments which require the lifting, turning, or moving of patients? Yes No

If "No", you will not be denied employment for this reason.

If "Yes", you can lift, turn or move patients, with or without accommodation, up to the following limits (in pounds).
 0 - 50 51 - 100 101 - 150 151 - 200 Over 200

How did you learn about PHS? _____

Have you ever been convicted of a crime, excluding misdemeanors and summary offenses? Yes No
(A conviction will not necessarily bar employment.)

If yes, describe fully: _____

Have you ever been rejected for a fidelity bond within the last 10 years? Yes No

If yes, describe fully: _____

What type of transportation do you intend to utilize to get to your assignments: _____

Do you have a driver's license? Yes No Automobile Insurance? Yes No

Please note: Priority Healthcare Services of Tennessee, Inc. does not provide automobile insurance coverage for you or your vehicle.

Educational Background

Attended	Name and Address	Length of Attendance	Graduated	Certificate
High School			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nurse Aide Training			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Health Aide Training			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Date of last physical exam _____ Date of last chest x-ray _____ Tb Test _____

CPR CERTIFIED Yes No Date _____ Source of training _____

Please explain any additional qualifications, education or training, including medication courses.

Do you have certificates or written documentation, if any, for the above? Yes No

PRIOR WORK HISTORY (List in order, last or present employer first)

1. Name _____ Phone _____

Street Address _____ City, State, Zip _____

Job Title	Salary	Dates Worked	From	To	Nature of Work	Supervisor
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Reason for Leaving _____

2. Name _____ Phone _____

Street Address _____ City, State, Zip _____

Job Title	Salary	Dates Worked	From	To	Nature of Work	Supervisor
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Reason for Leaving _____

3. Name _____ Phone _____

Street Address _____ City, State, Zip _____

Job Title	Salary	Dates Worked	From	To	Nature of Work	Supervisor
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Reason for Leaving _____

4. Name _____ Phone _____

Street Address _____ City, State, Zip _____

Job Title	Salary	Dates Worked	From	To	Nature of Work	Supervisor
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Reason for Leaving _____

May we contact the employers listed above? _____ If not, indicate below which one(s) you do not wish us to contact and why.

Professional References:

Please list the names of two licensed nurses.
(Excluding former employers or relatives)

Name and Classification	Address	Phone Number

Experience

Have you ever worked as a staff employee in a hospital? Yes No

If so, please list areas worked: _____

Written documentation received _____

Please check those patient care skills in which you have recent working experience:

Administer Oxygen	Yes	No	Enemas	Yes	No	Shampoo	Yes	No
			Feed Patients	Yes	No	Sitz Bath	Yes	No
- Ace Bandage	Yes	No				Supervise ADL	Yes	No
- Binders	Yes	No	- Bedpand/Urinals	Yes	No	TPR	Yes	No
- Hot water bottle	Yes	No	I & O	Yes	No	Tub Bath/Shower Bath	Yes	No
- Ice Bags	Yes	No	Insert Rectal Tubes	Yes	No	Turn & Position Patient	Yes	No
Assist w/Ambulation	Yes	No	Oral Hygiene	Yes	No	Treat Decubiti w/o Med.	Yes	No
Back Rubs	Yes	No	Personal Care	Yes	No	Weigh Patients	Yes	No
BP	Yes	No	Prepare Meals	Yes	No	Universal Precautions	Yes	No
Charting	Yes	No	Post Mortam	Yes	No	Documentation PT Care	Yes	No
Clinitest	Yes	No	Range of Motion	Yes	No	Emergency Procedures	Yes	No

Please explain any additional skills/experience you have with special equipment, tests, examinations and specialty areas in which you have worked:

Would you accept a Live-in assignment? Yes No Long-term? Yes No

I hereby authorize Priority Healthcare Services of Tennessee, Inc. and also authorize and request each former employer and person given as a reference to answer all questions that may be asked, and give all information that may be sought in connection with this application or concerning me or my work habits, character, skills, or my action in any transaction. I further authorize PHS to forward my complete personnel file to any other PHS office at which I may seek future employment. I further authorize PHS to provide all information concerning me to any individual or organization to which I may be assigned.

I understand that if I am applying for or accept "Live-In" assignments, they will include assignments during which time I will reside on the client's premises at the direction of PHS for 24-hour periods and that I will not be actually working or on duty at all times during such assignments. Some "Live-In" assignments are exempt from coverage under the Wage-Hour law. During any assignment that is not exempt, I understand and agree that in recognition of my ability to engage in such normal private pursuits while on the premises as eating, sleeping, watching television, listening to the radio, reading, doing personal laundry, resting, and of periods of personal time when I am completely relieved of all duties or can leave the premises for purposes of my own. I agree that 13 hours a day is a reasonable number of hours worked under all the circumstances, unless I have agreed otherwise with PHS with respect to a particular assignment. I further understand and agree that because client circumstances may change from time to time, that if my hours of work differ substantially from the number above, I will notify an appropriate supervisor at PHS whenever a significant difference occurs so that a new agreement can be reached for the assignment.

I agree to report to the office at the end of each assignment, if I am no longer available for work, or if my availability status has changed. I further understand that I cannot be paid until I present a slip signed by both the client and myself to the office.

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

I certify that I have read and fully understand the job description provided to me with this application and if accepted for employment will abide by the terms thereof.

Signature: _____ Date: _____

PLEASE CIRCLE ITEMS BELOW THAT APPLY:

Hours available for assignment: 7-3 3-11 11-7 Shift preference _____ Available for less for 8 hour shifts: Yes No If yes, indicate which hours: _____

Days available for assignment: Sat Sun Mon Tues Wed Thurs Fri Available for Weekends or occasional weekends? Yes No If yes, how often _____

Assignments willing and qualified to perform			DUTY PREFERENCE	COMMENTS
Hospital Staff	Yes	No	_____	_____
Hospital Private Duty	Yes	No	_____	_____
Nursing Home Staff	Yes	No	_____	_____
Nursing Home Private Duty	Yes	No	_____	_____
Home Care	Yes	No	_____	_____

Do you own a white uniform which you can wear if employed by us? Yes No

Comments: _____

Interviewer: _____

Pre-Employment Authorization Form

Note:

I understand the information requested on this form is for the sole purpose of conducting a pre-employment search and should be completed only by a candidate who has been offered (or is being considered for) a position with the Company. In giving this consent, I understand that a consumer report, court records, driving records, current and prior employment, personal references, education records, professional license records, social security records, or workers' compensation records may be requested and a search conducted to determine my suitability for employment. (Workers' compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or other applicable state laws.) I further understand if employment is denied in whole or in part because of information obtained by my employer or prospective employer from a consumer reporting agency, I have the right to make a written request within a reasonable time to receive information about the scope and nature of the search. I understand the information below regarding sex and date of birth is requested for the sole purpose of gathering information accurately, and will not be used to discriminate against me in violation of the law. A facsimile or photographic copy of this authorization shall be as valid as the original.

I also authorize all of my former employers (including personal and business references or self-employment) to provide any information they have regarding me, whether or not it is in their records. My authorization for conducting this pre-employment search expires 90 days from the date indicated below.

Candidate's Signature:

_____ **Date:** _____

This information must cover at least five years. If more room is needed, please use the back of this form.

_____ Last Name _____ First Name _____ Middle Name _____

_____ Maiden or Other Name _____ Social Security # _____ Date of Birth _____ M ___ F ___
Sex

Current Address:

_____ Street _____ City _____ State _____ Zip _____

_____ County _____ Yrs. In Residence _____ (_____) Phone Number _____

Previous Address:

_____ Street _____ City _____ State _____ Zip _____

_____ County _____ Yrs. In Residence _____ (_____) Phone Number _____

Priority Healthcare Services Fax: 865-588-2045 Phone: 865-584-4010

_____ Requester's Name _____ Date _____

_____ Tennessee Statewide Felony Record _____ Other Statewide or County _____ County Criminal Record _____

PRIORITY

HEALTHCARE SERVICES

Dear _____

One of your former employees has applied for temporary assignments as an employee of Priority Healthcare Services of Tennessee, Inc. We ask that you verify and complete this form at your earliest convenience and return it to our office. Our fax number is 588-2045. Thank you for taking the time needed to complete this reference form.

Very truly yours,

Administrator/Manager

Name of Applicant _____ Social Security Number _____

I, _____, release the above-named employer, Priority Healthcare Services, Inc. And their agents and employees from any liability claims I may have which arise or result from any reference provided pursuant to this authorization or any authorization or any authorized disclosure thereof.

I further understand that by signing this release I authorize permission to Priority Healthcare Services, Inc. To not only check my previous work history, but to also obtain a criminal background check by one or more law enforcement agencies. This may include, but not be limited to Knox County Police and Sheriff=s departments. This information will be used in strict confidence and only for the aid of decision making for employment purposes.

Signature _____ Date _____

EVALUATION	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality				
Quantity				
Attitude				
Dependability				
Punctuality				

Dates of Employment _____

Reason for Leaving _____

Eligible for re-employment: Yes _____ No _____ If not, please explain _____

Comments: _____

Signature: _____ Title: _____

Name of Company : _____ Date: _____

PRIORITY HEALTHCARE SERVICES

Professional License/Abuse Registry Verification

Employee Name: ✓ _____ Social Security Number: ✓ _____

Job Title: _____ Department: _____

License Data:

License Number: ✓ _____ Renewal Number: ✓ _____

Issuing State: _____ Expiration Date: _____

Verification:

The above listed license is valid:

✓ _____
Applicant's Signature

✓ _____
Date

Abuse Registry:

Verified by: _____ Date Verified: _____

I have examined the license and/or Abuse Registry on the above individual and it matches the individual name to the best of my knowledge:

Signature of individual verifying license and/or abuse registry

Date

PRIORITY

HEALTHCARE SERVICES

Drivers Evaluation

Name on License: _____ Tn. Drivers Lic. No. _____

Make & Year of Car _____ License No. _____

Expiration Date _____

Auto Ins. Co. _____ Policy No. _____

1. How long have you been driving:

- A 0 – 5 years
- B 6-10 years
- C Over 10 years

2. How many speeding tickets have you had in the last 5 years?

- A 0
- B 1 – 2
- C 3 – 5
- D Over 5

3. How many other moving violations have you had in the last 5 years:

- A 0
- B 1 – 2
- C 3 – 5
- D Over 5

4. How many automobile accidents have you been involved in?

- A 0
- B 1
- C 2
- D Over 5

5. Have you even been convicted of a DUI?

- A Yes
- B No

Signature _____ Date: _____