TOUCH OF HEALING NURSING SERVICES

APPLICATION FOR EMPLOYMENT

Position Applying for: ☐RN ☐LPN ☐HHA ☐GNA ☐CMA ☐OFFICE STAFF
Type of Employment: ☐FULL-TIME ☐PART-TIME ☐TEMPORARY ☐ON-CALL
Time of Availability: ☐MORNINGS ☐NIGHTS ☐WEEKENDS
Hours of Availability: _____

Basic Information

Name *(Last, First Middle Initial)*: _____
Date of Birth: _____ Social Security Number: _____-_____-_____
Address: _____
City/State: _____ Zip Code: _____
Home Telephone: _____ Mobile: _____ Other: _____
Desired Start Date of Employment: _____ Are you willing to travel? ☐Yes ☐No
Are you authorized to work in the United States on an unrestricted basis? ☐Yes ☐No
Do you possess a security clearance? ☐Yes ☐No

Personal Information

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married

In Case of an Emergency, Please Notify:

Name: _____ Relationship: _____
Home Telephone: _____ Alternative: _____

Educational History

Type of Degree Earned: ☐High School Diploma ☐G.E.D. ☐College ☐Grad. School
Additional Training: _____ Diploma/Degree? ☐Yes ☐No
Nursing School *(if applicable)*: _____
City/State: _____ Zip Code: _____
Dates Attended: _____ To: _____

I hereby certify that all information provided above is true and correct to the best of my knowledge. By signing below I authorize Touch of Healing Nursing Services to investigate and verify the information.

Signature of Applicant: _____ Date: _____

For Office Use Only

Person Conducting Interview: _____ **Date:** _____
Title: _____
Comments:
_____
_____

TOUCH OF HEALING NURSING SERVICES

Employment History

Company/Client's Name: ______________________________

Job Title: ____________________ Supervisor: ____________________

Address: ______________________________

City/State: ____________________ Zip Code: __________

Start Date: ____________________ End Date: ____________________

Starting Pay: __________ Ending Pay: __________

Duties Performed: ______________________________

____

Reason for Leaving: ______________________________

Comments: ______________________________

____

Company/Client's Name: ______________________________

Job Title: ____________________ Supervisor: ____________________

Address: ______________________________

City/State: ____________________ Zip Code: __________

Start Date: ____________________ End Date: ____________________

Starting Pay: __________ Ending Pay: __________

Duties Performed: ______________________________

____

Reason for Leaving: ______________________________

Comments: ______________________________

____

Company/Client's Name: ______________________________

Job Title: ____________________ Supervisor: ____________________

Address: ______________________________

City/State: ____________________ Zip Code: __________

Start Date: ____________________ End Date: ____________________

Starting Pay: __________ Ending Pay: __________

Duties Performed: ______________________________

____

Reason for Leaving: ______________________________

Comments: ______________________________

____

TOUCH OF HEALING NURSING SERVICES

License Verification Form

Employee Name: _____ Discipline: _____

Social Security #: _____-_____-_____

Maryland

License #: _____ Status: _____

For Office Use Only

Verified By: ☐Automated System ☐Verbal Contact (*If verbal, complete the following. If not, skip.)*

Spoke With: _____ Title: _____

Verified By: _____ Date: _____

Title: _____

Comments: _____

_____

License #: _____ Status: _____

For Office Use Only

Verified By: ☐Automated System ☐Verbal Contact *(If verbal, complete the following. If not, skip.)*

Spoke With: _____ Title: _____

Verified By: _____ Date: _____

Title: _____

Comments: _____

_____

License #: _____ Status: _____

For Office Use Only

Verified By: ☐Automated System ☐Verbal Contact (*If verbal, complete the following. If not, skip.)*

Spoke With: _____ Title: _____

Verified By: _____ Date: _____

Title: _____

Comments: _____

_____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

Reference Form

The undersigned, having applied for a position with our company, hereby authorizes you to release any information necessary relating to employment. This hereby releases your organization unconditionally from all liability for damage whatsoever that might result from furnishing this information.

Section I: *(To be completed by Applicant)*

Name: _____

Company Name: _____ Position: _____

Supervisor's Name: _____ Telephone: _____

Dates Employed: _____-_____

I acknowledge filing an application with Touch of Healing Nursing Services and authorize the release of information from my former employer.

Applicant Signature: _____ Date: _____

Section II: *(Supervisor, please confirm information in Section I and complete Section II.)*

Is the Applicant's position title correct? ☐Yes ☐No _____
(if no, please correct information)

Are the dates of employment correct? ☐Yes ☐No _____
(if no, please correct information)

Is this employee eligible for rehire? ☐Yes ☐No or ☐Conditional

_____
(if no/conditional, please explain)

Section II: Evaluation of Performance

Job knowledge/Technical skills:	☐Excellent	☐Good	☐Fair	☐Poor
Quality of work:	☐Excellent	☐Good	☐Fair	☐Poor
Ability to work with others:	☐Excellent	☐Good	☐Fair	☐Poor
Initiative:	☐Excellent	☐Good	☐Fair	☐Poor
Punctuality/Attendance:	☐Excellent	☐Good	☐Fair	☐Poor

Additional Comments: _____

_____

Information Verified by: _____ Title: _____

Reference record completed by *(Authorized Representative)*: _____

Title: _____ Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

Reference Form

The undersigned, having applied for a position with our company, hereby authorizes you to release any information necessary relating to employment. This hereby releases your organization unconditionally from all liability for damage whatsoever that might result from furnishing this information.

Section I: *(To be completed by Applicant)*

Name: _____

Company's Name: _____ Position: _____

Supervisor's Name: _____ Telephone: _____

Dates Employed: _____-_____

I acknowledge filing an application with Touch of Healing Nursing Services and authorize the release of information from my former employer.

Applicant Signature: _____ Date: _____

Section II: *(Supervisor, please confirm information in Section I and complete Section II.)*

Is the Applicant's position title correct? ☐Yes ☐No _____
(if no, please correct information)

Are the dates of employment correct? ☐Yes ☐No _____
(if no, please correct information)

Is this employee eligible for rehire? ☐Yes ☐No ☐Conditional

_____
(if no or conditional, please explain)

Section II: Evaluation of Performance

Job knowledge/Technical skills:	☐Excellent	☐Good	☐Fair	☐Poor
Quality of work:	☐Excellent	☐Good	☐Fair	☐Poor
Ability to work with others:	☐Excellent	☐Good	☐Fair	☐Poor
Initiative:	☐Excellent	☐Good	☐Fair	☐Poor
Punctuality/Attendance:	☐Excellent	☐Good	☐Fair	☐Poor

Additional Comments: _____

_____

Information Verified by: _____ Title: _____

Reference record completed by *(Authorized Representative)*: _____

Title: _____ Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name):

CONFIDENTIALITY STATEMENT

Disclosure of confidential information gained through your employment by is stated as an act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient's illness, family, financial condition or personal peculiarities is strictly confidential. When a patient's history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(TOUCH OF HEALING NURSING SERVICES Representative)

Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

EMPLOYEE CONFIDENTIALITY STATEMENT

I, _____, hereby agree and pledge that I will honor and respect the
(Applicant's Name, Please Print)
privacy and confidentiality of the agency, their clients and business associates. I will not divulge any information of any type obtained through my services as an employee of TOUCH OF HEALING NURSING SERVICES. I agree not to discuss nor release any information obtained within the agency regarding any TOUCH OF HEALING NURSING SERVICES clients, their medical record or any client's condition with any individual not directly associated with Touch of Healing Nursing Services, nor with Touch of Healing Nursing Services employees who are not directly associated with that client. I also agree that any information that is released regarding the client or client's record will only be done with proper authorization and/or in accordance with established agency policy for the release of the information: this includes, but is not limited to: the client's identity, description, medical condition, or addresses, the agency or their business associates, financial status or condition, or any and all commercial or private transactions of the agency.

My signature on this document indicates that I understand and I am aware of, and agree to abide by the aforementioned policies and that any breach will have significant consequences which may include suspension or termination of employment and/or civil prosecution.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Touch of Healing Nursing Services Representative)

Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

PERMISSION FOR PPD TEST

I, _____, voluntarily take the PPD test intradermally as a screening
(Applicant's Name, Please Print)
method for tuberculosis. I understand that a PPD test must be administered and read annually. A chest X-Ray must be done every five years as a pre-requisite for employment at Touch of Healing Nursing Services I release Touch of Healing Nursing Services of any liability. I confirm that I have/have not had a PPD test within the last year; and I have no known allergy to the PPD test.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Touch of Healing Nursing Services Representative)

Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

DECLINATION OF MANTOUX

I, _____, have submitted or will submit documentation of a PPD test
(Applicant's Name, Please Print)
and results of said test. If an employee has a known history of having had a Positive Tuberculin test the Mantoux method, he/she may decline the Mantoux test. He/she must agree to give the agency documentation of a negative chest X-Ray within the past 12 months.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Touch of Healing Nursing Services Representative)

Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

UNIVERSAL PRECAUTIONS

(OSHA BLOODBORNE PATHOGENS, SECTION 1910.1030 OF TITLE 29, CODE OF FEDERAL REGULATIONS)

I, _____, am aware and understand that due to my occupation, I am
(Applicant's Name, Please Print)
at risk for exposure to blood or other potentially infectious materials. Therefore, I have been given proper instruction on OSHA regulation and requirements. I also understand and I am aware of Universal Precautions and know that as a requirement of my job description I will practice Universal Precautions as described in my job description.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Touch of Healing Nursing Services Representative)

Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

IN-SERVICE REQUIREMENT

It is the policy of Touch of Healing Nursing Services that each licensed employee or independent contractor attends a minimum of four in-service hours per year. This is best accomplished by doing one (3) hour in-service every three (3) months, for a total of 12 hours per year.

Touch of Healing Nursing Services offers a variety of in-services throughout the year. You will be notified of scheduled in-services by memo in your paycheck. OSHA, Infection Control, and Tuberculosis are required annually. These courses must be home care focused. Should you attend an in-service elsewhere (i.e. hospital, nursing home, and/or other agencies), we will gladly accept a copy of your attendance record/certificate and will credit you with that in-service requirement.

By signing below, you acknowledge and understand that you must comply with the above requirement to remain in an "Active Status" with Touch of Healing Nursing Services.

Print Name: _____

Signature: _____

Date: _____

TOUCH OF HEALING NURSING SERVICES

Name (Last Name): _____

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. It is strongly suggested that I be vaccinated for HBV. I understand that I may decline the vaccination and I also understand that not being vaccinated; I continue to at risk for acquiring and remain susceptible to HBV, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated with the HBV vaccine, I can receive the vaccination series at no charge to me.

Touch of Healing Nursing Services has explained to me that I continue to be at risk for HBV until such time that I am immunized.

Print Name: _____

Signature: _____

Date: _____

Authorized Signature: _____ Title: _____

(Touch of Healing Nursing Services Representative)

Date: _____