Application Checklist for Non-Physicians

1099 Staff must also fill this application out

INSTRUCTIONS FOR EMPLOYMENT CONSIDERATION

Step 1: Enter your name and the position for which you are seeking employment in the fields below.

Step 2: Complete all attached forms in their entirety; If a form field or section is not applicable to you, please indicate this is so by entering "n/a" into the field -- do NOT leave form fields blank. **Note:** So that information can be referenced in the same manner across all personnel files, the policy of this organization requires that you copy applicable and relevant data from your resume to the Application for Employment and other underlying forms. Applications that instruct the Medical Staff Administration to "See Resume" instead of providing the information in the format requested will be considered incomplete and will not be processed.

Step 3: Provide clean, high resolution copies of unexpired and otherwise valid documents that are listed below. Copies too dark, too light, sized incorrectly or that are of expired documents will not be processed.

Step 4: Completed applications should be returned with legible copies of all requested documents to your facility contact according to his/her specific instructions. Please be sure to notate and explain any exceptions to the forms and documents.

Full Name: _____

Position Desired: _____

Complete the following attached forms:

1. Application for Employment
2. Employer References
3. Orientation Checklist
4. Annual In-Service Module
5. Confidentiality Agreement
6. Conflict of Interest Disclosure
7. Corporate Compliance Plan Attestation
8. Requirement to Report Adult/Elder Abuse
9. Background Check Authorization Form
10. Federal tax form w4/w9, as applicable
11. Form I-9 (Employment Eligibility Verification)
12. Annual Attestation of Health
13. Declination of Influenza Vaccination, if applicable
14. HEP B Immunization Consent / Refusal, if applicable
15. Informed Consent / Refusal for HIV testing, if applicable
16. Covid 19 Vaccine with Boosters Proof
17. Staff Competencies & Performance Evaluations

Provide the following documents:

1. Resume
2. Copy(ies) of Government-issued documentation for Employment Eligibility Verification pursuant to Form I-9 guidelines (typically a driver's license & social security card, or a U.S. Passport; or a Permanent Resident card, or any other documentation accepted by USCIS that both verifies identity and employment authorization.)
3. Copies of current Professional Licenses, as applicable
4. Copy of BLS/ACLS certificate, as applicable
5. Copies of other non-Medical Board certifications, as applicable
6. Evidence of PPD test or chest x-ray, current to within 1 year.
7. Evidence of flu vaccination, current to within 1 year (or complete declination form)
8. Evidence of HEP B vaccination (or complete HEP B Consent/ Refusal)
9. Evidence of HIV test performed by a facility-approved lab (or complete Informed Consent/Refusal form)

Thank you,

Human Resources

APPLICATION FOR EMPLOYMENT

INSTRUCTIONS

This healthcare organization does not discriminate on the basis of age, race, sex, color, religion, national origin, disability, or any other applicable status protected by state or local law. It is our intention that all qualified applicants be given equal opportunity and that selection decisions be solely based on proven skill level and verified experience.

Complete this employment application in its entirety using blue or black ink. Use a blank sheet of paper if answers to questions exceed the space provided**. YOU MUST SUBMIT FOR VERIFICATION ALL PROFESSIONAL LICENSES, NATIONAL CERTIFICATIONS OR ANY OTHER CREDENTIALS APPROPRIATE TO THE JOB FOR WHICH YOU ARE APPLYING. EXPIRED CREDENTIALS ARE NOT ACCEPTABLE.**

PERSONAL DETAILS

Full Legal Name: _____ Email: _____

Street Address: _____

City, State and ZIP: _____

Contact Phone: _____ Month/Year of Birth: _____ Last 4-digits of Social Sec. No.: _____

Emergency Contact: _____ Contact No.: _____ Relation: _____

Are you a citizen of the United States? Yes ☐ No ☐ If no, do you have authorization to work in the United States? Yes ☐ No ☐

Job applying for: Choose One _____ Are you available for: FT ☐ PT ☐ Temp ☐? When can you start? _____

Have you ever applied or been employed here before? Yes ☐ No ☐ If yes, when? _____

How were you referred to our company? School/College ☐ Employment Agency ☐ Walk-In ☐ Employee/Other ☐: _____

Availability:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From:							
To:							

PROFESSIONAL LICENSES and/or CERTIFICATIONS

Type: _____ Issuing Organization or State: _____ Document No.: _____ Expires: _____

Type: _____ Issuing Organization or State: _____ Document No.: _____ Expires: _____

Type: _____ Issuing Organization or State: _____ Document No.: _____ Expires: _____

Life Support Certifications: ACLS ☐ Expires: _____ BLS ☐ Expires: _____ PALS ☐ Expires: _____ None ☐

What skills or additional training do you have that are related to the job for which you are applying? _____

What specialized equipment can you operate that is related to the job for which you are applying? _____

If driving is a requirement of the job for which you are applying, do you have a current, unrestricted driver's license? Yes ☐ No ☐

If "yes," has your driver's license been suspended or revoked in the last 3 years? Yes ☐ No ☐ If yes, please explain: _____

_____

EDUCATION

	LIST NAMES OF SCHOOLS ATTENDED & LOCATION	FIELD OF STUDY	TYPE OF CREDENTIAL RECEIVED	YEAR GRADUATED
High School or GED:				
College or University:				
Vocational or Technical:				
Professional Education:				

EMPLOYMENT HISTORY

List names of employers in consecutive order with present or last employer listed first. Account for all periods of time including military service and any periods of unemployment. If self-employed, state as such and supply business references.

NAME OF EMPLOYER:	JOB TITLE:	
ADDRESS:	RESPONSIBILITIES:	
CITY, STATE, ZIP CODE:	DATES OF EMPLOYMENT (mm/yy) FROM: TO:	
SUPERVISOR:	TELEPHONE	REASON FOR LEAVING
NAME OF EMPLOYER:	JOB TITLE:	
ADDRESS:	RESPONSIBILITIES:	
CITY, STATE, ZIP CODE:	DATES OF EMPLOYMENT (mm/yy) FROM: TO:	
SUPERVISOR:	TELEPHONE	REASON FOR LEAVING
NAME OF EMPLOYER:	JOB TITLE:	
ADDRESS:	RESPONSIBILITIES:	
CITY, STATE, ZIP CODE:	DATES OF EMPLOYMENT (mm/yy) FROM: TO:	
SUPERVISOR:	TELEPHONE	REASON FOR LEAVING
NAME OF EMPLOYER:	JOB TITLE:	
ADDRESS:	RESPONSIBILITIES:	
CITY, STATE, ZIP CODE:	DATES OF EMPLOYMENT (mm/yy) FROM: TO:	
SUPERVISOR:	TELEPHONE	REASON FOR LEAVING

CERTIFICATION AND RELEASE. PLEASE READ EACH STATEMENT CAREFULLY BEFORE SIGNING.

1. I certify that all information provided in this employment application is true and complete. I understand that any false information or omission may disqualify me from further consideration for employment and may result in my dismissal if discovered at a later date.
2. I understand that Employer may request an investigative consumer report from a consumer-reporting agency. This report may include information as to my character, reputation, personal characteristics and mode of living obtained from interviews with neighbors, friends, former employers, schools and others. I understand I have a right to make a written request within a reasonable time for the disclosure of the name and address of the consumer-reporting agency so that I may obtain a complete disclosure of the nature and scope of the investigation.
3. I authorize the investigation by Employer of any and all statements contained in this application and also authorize any person, school, current employer (except as previously noted), past employers and organizations named in this application to provide relevant information and opinions that may be useful in making a hiring decision. I release such persons and organization from any legal liability in making such statements.
4. I understand that if I am offered employment it may be conditioned upon me successfully passing a pre-employment physical examination. I consent to the release of any or all medical information as may be deemed necessary by Employer to judge my capability to do the work for which I am applying.
5. I understand I may be required to successfully pass a drug screening examination as a contingency to any offer of employment. I hereby consent to a pre- and/or post-employment drug screen as a condition of employment, if required by Employer.
6. **I UNDERSTAND THAT THIS APPLICATION OR SUBSEQUENT EMPLOYMENT DOES NOT CREATE A CONTRACT OF EMPLOYMENT NOR GUARANTEE EMPLOYMENT FOR ANY DEFINITIVE PERIOD OF TIME. IF EMPLOYED, I UNDERSTAND THAT I HAVE BEEN HIRED AT THE WILL OF THE EMPLOYER AND MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME, WITH OR WITHOUT CAUSE AND WITH OR WITHOUT NOTICE.**
7. I have read, understand, and by my signature consent to the foregoing statements.

Applicant Signature:____ **Date:**____________________

DISCLOSURE of CRIMINAL HISTORY – DO NOT COMPLETE UNTIL INSTRUCTED .

STOP!! Do not complete this section unless you have been offered contingent employment and have been instructed to do so by Employer. Please note that a "Yes" answer to any of the following questions will not necessarily disqualify you from employment. Factors such as the age and time of the offense, seriousness and nature of the violation, and rehabilitation will be considered when making any employment decisions. Do not include convictions that were sealed or expunged pursuant to a court order. Do not include any misdemeanor conviction for which probation has been successfully completed or otherwise discharged and the case has been dismissed by a court.

1. Have you ever been convicted of a crime? Yes ☐ No ☐ If "Yes", please provide details:____________________

2. Are you currently awaiting trial for any criminal offense? Yes ☐ No ☐ If "Yes", please provide details:____________________

3. Have you ever initiated an act of violence in the workplace? Yes ☐ No ☐ If "Yes", please provide details:____________________

Applicant Signature:____ **Date:**____________________

AUTHORIZATION FOR PREVIOUS EMPLOYER TO RELEASE INFORMATION

APPLICANT: PLEASE COMPLETE AND SIGN ONLY THE TOP PORTION OF THIS FORM

I. EMPLOYMENT REFERENCE AUTHORIZED BY APPLICANT: _____

Name of Prospect Employer ("Prospect Employer"):_____

Name of Previous Employer ("Previous Employer"):_____

Previous Employer's person of contact:_____, and title:_____

Previous Employer's contact phone no.:_____, and email:_____

Reason for leaving this company:_____

RELEASE STATEMENT

"I hereby authorize Previous Employer to release any and all information relating to my employment with them to Prospect Employer. I further release and hold harmless both Previous Employer and Prospect Employer from any and all liability that may potentially result from the release and/or use of such information. I understand that any information released by Previous Employer will be held in strictest confidence, that it will be viewed only by those involved in the hiring decision, and that neither I nor anyone else not so involved will have the right to see the information."

Applicant Signature: _____ **Date:**_____

↓ DO NOT WRITE BELOW THIS LINE ↓

II. VERIFICATION OF EMPLOYMENT BY EMAIL

1. What was his/her position?_____What were the dates of his/her employment?_____
2. What was your relationship to him/her? (e.g., supervisor, co-worker, etc.) _____
3. What were his/her strengths as an employee?_____

_____

4. On a scale of 1 to 5 (5 being the highest), how would you rate his/her overall performance?_____

_____

5. If you had an opening today for the same job, would you hire him/her? Why or why not?_____

_____

6. Was he/she dependable? Yes ☐ No ☐ Did he/she work well with others? Yes ☐ No ☐ Did he/she exhibit initiative? Yes ☐ No ☐
7. If we were to extend an employment offer, what suggestions might help contribute towards his/her success on the job?

_____

8. Is there anything else you think might be helpful for us to know about him/her before making our hiring decision?

_____

_____

AUTHORIZATION FOR PREVIOUS EMPLOYER TO RELEASE INFORMATION

APPLICANT: PLEASE COMPLETE AND SIGN ONLY THE TOP PORTION OF THIS FORM

I. EMPLOYMENT REFERENCE AUTHORIZED BY APPLICANT: _____

Name of Prospect Employer ("Prospect Employer"):_____

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Reason for leaving this company:_____

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Applicant Signature: _____ **Date:**_____

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3. What were his/her strengths as an employee?_____

_____

4. On a scale of 1 to 5 (5 being the highest), how would you rate his/her overall performance?_____

_____

5. If you had an opening today for the same job, would you hire him/her? Why or why not?_____

_____

6. Was he/she dependable? Yes ☐ No ☐ Did he/she work well with others? Yes ☐ No ☐ Did he/she exhibit initiative? Yes ☐ No ☐
7. If we were to extend an employment offer, what suggestions might help contribute towards his/her success on the job?

_____

8. Is there anything else you think might be helpful for us to know about him/her before making our hiring decision?

_____

_____

ORIENTATION CHECKLIST

ORIENTATION ITEMS FOR REVIEW	DATE COMPLETED	ORIENTATION BY	EMPLOYEE INITIALS
1. FACILITY OVERVIEW ☑ Organization Mission Statement, Vision Statement and its goals ☑ Organizational Chart ☑ Corporate Compliance Program ☑ Introduction to Facility Personnel ☑ Tour of Facility ☑ Introduction to Work Stations ☑ Equipment Management ☑ Storage, handling and access to the medical record			
2. HUMAN RESOURCE POLICIES ☑ Quality Management Plan ☑ Incident reporting (aka Adverse Event) ☑ Staff grievance and complaints policy FORMS STAFF MEMBER COMPLETES ☑ Employment Application ☑ Employer References ☑ Job Descriptions ☑ Competency Assessments ☑ Performance Evaluations ☑ Orientation Checklist ☑ Annual In-Service Module ☑ Confidentiality Agt/HIPAA ☑ Conflict of Interest ☑ Employment Verification ☑ Health Status Attestation ☑ Flu, HEP-B, HIV Consents DOCUMENTS STAFF MEMBER PROVIDES ☑ Curriculum Vitae/Resume ☑ Valid, unexpired professional licenses and other credentials for inspection & photocopy ☑ Valid, unexpired CPR certificate (ACLS/BLS) ☑ Valid, unexpired US Passport, or government-issued photo ID in conjunction with a Social Security Card, or other acceptable form of photo ID listed on page 9 of Form I-9 ☑ PPD/CXR TB Results; Immun. Record			
3. ENVIRONMENT OF CARE EMERGENCY PREPAREDNESS ☑ Life & Fire Safety ☑ Emergency Evacuation ☑ Actions in Unsafe Situations ☑ Emergency Management Plan			
4. INFECTION PREVENTION AND CONTROL PRACTICES ☑ Universal Precautions ☑ Influenza Vaccination Program ☑ OSHA Bloodborne Pathogens ☑ Sharps Injury Prevention ☑ Hand Hygiene ☑ Personal Protection Equipment (PPE) ☑ Identifying, handling, and disposing of hazardous or infectious materials.			
5. PATIENT CARE ☑ Ethical aspects of patient care. ☑ Patient care services this facility provides. ☑ Patient safety. ☑ Patient confidentiality, privacy, and HIPAA requirements. ☑ Patient rights and responsibilities. ☑ Advance Directives. ☑ Responsibility to report patient abuse and neglect.			

The above facility policies and procedures have been reviewed with me. I understand it is my responsibility to direct any questions regarding the foregoing to my manager or to Human Resources personnel for further clarification.

Print Employee Name: _____

Employee Signature: _____ Date: _____

Supervisor / HR Signature: _____ Date: _____

NON-DISCLOSURE / CONFIDENTIALITY AGREEMENT

I have read and understand the policies of this healthcare facility (herein "Facility") regarding the privacy of individually identifiable health information (or protected health information ("PHI")), pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Also, I acknowledge that I have received training concerning the use, disclosure, storage and destruction of PHI as required by HIPAA, and that I have read and understand the material outlined in the HIPAA Training Handbook(s) provided by Facility.

I further understand that through my affiliation with Facility I may be exposed to information considered beyond the purview of HIPAA that is confidential, sensitive, personal, intimate, private or propriety in nature regarding patients, contractors, employees and other third-party entities with whom Facility has a fiduciary affiliation or relationship (such information and PHI shall collectively be referred to as "PHI" herein).

In consideration of my employment with and/or compensation from Facility, I hereby agree that I will not at any time—either during or after my employment or affiliation with Facility—use, access or disclose PHI in any manner to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities with Facility as permitted under their privacy policies and procedures as adopted and amended from time to time or as permitted under HIPAA. I understand that this prohibition includes, but is not limited to, disclosing any information about the identity of the patients with whom I work or any information about them, including their medical and other personal information, to family, friends, other patients, vendors, or co-workers, unless such person is lawfully authorized to receive such information. I agree to document uses and disclosure of PHI as required by HIPAA and to return or destroy all PHI associated with patients or Facility upon the termination of my services. I agree that I will immediately report to Facility any impermissible PHI use or disclosure. I understand that my person access code, user ID, access key, password and similar access information will be kept confidential at all times. I understand that I will not remove from Facility any devices or media unless instructed or authorized to do so. I agree to return all means of access to PHI upon termination of my employment with Facility.

I understand and acknowledge my responsibility to apply the policies and procedures of Facility. I understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including the termination of employment or affiliation with Facility and could result in the imposition of civil and criminal penalties under applicable laws, as well as professional disciplinary action. I understand that my obligations will survive the termination of my employment or end of my affiliation with Facility, regardless of the reason for such termination. I understand that my obligations extend to any PHI that I may acquire during the course of my employment or affiliation with Facility, whether in oral, written or electronic form and regardless of the manner in which access was obtained. I understand that I should contact an administrative officer of Facility if I have any questions, comments or concerns about the training I received or my obligations under this agreement.

Print Name: _____

Signature: _____ Date: _____

CONFLICT OF INTEREST DISCLOSURE

A conflict of interest occurs when the leadership or staff enters into a relationship with another organization or individual(s) which, in its content or process may adversely affect or have the appearance of adversely affecting the staff's commitment to the facility and to the culture of safety and quality.

Conflicts of interest may include, but shall not be limited to, relationships, associations or business dealings with vendors, suppliers, other healthcare organizations or individuals.

A conflict of interest may take overt or covert forms, and can represent many situations. However, it is generally understood that a conflict of interest constitutes a situation when the organization as a whole or individual representatives of the organization, has competing professional or personal obligations or personal or financial interests that would make it difficult for the organization or the individual(s) to fairly fulfill the mission, vision, values and goals of the institution.

In general, conflicts of interest relate to the potential for self-gain typically, but not always, of a fiscal nature. Potential for self-gain can serve to undermine the judgment or objectivity of licensed independent practitioners (LIPs), administrators, employees, consultants and designated contractors such that their mission and dedication to the values and activities of this healthcare institution are compromised.

The goal of the Conflict of Interest Policy is to ensure that the mission and responsibility to the residents and community served by this facility are not harmed by any professional, ownership, contractual or other relationships. This policy aims to preserve the integrity of decision making, and to ensure that directors and staff act in the best interests of the organization.

Members of this facility's patient care team and staff are required to disclose all professional and personal relationships, and/or interests, from which any financial or personal profit and/or gain may be directly or indirectly derived, or that otherwise conflict, or have the potential to conflict, with this facility's responsibilities to patients and their families, its public service mission, and its adherence to ethical business practices.

Please select either YES or NO and sign where indicated below.

☐ **YES, I may have conflicts of interest to disclose.**

Please describe below any relationships, positions, or circumstances in which you are involved in which you believe could contribute to a Conflict of Interest arising:

_____

_____

☐ **NO, I have no conflicts of interest to disclose at this time.**

I hereby certify that the information set forth above is true and complete to the best of my knowledge. I have reviewed, and agree to abide by, the Policy of Conflict of Interest of this facility, which is currently in effect.

Print Name: _____ Date: _____

Signature: _____

CORPORATE COMPLIANCE PLAN
REVIEW & TRAINING ATTESTATION

I ATTEST TO, AND AM IN AGREEMENT WITH, THE FOLLOWING STATEMENTS:

1. I have reviewed this facility's policies and procedures relating to Medicare/Medical fraud and abuse.
2. I have received and read a copy of this facility's Corporate Compliance Plan and the Code of Conduct and an explanation of the federal False Claims Act.
3. I have completed this facility's Corporate Compliance Plan training program (in conjunction with the Health Insurance Portability and Accountability Act (HIPAA) Compliance Plan).
4. I understand that I have a continuing responsibility to comply with the Code of Conduct and participate fully in this facility's ongoing Corporate Compliance Plan in its entirety.
5. I understand that my failure to comply with this facility's Code of Conduct policies and procedures and its Corporate Compliance Plan, or to observe the Health Insurance Portability and Accountability Act (HIPAA) or abide by government law and regulation pertaining to healthcare fraud and abuse, including my responsibility to report possible violations, may result in disciplinary action, up to and including termination.

Signature: _____ Date: _____

Print Name: _____

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

California law requires certain people to report known or suspected dependent adult or elder abuse or neglect. You have been identified as one of those people who may be a "mandated reporter." Mandated reporters are individuals who have "assumed full or intermittent responsibility for the care or custody of an elder or dependent adult," as well as health care practitioners, clergy members, and law enforcement personnel. [W&I § 15630(a)]

DEPENDENT ADULTS AND ELDERS

A dependent adult is a California resident aged 18-64 who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. These include persons with physical or developmental disabilities or whose physical or mental abilities have diminished with age. [W&I 15610.23] Elders are California residents age 65 or older. [W&I15610.27]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be dependent adult or elder abuse or neglect, or who is told by a dependent adult or elder that he or she has experienced abuse or neglect, or reasonably suspects abuse or neglect, must report this information by telephone immediately or as soon as practically possible, and by written report within two (2) working days. [W&I 15630(b)]

ABUSE THAT MUST BE REPORTED

- Physical abuse [W&I § 15610.63]
- Neglect [W&I § 15610.57]
- Financial abuse [W&I § 15610.30(a)]
- Abandonment [W&I § 15610.65]
- Isolation [W&I § 15610.43]
- Abduction [W&I § 15610.06]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

If the abuse occurred in a long-term care facility or residential facility serving adults or elders or an adult day program, you must report to either local law enforcement or the local long-term care ombudsman. [W&I § 15630(b)(1)(A)]. Otherwise, you must report to local law enforcement (including Campus Police) or county adult protective services. [W&I § 15630(b)(1)(C)] Forms for submitting written reports may be found online at http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm. In addition, an internal report must be made to your supervisor or to the University Compliance Hotline. This internal report may be made anonymously.

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to make a mandatory report may result in fines ranging from $1000-$5000 and imprisonment for 6 months to 1 year, depending on the circumstances. [W&I § 15630(h)]

ACKNOWLEDGEMENT OF RESPONSIBILITY

I acknowledge my responsibility to report known or suspected dependent adult or elder abuse or neglect in compliance with California Welfare and Institutions Code W&I § 15630.

Signature: _____ Date: _____

Print Name: _____

AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES

The position for which you are being considered requires that you consent to a criminal background check as a condition of employment. As such, and with your signature at the bottom of this page, you hereby authorize Employer and its designated agents and representatives to conduct at its discretion a comprehensive review of your background through a consumer report and/or investigative consumer report generated by an employee background screening company ("Screening Company") of Employer's choosing for purposes of employment, which include hiring, promoting, reassigning or retaining an employee. You acknowledge the scope of the consumer report and/or investigative consumer report may include, but is not limited to, the following areas: names and dates of previous and current employment; work experience; Bureau of Workers Compensation/Claims; criminal history records (from local, state, federal, international and other law enforcement agencies' records); sexual offender lists; wants and warrants records; motor vehicle records; military records; education verification; license verification; credit history; civil cases; OIG/GSA; USA PATRIOT Act/OFAC; any sanction lists, FBI finger printing and drug testing. You further acknowledge you have received a copy of "A Summary of Your Rights Under the Fair Reporting Act" prescribed by the Federal Trade Commission and that questions regarding your rights and this form, if any, have been satisfactorily answered. Employer will supply to you a copy of the completed consumer report and/or investigative consumer report if information contained in these reports leads to an adverse decision or action taken against you as it relates to your employment status or potential employment.

Please complete the following information as it is required by law enforcement agencies and other entities for identification purposes when checking records. It is confidential and will not be used for any other purpose.

Identifying Information

Full legal name (first middle last): _____ Position(s) Applied for: **Choose One**

Other names used in the past 7 years: _____

Current address: , _____

Most recent previous address: _____

Other addresses used in the past 7 years: _____

Phone No: _____ Alt Phone No: _____ Social Sec No: _____

Date of Birth: _____ Driver's Lic No: _____ State of Issue: _____

Email Address: _____ Gender: Male☐ Female☐

Disclosure of Criminal Offenses

Have you ever been convicted of a criminal offense or are pending criminal charges currently filed against you? (This refers only to felonies and misdemeanors; you do not need to include non-criminal traffic violations or municipal ordinance violations): Yes☐ No☐

If "yes", please provide details: _____

Authorization and Release

I, _____, authorize the complete release of records or data pertaining to me, which an individual, company, firm, corporation, or public agency may have in its posession. I authorize the full release of the information described above, without any reservation, throughout any duration of my employment with Employer. I hereby release Screening Company and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may at any time, result to me, my heirs, family or associates because of compliance with this authorization for release form. I certify that all information provided herein and on my résumé and/or job application or other attachments is, to the best of my knowledge, true, correct and complete. Any false statements provided on this form and/or my résumé or job application will be considered just cause to deny or rescind employment offerings made to me by Employer, or to terminate my existing employment at any time. This authorization and consent shall be valid in original, fax, or copy form.

_____ _____

Signature Date

CERTIFICATE OF HIPAA

This certifies that

Has successfully completed the training program requirement for

HIPAA PRIVACY & PROTECTIONS

And is therefore considered compliant and fully certified.

Troy L. Lair

DATE

Facility Compliance Officer

HEALTH ATTESTATION FORM

Print Staff Member name: _____

Please explain any "yes" answers in the space provided on this form or by attaching a separate sheet. This form is confidential and will be kept in your credentials file.

Do you presently have any physical or mental condition that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to any physical or mental condition that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Do you presently suffer from an addiction to drugs, alcohol, or other chemical substances that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to an addiction to drugs, alcohol, or other chemical substances? If yes, please explain: _____	☐ Yes ☐ No
Are you currently taking any medications that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Do you have any communicable diseases? If yes, please explain: _____	☐ Yes ☐ No
Please provide the date of your most recent physical exam: _____ Performed by: _____	

Please provide dates for the following vaccinations/tests and attach supporting documentation:

- Annual TB Screening: PPD_____ (Result_____) or Chest X-ray_____ (Result_____)
- Annual Influenza: _____, or check here ____ to decline (complete Influenza Declination and attach).
- Hepatitis B (initial attestation only): ____ ____ ____, or check here ____ to decline (complete HEP B Declination and attach)
- HIV Test (initial attestation only): _____, or check here ____ to decline (complete HIV Test Declination and attach).

I (please print full name) _____ attest that I am in good health and have no physical or mental conditions that may affect my ability to perform clinical or professional duties. I also attest that I have no current addictions to drugs, alcohol, or any other recreational chemical substances. I understand that I may not hold [name of health center] responsible for any physical or mental conditions or addictions that I have or have not disclosed.

Staff Member signature: _____ Date: _____

** PPD tests are only good for one year, if you've had the test within the past 12 months, then a copy of that test with whomever gave it to you can be used for this requirement. If you've previously tested positive then a chest x-ray every two years is required. You do not need a chest x-ray if you've never tested positive. Flu Vaccines are valid for one year only. Only direct-patient caregivers need to have a PPD test on an annual basis. If you do not come into contact with patients, then there is no need or requirement for you to comply to the annual PPD (TB) testing.* Did you remember to provide Vaccination proof for Covid and Boosters?

SEASONAL INFLUENZA VACCINATION PROGRAM

Please select either YES or NO and sign where indicated below.

☐ YES, I will participate in the Influenza Vaccination Program.

I choose to participate in this healthcare facility's seasonal influenza vaccination program. I understand I am responsible for procuring my own vaccination and agree to provide evidence of having been vaccinated for inclusion in my employee health record. I further agree to reaffirm my participation in this program annually.

☐ NO, I will not participate in the Influenza Vaccination Program.

This healthcare facility recommends that I participate in its Influenza Vaccination Program to protect the patients I serve, in part, because of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread it to others and they can become seriously ill, even if my symptoms are mild or non-existent.
- The strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.

After reviewing information given to me regarding my occupational risk to the Influenza virus and measures to safeguard against infection, including seasonal vaccination, I choose not to participate in this healthcare facility's Influenza Vaccination Program. I understand the consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, my coworkers, my family, and my community. Knowing these facts, I still choose not to participate in the Influenza Vaccination Program at this time for the following reason:

- ☐ I am allergic to components of the vaccine (specify): _____
- ☐ I don't believe in vaccines.
- ☐ I won't take the vaccine because of side effects.
- ☐ I never get influenza.
- ☐ I have had Guillen Barre or other medical problems that preclude me from receiving the vaccine.
- ☐ I got severe influenza-like symptoms from the influenza vaccine and won't get it again.
- ☐ Other (specify): _____

I have read and fully understand the information on this page.

Signature: _____ Date: _____

Print Name: _____

HEPATITIS B IMMUNIZATION CONSENT/REFUSAL

Please select either YES or NO and sign where indicated below.

☐ **YES, I want to receive the Hepatitis B vaccine.**

After reviewing information given to me regarding my occupational risk to the Hepatitis B virus and measures to safeguard against infection, I elect to participate in this facility's Hepatitis B Immunization Program. I understand this includes three injections at prescribed intervals over a 6-month period. I understand that there is no guarantee that I will become immune to Hepatitis B and that I might experience adverse side effects as the result of the vaccination. A staff physician has satisfactorily answered all my questions relating to this immunization program.

	Date Given	Lot No.	Administered By	Next Date Due
1st Dose:				
2nd Dose:				
3rd Dose:				

☐ **NO, I don't want to receive the Hepatitis B vaccine.**

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

I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason (check one):

☐ I have previously received the complete Hepatitis B vaccination series (provide immunization record).

☐ Antibody testing has revealed I am immune to Hepatitis B (provide laboratory numerical proof of immunity.)

☐ The vaccine is contraindicated for the following medical reasons:

_____

_____

_____

☐ Other, explain:

_____

_____

_____

Print Name: _____

Signature: _____ Date: _____

HIV Test Informed Consent / Refusal

Please select either YES or NO and sign where indicated below.

☐ **YES. I am informed and I consent to an HIV test.**

I consent to a Human Immunodeficiency Virus (HIV) test and authorize its results to be used to evaluate eligibility for insurance coverage should I be exposed to HIV during my course of work at this facility. By signing and dating this form, I agree that the HIV antibody test may be performed on samples of my blood, urine, and saliva and that underwriting decisions may be based on the test results.

I have been advised of the implications of the test and have been given an opportunity to ask questions and have my questions answered.

I understand I will receive my test results in person.

...OR...

☐ **NO. Though I am informed, I do not consent to an HIV test at this time.**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk to Human Immunodeficiency Virus (HIV) infection. I also understand that Workers Compensation insurance may be denied to me if I become infected with HIV during the course of my work without having first provided a HIV test result to evaluate insurance coverage eligibility.

I choose not to have the recommended HIV test at this time because:

☐ I don't want blood drawn
☐ I don't want to know my HIV status
☐ Other (please specify):

_____

_____

_____

In the event of occupational exposure to HIV or other infectious materials while working at this facility you are required to notify the Medical Director immediately and be tested for HIV, regardless to whether you have, or have not, previously consented to such a test (workers compensation laws protect the employer from litigation should it be necessary to perform such a test in this manner). If you refuse to test for HIV upon occupational exposure, then you are waiving your right to claim any medical condition that should arise from that incident hereto.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.