

# All N One Home Health, LLC Application

Today's Date: \_\_\_\_\_

## Personal Data

Last Name		First Name	Middle	
Home Address		City	State	Zip
Home Phone	Cell Phone	Pager	Email	Fax
Driver's license or State Identification		Social Security	Birthdate	
Policy Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Expiration Date		
Auto Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have a car? <input type="checkbox"/> Yes <input type="checkbox"/> No      If NO, How would you get to work?				
Have you had any accidents during the past three years? <input type="checkbox"/> No <input type="checkbox"/> Yes      How many? _____				
Have you had any moving violations during the past three years? <input type="checkbox"/> No <input type="checkbox"/> Yes      How many? _____				

## Emergency Contact Information

Name of Emergency Contact	Relation	Emergency Telephone Number
Name of Emergency Contact	Relation	Emergency Telephone Number
Physician	Telephone Number	Address
Hospital	Telephone Number	Address

## Job Information

Position (Job Class) Applying for:

RN    PT    LP/VN    CNA    OT    PTA    Clerical    Other \_\_\_\_\_      Date Available: \_\_\_\_\_

### Work Experience/Skills

Please check the areas you have experience in (min 1 year exp.) and are clinically competent to work:

- |                                |                                    |                                     |   |
|--------------------------------|------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Burn  | <input type="checkbox"/> ENT       | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Detox/Drug Rehab |
| <input type="checkbox"/> L & D | <input type="checkbox"/> Rehab     | <input type="checkbox"/> Telemetry  | <input type="checkbox"/> Post Partum      |
| <input type="checkbox"/> MICU  | <input type="checkbox"/> Nursery   | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Orthopedics      |
| <input type="checkbox"/> NICU  | <input type="checkbox"/> Dialysis  | <input type="checkbox"/> Stepdown   | <input type="checkbox"/> Mother/Baby      |
| <input type="checkbox"/> PACU  | <input type="checkbox"/> Geriatric | <input type="checkbox"/> Oncology   | <input type="checkbox"/> Recovery Room    |
| <input type="checkbox"/> SICU  | <input type="checkbox"/> Pedi ICU  | <input type="checkbox"/> Neurology  | <input type="checkbox"/> Operating Room   |
| <input type="checkbox"/> CCU   | <input type="checkbox"/> Med/Surg  | <input type="checkbox"/> Open Heart | <input type="checkbox"/> Emergency Room   |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other     | <input type="checkbox"/> Other      | <input type="checkbox"/> Other            |

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**Previous Facility Types Worked: Check All That Apply -**

Hospital    Hospice    Nursing Home    Rehab    Private Duty    Assisted Living / Residential Treatment

Language Skills: **Other than English, please check any other languages you speak -**

Spanish    French    German    Other: \_\_\_\_\_

**Check the type of assignment you are available for:**

Full-time    Part-time    Contract    Travel

**Check the days of the week you are available to work:**

Monday    Tuesday    Wednesday    Thursday    Friday    Saturday    Sunday

**Shifts available to work:** Days  Evenings  Nights

**Do you work Doubles:** Day/Evening  Evening/Night

Holidays available to work: \_\_\_\_\_

License Type	License/Certification #	State	Expiration Date

License Type	License/Certification #	State	Expiration Date

Has your professional license ever been suspended, revoked or under investigation?  Yes    No

If Yes, Please explain: \_\_\_\_\_

Have you ever been denied a Fingerprinting Clearance Card?  Yes    No

If Yes, Please explain: \_\_\_\_\_

**Certifications: Check all applicable certifications and enter expiration date:**

<input type="checkbox"/> ACLS	Expiration Date: _____	<input type="checkbox"/> Other	Expiration Date: _____
<input type="checkbox"/> BCLS	Expiration Date: _____	<input type="checkbox"/> IV	Expiration Date: _____
<input type="checkbox"/> CPR	Expiration Date: _____	<input type="checkbox"/> NALS	Expiration Date: _____
<input type="checkbox"/> PALS	Expiration Date: _____		

**Do you have the following items needed to work Registry: Check all applicable and enter expiration date as needed:**

License/Certification   Expiration Date: \_\_\_\_\_ (Must provide proof)

TB Test   Expiration Date: \_\_\_\_\_ (Must provide proof)

CPR   Expiration Date: \_\_\_\_\_ (Must provide proof)

Fingerprint Clearance Card   Expiration Date: \_\_\_\_\_ (Must provide proof)

Drug Test   Date Performed : \_\_\_\_\_ (Must provide proof)

Annual Physical   Date Performed: \_\_\_\_\_ (Must provide proof)

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**Chicken Pox Verification**

I certify I have had the Chicken Pox Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Hepatitis B Declination Form:** 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 Hepatitis B vaccine, at no charge to myself. However, I decline 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 Hepatitis B vaccine, I can receive the vaccination series at no charge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Immunization Record:**

MMR Vaccination  Immunization  Titer Date: \_\_\_\_\_

Varicella (Chicken Pox)  History  Titer Date: \_\_\_\_\_

Hepatitis B Vaccination: Date: \_\_\_\_\_

Negative TB Test (Annual) Date: \_\_\_\_\_

Negative Chest X-Ray (If positive TB Test) Date: \_\_\_\_\_



# All N One Home Health, LLC Application

Facility/Employer Name _____	Date Employed From: _____ To: _____
Address _____	Title _____
City/State/Zip _____ Country _____	Unit _____
Number of Beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor _____
Describe duties and specialty areas: _____	Telephone #: _____
Pay Rate/Salary: Hourly _____ Yearly _____	May We Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why? _____
Reason for leaving: _____	If this was a travel assignment, name of agency: _____
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, what name? _____	Supervisory Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No – How often? _____
~~~~~	
Facility/Employer Name _____	Date Employed From: _____ To: _____
Address _____	Title _____
City/State/Zip _____ Country _____	Unit _____
Number of Beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor _____
Describe duties and specialty areas: _____	Telephone #: _____
Pay Rate/Salary: Hourly _____ Yearly _____	May We Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why? _____
Reason for leaving: _____	If this was a travel assignment, name of agency: _____
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what name? _____	Supervisory Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No – How often? _____

Please list any other work related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, additional work experience, etc.

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# All N One Home Health, LLC

## Application

### Additional Information:

1. Are you legally authorized to work in the USA?  Yes  No
2. Have you ever been convicted of a felony?  Yes  No
3. Can you pass a pre-employment drug test?  Yes  No
- 4.
5. How were you referred to Registry, LLC?  
 Newspaper  Trade Publication  Job Fair/Open House  Internet Site  
 Company Employee – Name: \_\_\_\_\_

I understand that I **must** report all accidents to my immediate supervisor **and** to All N One Home Health Agency, LLC -- No MATTER HOW SLIGHT.  Yes

I also understand that I must wear all required personal protection equipment (PPE).  Yes  
The penalty for not wearing PPE is disciplinary action, up to and including termination.

\_\_\_\_\_  
Signature

### ACKNOWLEDGMENT *(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 All N One Home Health Agency, LLC permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by All N One Home Health Agency, LLC 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, All N One Home Health Agency, LLC may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release All N One Home Health, LLC, its agents, and all affiliated entities, as well as any person or situation that provides 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 All N One Home Health Agency, LLC, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an Independent Contractor at will and employed for no definite period of time.

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 the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I understand that All N One Home Health Agency, LLC is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies All N One Home Health, LLC against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

**I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_