

## Application For Employment

**It is this agency's policy to provide equal employment opportunities without regard to age, race, color, religion, military status, gender preference, sex, marital status, national origin, or disability.**

Applicant Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Present Address  
City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Are You at Least 18 Years Old?  Yes  No

Position Applying For:  Full Time  Part Time Per Visit  Shift:  Day  Night  
 Part Time  Pool  Evening  W/E

Salary Requirements: \_\_\_\_\_ Date Available \_\_\_\_\_ If you are not a US Citizen, have you the legal right to remain permanently in the US?  Yes  No

Do you have adequate means of transportation to get to work on time each day and when called in on short notice during normal working hours?  Yes  No

Have you been convicted of a crime (excluding misdemeanors and traffic offenses) and/or released from confinement following a conviction for any criminal offense within the past 7 years?  Yes  No If Yes, please give date, place and nature of each such conviction.

Are you presently charged with any violation of the law other than traffic violation?  Yes  No If Yes, give date, place and nature of each such conviction.

### Educational History

| Type of School | Name & Location of School | Circle Last Year Attended | Graduated | Degree |
|----------------|---------------------------|---------------------------|-----------|--------|
| High School    |                           | 9 10 11 12                |           |        |
| College        |                           | 1 2 3 4                   |           |        |
| College        |                           | 1 2 3 4                   |           |        |
| Other          |                           | From: To:                 |           |        |

List professional licenses you possess. Indicate type of license, number and state

List any memberships in professional organizations, honors or activities which you feel would enhance your application, excluding those that would indicate age, race, color, religion, military status, gender preference, sex, marital status, national origin, or disability.

List languages spoken other than English:

List other skills applicable to the position for which you are applying, including computer experience, typing speed, etc:

In case of an emergency notify \_\_\_\_\_ Relationship \_\_\_\_\_

Out of state contact, if possible \_\_\_\_\_ Relationship \_\_\_\_\_

NAME \_\_\_\_\_

**Work History**

Attach an additional sheet listing other work experience pertinent to the position for which you are applying if the space below is insufficient

|                           |  |                    |  |
|---------------------------|--|--------------------|--|
| Company Name              | Complete Address incl City/State/Zip   | Phone Number       | Supervisor's Name  |
| Date Started<br>Date Left | Type of Business<br><input type="checkbox"/> Full Time<br><br><input type="checkbox"/> Part Time<br><br><input type="checkbox"/> Per Visit<br><br>Salary | Reason For Leaving | OK to Contact Supervisor<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No |

Describe your job title, responsibilities and accomplishments

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|                           |  |                    |  |
|---------------------------|--|--------------------|--|
| Company Name              | Complete Address incl City/State/Zip   | Phone Number       | Supervisor's Name  |
| Date Started<br>Date Left | Type of Business<br><input type="checkbox"/> Full Time<br><br><input type="checkbox"/> Per Visit<br><br><input type="checkbox"/> Part Time<br><br>Salary | Reason For Leaving | OK to Contact Supervisor<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No |

Describe your job title, responsibilities and accomplishments

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|                           |  |                    |   |
|---------------------------|--|--------------------|---|
| Company Name              | Complete Address incl City/State/Zip   | Phone Number       | Supervisor's Name   |
| Date Started<br>Date Left | Type of Business<br><input type="checkbox"/> Full Time<br><br><input type="checkbox"/> Part Time<br><br><input type="checkbox"/> Per Visit<br><br>Salary | Reason For Leaving | OK to Contact Supervisor<br><br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> |

Describe your job title, responsibilities and accomplishments

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NAME: \_\_\_\_\_

PERSONAL REFERENCES: (Name,Phone ,Relationship) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please review and sign**

In making application for employment:

- I certify that the information in this application is true and complete, for all practical purposes. It may be verified by the facility or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the facility or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate discharge without recourse.
- I understand that an investigative report may be made by a consumer reporting agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I understand that I will receive notice that such report has been requested, and that I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.
- I understand and agree that if I am offered employment by the facility, my employment will be for no definite term and that either I, or the facility will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the facility.
- I understand, if I am an unlicensed person who has face-to-face patient/client contact, that the agency will perform a criminal history check per State Regulations as well as a check of the Nurse Aide Registry and Employee Misconduct Registry. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in DADS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Department of Aging and Disability Services (DADS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All DADS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, **unemployable**.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

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

|                        |  |                                   |                                    |
|------------------------|--|-----------------------------------|------------------------------------|
| FOR OFFICE<br>USE ONLY | <input type="checkbox"/> References<br>Checked | If Hired:    Position:<br>Salary: | Start Date:<br><br>FT/PT/Per Visit |
|------------------------|--|-----------------------------------|------------------------------------|

**Reference Request****Eminent Home Healthcare LLC**

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

Check method of gathering reference data:  Verbal  Mail

Name of person giving reference: \_\_\_\_\_ Facility: \_\_\_\_\_

The individual named below is applying for a position as \_\_\_\_\_  
 and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a  
 prompt and thoughtful response.

Thank you in advance \_\_\_\_\_  
 (Name of Company Representative)

**Applicant Release**

Applicant \_\_\_\_\_  
 Last First MI Maiden

Position Held \_\_\_\_\_

Social Security # \_\_\_\_\_ Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my  
 employment with them. I understand that this information may be released to clients of the requesting company and other requesting third  
 parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

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

1) Please confirm the applicant's employment. From \_\_\_\_\_ To \_\_\_\_\_  
 Date Date

2) Please comment on the applicant's attributes using the following scale:  
 4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work \_\_\_\_\_

Knowledge &amp; Skills \_\_\_\_\_

Reliability &amp; Attendance \_\_\_\_\_

Cooperation \_\_\_\_\_

Competence \_\_\_\_\_

Supervisory ability &amp; capacity \_\_\_\_\_

Grooming \_\_\_\_\_

3) Please indicate specialty areas in which the applicant has had experience: \_\_\_\_\_  
 \_\_\_\_\_

4) Please indicate any special considerations necessary when giving assignments to this individual:  
 \_\_\_\_\_  
 \_\_\_\_\_

5) Is applicant eligible for rehire?  Yes  No If no, why not? \_\_\_\_\_  
 \_\_\_\_\_

Please attach any additional comments.

\_\_\_\_\_  
 Signature Position/Title Date

**Reference Request****Eminent Home Healthcare LLC**

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

Check method of gathering reference data:  Verbal  Mail

Name of person giving reference: \_\_\_\_\_ Facility: \_\_\_\_\_

The individual named below is applying for a position as \_\_\_\_\_ and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance \_\_\_\_\_  
(Name of Company Representative)

**Applicant Release**

Applicant \_\_\_\_\_  
Last First MI Maiden

Position Held \_\_\_\_\_

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I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

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

1) Please confirm the applicant's employment. From \_\_\_\_\_ To \_\_\_\_\_  
Date Date

2) Please comment on the applicant's attributes using the following scale:  
4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work \_\_\_\_\_

Knowledge &amp; Skills \_\_\_\_\_

Reliability &amp; Attendance \_\_\_\_\_

Cooperation \_\_\_\_\_

Competence \_\_\_\_\_

Supervisory ability &amp; capacity \_\_\_\_\_

Grooming \_\_\_\_\_

3) Please indicate specialty areas in which the applicant has had experience: \_\_\_\_\_

4) Please indicate any special considerations necessary when giving assignments to this individual:  
\_\_\_\_\_

5) Is applicant eligible for rehire?  Yes  No If no, why not? \_\_\_\_\_

Please attach any additional comments.

\_\_\_\_\_  
Signature Position/Title Date

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification** *(To be completed and signed by employee at the time employment begins.)*

|   |       |                |                                       |
|---|-------|----------------|---------------------------------------|
| Print Name: Last                        | First | Middle Initial | Maiden Name                           |
| Address <i>(Street Name and Number)</i> |       | Apt. #         | Date of Birth <i>(month/day/year)</i> |
| City                                    | State | Zip Code       | Social Security #                     |

**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):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) \_\_\_\_\_
- An alien authorized to work (Alien # or Admission #) \_\_\_\_\_ until (expiration date, if applicable - month/day/year)

|                      |                              |
|----------------------|------------------------------|
| Employee's Signature | Date <i>(month/day/year)</i> |
|----------------------|------------------------------|

**Preparer and/or Translator Certification** *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

|  |            |
|--|------------|
| Preparer's/Translator's Signature                              | Print Name |
| Address <i>(Street Name and Number, City, State, Zip Code)</i> |            |
| Date <i>(month/day/year)</i>                                   |            |

**Section 2. Employer Review and Verification** *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

| List A                                  | OR | List B | AND | List C |
|---|----|--------|-----|--------|
| Document title: _____                   |    | _____  |     | _____  |
| Issuing authority: _____                |    | _____  |     | _____  |
| Document #: _____                       |    | _____  |     | _____  |
| Expiration Date <i>(if any)</i> : _____ |    | _____  |     | _____  |
| Document #: _____                       |    | _____  |     | _____  |
| Expiration Date <i>(if any)</i> : _____ |    | _____  |     | _____  |

**CERTIFICATION:** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* \_\_\_\_\_ and that to the best of my knowledge the employee is authorized to work in the United States. **(State employment agencies may omit the date the employee began employment.)**

|  |            |                              |
|--|------------|------------------------------|
| Signature of Employer or Authorized Representative   | Print Name | Title                        |
| Business or Organization Name and Address <i>(Street Name and Number, City, State, Zip Code)</i> |            | Date <i>(month/day/year)</i> |

**Section 3. Updating and Reverification** *(To be completed and signed by employer.)*

|                                    |  |
|------------------------------------|--|
| A. New Name <i>(if applicable)</i> | B. Date of Rehire <i>(month/day/year)</i> <i>(if applicable)</i> |
|------------------------------------|--|

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

|                       |                   |   |
|-----------------------|-------------------|---|
| Document Title: _____ | Document #: _____ | Expiration Date <i>(if any)</i> : _____ |
|-----------------------|-------------------|---|

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 | Date <i>(month/day/year)</i> |
|--|------------------------------|

# Form W-4 (2011)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

|          |  |          |               |
|----------|--|----------|---------------|
| <b>A</b> | Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .  | <b>A</b> | <u>      </u> |
| <b>B</b> | Enter "1" if: <span style="font-size: 2em; vertical-align: middle;">{</span> <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul> <span style="font-size: 2em; vertical-align: middle;">}</span> . . . . .   | <b>B</b> | <u>      </u> |
| <b>C</b> | Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .  | <b>C</b> | <u>      </u> |
| <b>D</b> | Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .   | <b>D</b> | <u>      </u> |
| <b>E</b> | Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .  | <b>E</b> | <u>      </u> |
| <b>F</b> | Enter "1" if you have at least \$1,900 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .<br>( <b>Note.</b> Do <b>not</b> include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)  | <b>F</b> | <u>      </u> |
| <b>G</b> | <b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have three or more eligible children.</li> <li>• If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" <b>additional</b> if you have six or more eligible children . . . . .</li> </ul>   | <b>G</b> | <u>      </u> |
| <b>H</b> | Add lines A through G and enter total here. ( <b>Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶  | <b>H</b> | <u>      </u> |
|          | For accuracy, <b>complete all worksheets that apply.</b> <span style="font-size: 2em; vertical-align: middle;">{</span> <ul style="list-style-type: none"> <li>• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul> <span style="font-size: 2em; vertical-align: middle;">}</span> |          |               |

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

|  |   |   |
|--|---|---|
| Form <b>W-4</b><br>Department of the Treasury<br>Internal Revenue Service  | <h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b></p> | OMB No. 1545-0074<br><br><span style="font-size: 2em; font-weight: bold;">2011</span>   |
| 1 Type or print your first name and middle initial.  | Last name   | 2 Your social security number   |
| Home address (number and street or rural route)  |   | 3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate.<br><b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |
| City or town, state, and ZIP code  |   | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>   |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)   | 5 <u>      </u>   |   |
| 6 Additional amount, if any, you want withheld from each paycheck . . . . .  | 6 \$ <u>      </u>  |   |
| 7 I claim exemption from withholding for 2011, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶ |   | 7 <u>      </u>   |
| Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.   |   |   |
| <b>Employee's signature</b><br>(This form is not valid unless you sign it.) ▶  |   | <b>Date</b> ▶   |
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)  | 9 Office code (optional)  | 10 Employer identification number (EIN)   |

**STATEMENT OF EMPLOYABILITY**

By execution of this document, I acknowledge that I have been informed by the Agency and agree that the Agency may conduct a State of Texas criminal history check. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I understand that I am unemployable if listed in the NAR or EMR per TAC §93.3 and TxH&SC Chapter 253.

**Criminal History Check**

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check, and that I may not have face-to-face patient contact until results are returned. I will be notified of results.

**CONVICTIONS BARRING EMPLOYMENT.**

(A) A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:

- ◆ An offense under Chapter 19, Penal Code (criminal homicide);
- ◆ An offense under Chapter 20, Penal Code (kidnaping and unlawful restraint);
- ◆ An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);
- ◆ An offense under Section 21.08, Penal Code (indecent exposure);
- ◆ An offense under Section 21.11, Penal Code (indecent with a child);
- ◆ An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- ◆ An offense under Section 21.15, Penal Code (improper photography or visual recording);
- ◆ An offense under Section 22.011, Penal Code (sexual assault);
- ◆ An offense under Section 22.02, Penal Code (aggravated assault);
- ◆ An offense under Section 22.021, Penal Code (aggravated sexual assault);
- ◆ An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or a disabled individual);
- ◆ An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- ◆ An offense under Section 22.05, Penal Code (deadly conduct);
- ◆ An offense under Section 22.07, Penal Code (terroristic threat);
- ◆ An offense under Section 22.08, Penal Code (aiding suicide);
- ◆ An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- ◆ An offense under Section 25.08, Penal Code (sale or purchase of a child);
- ◆ An offense under Section 28.02, Penal Code (arson);
- ◆ An offense under Section 29.02, Penal Code (robbery);
- ◆ An offense under Section 29.03, Penal Code (aggravated robbery);
- ◆ An offense under Section 33.021, Penal Code (online solicitation of a minor);
- ◆ An offense under Section 34.02, Penal Code (money laundering);
- ◆ An offense under Section 35A.02, Penal Code (Medicaid fraud);
- ◆ An offense under Section 42.09, Penal Code (cruelty to animals);
- ◆ An offense under Section 36.06, Penal Code (obstruction or retaliation);
- ◆ An offense under Section 42.09, Penal Code (cruelty to livestock animals);
- ◆ An offense under Section 42.092, Penal Code (cruelty to nonlivestock animals); or
- ◆ A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.
- ◆ An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves

(B) A person may also be barred from employment the duties of which involve direct contract with a client in a facility if convicted of any of the following crimes within the past 5 years:

- ◆ An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or as a felony);
- ◆ An offense under Section 30.02, Penal Code (burglary);
- ◆ An offense under Chapter 31, Penal Code (theft that is punishable as a felony);
- ◆ An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or
- ◆ An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or a felony).
- ◆ An offense under Section 37.12, Penal Code (false identification as a peace officer); or
- ◆ An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).

(C) In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- ◆ Of an offense under Section 30.02, Penal Code (burglary); or
- ◆ Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

(D) In addition to the prohibitions on employment prescribed by Subsections (A), (B) and (C), a nurse aide listed as unemployable per amendment to TAC 40, §94.10(l) and §94.11(c) (d) and is listed on the NAR or EMR stating a finding of abuse, neglect or misappropriation will not be recertified therefore, is unemployable.

(E) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**For Agency Use Only: Criminal History, Employee Misconduct Registry (EMR), and Nurse Aide Registry (NAR) checks completed:**

- Criminal History Check completed on-line     Other Convictions identified on Criminal History. (Document reason hiring in Comments below)
- NAR     EMR checked online at <http://www.dads.state.tx.us/providers/employability/esearch.cfm>
- Applicant employable     Applicant not employable     Comments: \_\_\_\_\_

## EMPLOYEE ACKNOWLEDGMENT

**Confidentiality:** Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information on clients/patients and staff members. The health care professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain information may be shared, s/he should consult with his/her supervisor.

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**Drug Testing Policy:** Agency does not conduct testing of its employees. Agency maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on Company paid time. Violation of this policy can result in disciplinary action, up to and including termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

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**Harassment Policy:** This agency is committed to providing a work environment, that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employment. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager or Human Resources.

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**Non Solicitation/Illegal Remuneration:** Agency does not reimburse or provide incentives to physicians, durable equipment providers, family or other referral entities for patient referrals for home health services. Employees may not solicit patients for the agency. Employees found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

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**Non-Discrimination:** Agency does not discriminate against clients or volunteers based on age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, disability, or source of payment.

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**Abuse, Neglect, and Exploitation:** Agency employees will report suspected abuse, neglect and/or exploitation to the state departments of both the Texas Department of Family and Protective Services, the Department of Aging and Disability Services, and Agency management. Agency employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

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**Workers' Compensation:** Agency is a non-subscriber to workers' compensation insurance. An employee who incurs an injury on the job that requires emergency medical treatment or is life threatening should proceed to the nearest emergency room. Emergency medical treatment (non life threatening) or non-emergency treatment should be referred to the agency's designated clinic. Notify the agency of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God, and/or acts of a third party.

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**Progressive Discipline Policy:** Agency utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes verbal warning, written warning and final warning. Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

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**Agency Policies:** I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines.

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Employee: \_\_\_\_\_ Date: \_\_\_\_\_

## HEPATITIS B VACCINATION

Due to your occupational exposure to blood or other potentially infectious materials, you may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available, at no cost, to you. Please indicate below your declination or acceptance to receive the vaccine.

Hepatitis B is a blood borne virus which can cause a range of symptoms from mild to serious, and possibly result in fatal liver damage to health care workers who become infected. The virus can be transmitted through contact with infectious fluids of a client who has hepatitis B virus. You have been taught the concepts of Universal Precautions concerning safe client care and the use of equipment to avoid unnecessary exposure.

Synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals (initial shot, one month later, and six months later). It has proven to be over 80-90% effective in protecting against the disease. There may be hypersensitivity to the vaccine, and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of under 3% of injections.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast or hepatitis antigen and will only be given with your personal physician's recommendations in the cases of pregnancy or presence of other infection of immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

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**Acceptance:** I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the hepatitis B vaccine.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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**Declination:**  I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material (OPIM) and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I have already received the hepatitis vaccine at an earlier date. I am  am not  providing a copy of the record to the agency

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**ORIENTATION CHECKLIST**

- |   |  |
|---|--|
| <p><b>I) Introduction</b><br/>Agency Vision/Philosophy<br/>Overview/Scope of Services<br/>Organizational Structure<br/>Geographical Area<br/>Communication<br/>Ethics<br/>Confidentiality/HIPAA<br/>Personal Safety<br/>Emergency Preparedness</p> <p><b>II) Exposure Control/Universal Precautions</b><br/>Standard Precautions/OSHA/Hazardous Waste/Infection Control<br/>Hand Washing<br/>Equipment Maintenance<br/>Equipment Safety</p> <p><b>III) Human Resource Policies</b><br/>Dress Code<br/>Paid Time Off<br/>Insurance<br/>Evaluation Policy<br/>TB (<i>according to agency policy</i>)<br/>Hepatitis Consent/Declination<br/>On The Job Injury<br/>Pay Schedule<br/>Employee Illness<br/>On Call<br/>Inclement Weather<br/>Progressive Discipline Policy (i.e. internet use)<br/>Employee Grievance Procedure<br/>Non-discrimination Policy<br/>Education Requirements<br/>Illegal Remuneration<br/>Fraud and Abuse</p> | <p><b>IV) General Policies &amp; Procedures</b><br/>Patient Supplies<br/>Patient Durable Medical Equipment<br/>Home Health Agency Paperwork<br/>Schedules/Time frames<br/>Communication with L.E.P. persons<br/>Communication with visually, hearing and speech impaired persons</p> <p><b>V) Clinical</b><br/>Policy &amp; Procedure Manual<br/>Community Resources<br/>Advance Directives<br/>Patient Care Responsibilities<br/>Coordination of Care<br/>Abuse &amp; Reporting<br/>Death &amp; Dying Policy<br/>Medicare Guidelines<br/>Storage &amp; Handling of Drugs<br/>Referral Guidelines</p> <p><b>VI) Tour of Office</b></p> |
|---|--|

\_\_\_\_\_  
Employee Signature                      Date

\_\_\_\_\_  
Employer Signature                      Date