HOME-N-HEALTHCARE
COORDINATORS LLC.

New Employee Checklist

- ◊ Application Form
- ◊ Resume
- ◊ Hawaii Nursing License/Application (If applicable)
- ◊ Skills Checklist
- ◊ TB Clearance & other required immunizations
- ◊ BCLS (American Heart required)
- ◊ ACLS (Required for specialty areas)
- ◊ Physical Exam (Must be within last 12 months)
- ◊ 2 Forms of ID With Tax (W-4 & HW-4) and I9 forms

*Each individual Employee Classification will need to complete skills and competency exams prior to their start date.

HOME-N-HEALTHCARE
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"Providing quality, comfort & care"

For Official Use Only
Position Applying for:
Date of Interview:
Interview Completed by:

Employment Application

PERSONAL INFORMATION

Name:		Social Security #:	
Address:			
Phone:		Email Address:	

Preferred Method of Contact: ☐ Phone ☐ Text Message ☐ Email

Please answer the following questions:	Yes	No
Are you at least 18 years of age?		
Are you legally able to work in the USA?		
Have you ever been convicted of a felony?		
Do you have reliable transportation?		
Do you have any professional licenses? If yes, please list and attach copy:		
Do you possess any special skills relevant to the position you are applying for? If yes, please list:		
Other information relevant to the position? If yes, please list:		

EMPLOYMENT HISTORY

Employer Name:		Dates of Employment:	
Employer Address:		Employer Phone:	
Position Held:		Name of Supervisor:	
Duties of Position:			
Starting Salary:		Ending Salary:	
Reason for leaving:			

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Employer Address:		Employer Phone:	
Position Held:		Name of Supervisor:	
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Reason for leaving:			

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HOME-N-HEALTHCARE COORDINATORS LLC.

EDUCATION

Name of High School:			
Address:			
College/Tech. School:			
Address:			
Field of Study:		Degree Obtained:	
College/Tech School:			
Address:			
Field of Study:		Degree Obtained:	

REFERENCES (Professional other than supervisors listed above)

Name/Title	Years known	Contact Number

AVAILABILITY

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

CERTIFICATION

I certify that the information provided by me on this application is correct. I understand that the furnishing of any misleading or incorrect information on this application or its attachments will be just cause for termination should I become employed at this company. I hereby give permission to the persons and companies named on this application and its attachments to provide any pertinent information to this company, or its duly authorized representative except where otherwise indicated. I release said parties from all liability for any damages resulting from issuance of such information.

As a condition of employment, I hereby voluntarily give my consent to this company and its designated agents to do testing for alcohol and/or controlled substances. Such testing may occur as a precondition to my being employed and as specified in the Company's Drug and Alcohol Policy. I understand that refusal to submit to such testing may result in my termination.

_____ _____

Applicant Signature Date

HOME-N-HEALTHCARE
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HIPAA Confidentiality Form

I, _____, an employee of Home-N-Healthcare Coordinators LLC (HNHC) have an obligation to safeguard and protect any and all confidential and sensitive information in a manner to prevent the unauthorized disclosure of client information.

HNHC employees shall maintain patient privacy and confidentiality of patient information and other information in accordance with all legal and ethical standards. Personal and proprietary information regarding client companies, including health information about patients is highly confidential. State and federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), regulates use and disclosure of such information.

HNHC employees shall refrain from revealing any personal or confidential information unless expressly authorized by the HIPAA act or any other state or federal regulations.

HNHC employees agree to the following conditions regarding confidential information:

- Discuss patient information in a private area.
- Never alter or tamper with any type of medical information, this is a breach of confidentiality.
- Discussion of proprietary information by co-workers will not be tolerated and must be reported to a supervisor.
- Disposal of patient records shall follow the client's disposal of documentation procedures.
- Access of information for individuals such as family, friends and co-workers is prohibited.

I have read, understand and agree with the above HIPAA confidentiality information, and will abide by all guidelines established. I understand that failure to abide by HIPAA regulations will result in my immediate dismissal of employment and I assume responsibility for legal liability regarding disclosure of information.

Signature_____ Date_____

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Hepatitis B Vaccination Declination Form

Employee Name_____

I understand that due to my occupational exposure to blood and other potentially infectious materials that I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated at no charge to myself. However, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk for exposure to Hepatitis B. I understand that in the future, should I so choose, I may receive the Hepatitis B Vaccination series at no charge to me.

☐ I have already received the hepatitis B vaccination series

Signature_____ Date_____

HOME-N-HEALTHCARE COORDINATORS LLC.

Physician Statement and Medical History Form

Employee Name:	Classification/Title:

History: (Place a checkmark next to all that apply)			
Heart Disease		Stroke	
Liver Disease		Back/Spinal problems	
Allergies		Audio/ visual problems	
Epilepsy/Seizures		Shortness of breath	
Kidney Disease		Arthritis	
Blood Disorder		Hypertension	
Tuberculosis		Mental Disorder	
Cancer		Other: Please specify	

If yes to any please explain in space provided below

Physician Statement:

_____ has been examined by me and has been found to be in good general, physical and mental health, free from any communicable disease and able to meet the demands of his or her profession without limitation.

Work Restrictions?		YES		NO	**If yes, please explain below:**

May safely wear HEPA mask?		YES		NO

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

* You will need to provide a current TB clearance. Attach to this page with any other documented vaccinations associated with your profession