Georgia NurseCare
In-Home Assisted Living & Pediatric Care

EMPLOYMENT APPLICATION

Georgia NurseCare, LLC (GNC) is Drug Free Workplaces and Equal Opportunity Providers.

General:

Position(s) and Location(s) you are applying for:
_____

Date Submitted: _____

- Please complete this application in its entirety.
- Incomplete applications will not be considered.
- You may attach supporting documents such as your resume or cover letter.

Where did you hear about this position?

□ Friend/ Name: _____
□ Relative/ Name: _____
□ Internet/ If so, where? _____
□ GNC Website
□ Walk-in
□ Other: _____
□ Employee/ Name: _____

Important Information:

Due to state and federal regulations along with GNC's dedication to providing our patients and employees with a safe and comfortable environment, all individuals offered employment at GNC are required to successfully complete our pre-employment process, which consists of a drug screen, criminal background check, job-related physical evaluation, and verification of education and employment history.

Personal Information:

Name:_____
First Middle Last

List any other names or aliases:_____

Mailing Address:_____
Street (Apt #) City State Zip

Physical Address:_____
Street (Apt #) City State Zip

Phone#: (_____)_____-_____ Email: _____
(Home)

Phone#: (_____)_____-_____ Driver's License State and #: _____
(Cell/Other)

Are you a veteran? □ Yes □ No Military Branch:_____

Social Security #:_____ Date of Birth:_____

Background Information:

We perform criminal background and state law enforcement checks as a condition of employment. If you answer "yes" to any of the background information questions you will NOT be disqualified from employment consideration, except as required by state or federal law. Please note: Failure to fully disclose your background information will render you INELIGIBLE for employment at GNC. All background checks will be conducted in accordance with the Georgia Long-Term Care Background Check Program (O.C.G.A. §31-7-350 et seq.) and federal OIG exclusion standards.

Have you ever been convicted, pled guilty, nolo contendere, no contest, or had adjudication withheld as to any crime or offense? □ Yes □ No If yes, please explain: _____

_____

Have you ever been a defendant in a civil action for an intentional tort (i.e., assault and battery, false imprisonment, etc.)? □ Yes □ No If yes, please explain: _____

_____

_____

Have your professional certifications ever been suspended, revoked or on probation? □ Yes □ No
If yes, please explain:_____

_____

_____

Have any disciplinary actions ever been initiated and/or are now pending against you by any state licensure board? □ Yes □ No If yes, please explain:_____

_____

_____

Have you had any traffic violations in the past 3 years including accidents or speeding tickets? □ Yes □ No
If yes, please explain:_____

_____

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (i.e. Medicare or Medicaid)? □ Yes □ No If yes, please explain: _____

_____

Additional Information:

1) Please indicate your availability: □ Full Time □ Part Time □ PRN (as needed) □ Nights □ Days
If part time or PRN, please list availability:_____

Would you consider working weekends and/or holidays? □ Yes □ No

2) Date you are available to start work: _____/_____/_____ Desired Compensation: _____

3) Are you able to perform the essential function of the job(s) for which you are applying with or without accommodation? □ Yes □ No

4) Have you ever been terminated or asked by an employer to voluntarily resign? □ Yes □ No

5) Are you at least 18 years of age? □ Yes □ No

6) Are you legally eligible for employment in the United States? □ Yes □ No

7) Have you signed a non-compete, non-piracy or similar agreement and/or contract with a former employer? □ Yes □ No If yes, please attach a copy to this application.

Question:	Yes	No	When applicable, please provide additional information.
Are any of your relatives or domestic partners employed by GNC?			If yes, state name, relationship, & department:
Have you ever applied for employment at GNC?			Date: _____/_____ /_____ Position applied for:
Have you ever been employed by GNC or an affiliate: Georgia Home Health or Hearth Hospice?			From: _____/_____/_____ To: _____/_____ /_____

Education:

Name and Location of High School: _____

Did you earn: □ Diploma □ GED □ None

If you answered none, please indicate highest level completed:_____

Additional Education/Training:

Name of Institution: College, University, Professional School, Vocational, Trade, Government, Military etc.	Location (City, State)	Major/Minor or Course of Study	Please list any degree, license, or certificate earned.

Licensure, Certification, Registration (if applicable):

Licensure, Certification, Registration:	Number:	Date Received:	Expiration Date:	State/Licensing Agency:

Emergency Contacts:

Name and Relationship:	Home Number:	Cell Number:	Address:

Professional References:

Name:	Phone Number:	Address:	Occupation:

Please note: The acknowledgment and liability release at the end of this application releases GNC, any

former employers, educational institutions, and any other persons giving references free of liability for any damages caused by the exchange of reference information and any other reasonable and necessary information incident to the employment process.

Georgia NurseCare is an Equal Opportunity Employer and does not discriminate based on race, color, religion, sex, national origin, age, disability, or any other status protected by applicable law.

Employment History:

- Please describe your work experience for the last 10 years beginning with your current or most recent job. (You may attach a resume detailing the information needed below.)
- Please fill out the entire box for each employer
- This application will not be considered complete if information is missing from this section.

(1) Name of Present or Last Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ □FT □PT □ PRN Supervisor's Name:_____

Duties and Responsibilites:_____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

May we contact your current employer: □ Yes □ No If no, why?_____

(2) Name of Next Previous Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ □FT □PT □ PRN Supervisor's Name:_____

Duties and Responsibilities: _____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

(3) Name of Next Previous Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ □FT □PT □ PRN Supervisor's Name:_____

Duties and Responsibilites:_____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

(4) Name of Next Previous Employer: _____

Address: _____
Street (Suite #) City State Zip

Phone #: (_____)_____-_____ Employed From: _____/_____ To: _____/_____ (month/year)

Job Title: _____ □FT □PT □ PRN Supervisor's Name:_____

Duties and Responsibilites:_____

_____

_____

Reason for Leaving: _____Compensation: Starting _____Ending _____

Volunteer Experience:

Name and Address of Organization:	Period of Service (month/year):	Type of Organization:	Responsibilities:

Statement of Acknowledgment and Liability Release:

By signing below, I hereby attest that the signature below is the signature version of the printed name listed above it. Any medical record entries or other documents with that signature are true, accurate, and complete to the best of my knowledge. I understand that any false information, omissions, or misrepresentations of facts called for in this application or any supplements thereto, is cause for rejection of my application or discharge at any time during my employment. I understand that as a condition of employment I will be required to complete the organization's pre-employment health and background screenings. I understand that any offer of employment is contingent on my producing appropriate documentation verifying my identity and employment authorization, as required under the Immigration Reform and Control Act. I understand that my employment is terminable at-will, that I am not being employed for any specified time, and that this application is not and is not intended to be a contract for continued employment. If I am employed, I agree to abide by and observe all rules and regulations of the organization. **I voluntarily authorize my former employers, schools and persons named herein to give information regarding me, whether or not such information is part of their records. I hereby release said organizations or persons from any liability or damages whatsoever for issuing this information.**

Lastly, under GA Rule 290-5-54-.09(3)(a)1, I declare that I have never been shown to have abused, neglected, sexually assaulted, exploited or deprived any person OR caused serious injury as a result of intentional or grossly negligent misconduct.

This form may be photocopied or reproduced as a facsimile, and these copies will be as effective a release or consent as the original which I signed.

If you have any questions regarding this application. Please contact the appropriate office below.

Brunswick
P: 912-264-0040
F: 912-261-1292
E: staff@ganursecare.com

_____

Applicant's Printed Name

_____ _____

Applicant's Signature **Date**

Hourly or Per-Visit Employee Contract

This agreement is entered into by and between Georgia NurseCare, LLC ("Agency") and _____ ("Employee"), for the purpose of providing certain non-medical/medical (refer to your signed job description) services in Georgia. For a fee agreed upon
by both parties, which may vary from case to case depending upon the job requirements, certain services
will be performed by the employee within the stipulations and guidelines as set forth below.

1. Employee agrees to abide by the Confidentiality and Security Agreement, Code of Conduct, and Employee Handbook.
2. Employee agrees to conform to all the applicable Agency policies and procedures.
3. All business contacts with Agencies' clients will be made exclusively by Agency.
4. If unable to report for an assigned duty, Employee will notify Agency at least eight (8) hours prior to time to report for duty. Agency will arrange for replacement from its registry and notify client of any changes.
5. As a condition of employment, Employee agrees to maintain a current Professional License, Certification,
and any requirements as required by state and federal regulations.
6. Employee agrees to notify Agency if at any time during employment Employee is
   a. named as a defendant in a civil or criminal action,
   b. notified that they are restricted from participating in any private, federal, or state health insurance program (i.e. Medicare or Medicaid)
   c. notified that a disciplinary action had been initiated or is pending against them by any state licensure board, OR
   d. in a car accident or receives a traffic violation.
7. An Agency name pin or badge will be provided and MUST be worn at all times when on duty.
8. Each Employee will have on file a current PPD or Chest X-Ray (if positive PPD in the past) as required by Agency policy.
9. Employee agrees not to offer or accept employment from any Agency client for any services provided by Agency. Should Employee do so, Employee agrees to pay immediately to Agency as liquidated damages the sum of three thousand ($3,000.00) dollars. Employee also agrees to pay any and all cost(s) incurred in collecting said fee including court costs and attorney's fees.
10. Employee understands that employment is temporary and there is no guarantee of employment or a set number of hours.
11. Employee understands and agrees to abide by all company policies related participation in plans of care,procedures for submitting clinical and progress notes, scheduling of visits, and periodic patient evaluation.

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12. Any of the following will result in termination of employment without advance notice:
    a. Falsifying patient records or time cards
    b. Making private financial arrangements with Agency clients, either personally or for another agency.
    c. Stealing or any other act of dishonesty.
    d. Possessing or being under the influence of alcohol or drugs while on duty.
    e. Failing to appear or to perform assigned job without advance notice to Agency
    f. Sleeping while on duty, unless specifically authorized in writing.
    g. Violation of the Employee Policy and Procedures Manual or Code of Conduct, which Employee
    h. acknowledges they have read and understood.
13. The initial rate of payment will be _____per hour for office work/in-service/case conferences etc. or per
14. visit as defined in the Georgia NurseCare Pay Per Visit sheet signed by employee less applicable taxes and deductions as required by law.
15. Employee understands that the Agency is in charge of collecting payment for services provided to patients and Employee agrees to NEVER accept a CASH payment directly from the patient or a check made out to Employee. Employees may deliver checks made out to Georgia NurseCare to the office.

This agreement is entered into this _____ day of _____ 20_____.

_____	_____
Employee	Authorized Agent of Georgia NurseCare
_____	_____
Employee Name (Printed)	Authorized Agent's Name Printed

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In accordance to TAG 09191 Administration and Organization 290-5-54-.09(3)(a)1, you are required to sign this form in order to become an employee of Georgia NurseCare.

As a current or prospective employee of Georgia NurseCare, I attest that I have never been shown by credible evidence (e.g. a court or jury, a department investigation, or other reliable evidence to have abused, neglected, sexually assaulted, exploited, or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct. My signature below is my written statement to this effect affirming this information at the time of my application and/or employment.

_____

Printed Name:

_____

Signature:

_____

Date:

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SUBSTANCE SCREEN (Part 1)

To be filled out by person being screened.

GNC is a Drug-Free Workplace and Equal Opportunity Provider

Name: _____

Date of Birth:_____

Social Security Number:_____

List of Substances:

Please list all medications, pills, drugs, or other substances you have used within the last thirty (30) days. This information will be used to help interpret the results of your blood/and or urine tests. Please note that false or incomplete information is cause for disqualification or dismissal.

Medication:	**Used For:**
_____	_____
_____	_____
_____	_____
_____	_____

Consent and Release:

I understand that pursuant to Georgia NurseCare' Policy for a Drug and Alcohol-Free Workplace, I am required to complete this drug screen test. I hereby consent to submit to urinalysis, breath, blood, and/or other tests as shall be determined by Georgia NurseCare for the purpose of determining the use of alcohol and/or illegal drugs.

I agree that Georgia NurseCare may collect these specimens for these tests and may test them or forward them to a testing laboratory designated by Georgia NurseCare for analysis. I further agree to and hereby authorize the release of the results of said tests to the Georgia NurseCare.

I understand that a positive drug or alcohol test or my refusal to produce a specimen upon request can be cause for termination or will prevent GNC from hiring me. I also understand that the illegal use, sale, possession, or distribution of drugs or alcohol, as well as illegally obtained prescription medication, is a violation of company policy and is cause for immediate termination.

I am unaware of any medical condition that would indicate that either the screen or physical examination might endanger my physical health.

I agree to hold harmless Georgia NurseCare and its agents from any liability arising in whole or part out of the collection of specimens, testing, and use of the information from said testing in connection with the Georgia NurseCare' consideration of my continuing employment.

I agree that a reproduced copy of this consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

_____ _____

Signature **Date**

SUBSTANCE SCREEN (PART 2): RESULTS	
Oxidant/PCC	
SG	
pH	
NIT	
GLUT	
CRE	
mAMP	
OPI	
PCP	
BZO	
BAR	
AMP	
COC	
THC	

SUMMARY:

Date: _____

Controls within normal limits: □ Yes □ No

Comments for any positives:_____

_____

_____

_____

_____ _____

Tester's Signature Tester's Name Printed

HEALTH SCREEN (Part 1)
Health Questionnaire

To be filled out by person being screened.

Name: _____ Date:_____
Primary Medical Doctor:_____
Primary M.D.'s Phone #:_____
Are you returning from a leave of absence? □ Yes □ No

Have you had or do you now have any of the following?			
Symptom	**Y**	**N**	**If yes, provide additional information.**
1. Cough			When did it start? End? What color is the mucus, if any? Have you coughed up blood?
2. Chest pain(s)			When did it start? End?
3. Fever(s)			
4. Night sweats			
5. Loss of weight without trying			Number of pounds:
6. Weakness or Fatigue			When did it start? End?
7. Shortness of breath			When did it start? End?
8. Do you know anyone who has the symptoms listed in 1-7?			Name: _____Phone #: _____ Address: _____
9. Change in mole or bleeding from a mole			
10. Decreased ability to see			
11. Bruising easily or difficulty stopping bleeding from even a small cut.			
12.Wheezing			
13. Temporary loss of vision			
14. Racing or thumping of your heart			
15. Shortness of breath			
16. Trouble breathing when you exert yourself			
17. Swelling in your feet or ankles			
18. Pain or cramps in your legs when you walk			
19. Difficulty swallowing			
20. Alcohol Abuse			
21. Drug Abuse			
22. Pulmonary Disease/Asthma			
23. Heart Disease/ High or Low Blood Pressure			
24. Cancer			
25. Arthritis/Rehumatism/Bursitis			
26. Diabetes			
27. Allergies			Please List:
28. Skin Disease			
29. Reaction to Serum/Drug/Medicine/Latex			
30. Mental Disorder			
31. Depression/Anxiety			
32. Head Injury			Date: Loss of Consciousness?
33. Dizziness; Fainting Spells			
34. Epilepsy or Seizures			
35. HIV or Aids			
36. Jaundice, Hepatitis, Syphillis or Gonorrhea			Which one?

Tuberculosis (TB)

Have you ever been tested for TB before? □ Yes □ No (If no, skip this section.)
Last Skin Test: _____
(Name, address, city, state, zip, and phone number of place where test was given.)
Test Date: _____ Results: _____mm □ Positive □ Negative
Chest X-Ray: □ Normal □ Abnormal □ Not Needed
Have you ever been treated for…
Latent TB infection (LTBI)? □ Yes □ No #Months _____ TB Disease? □ Yes □ No #Months _____
If yes, When? _____ Where?_____
Name of Medications: _____

List any surgeries, injuries, or blood transfusion(s):

_____
_____

List any over-the-counter or prescription medications you are taking:

_____
_____

Vision:

Do you wear glasses? □ Yes □ No If yes, for how many years?_____
Do you wear contact lenses? □ Yes □ No If yes, for how many years?_____
Have you had Lasik or other corrective eye surgery? □ Yes □ No If yes, when?_____
Are you color blind? □ Yes □ No If yes, what colors?_____

Hearing:

Do you have any type of hearing loss? □ Yes □ No
Do you wear any type of hearing aids? □ Yes □ No

Anything Else?

Please provide anything pertinent which has not been included in this questionnaire:

_____
_____

Acknowledgement:

The information I have given is true to the best of my knowledge. I understand that false statements and/or omissions can be grounds for immediate dismissal. I also understand that I am obligated to have an employee health screening on a yearly basis as long as I am an employee of GNC. This is for the purpose of determining my physical ability to perform my job and is not considered a substitute for medical care. I understand that in my role at GNC there is a risk of exposure to bloodborne pathogens including but not limited HIV and Hepatitis B. Therefore, I will comply with all GNC policies and procedures pertaining to blood born pathogens including, but not limited to wearing all required PPE including particulate respirators (TB) and following standard precautions like hand washing.

_____ _____
Signature Name Printed

HEALTH SCREEN (Part 2)
Hepatitis B Vaccine

Directions: Please read the information below, ask any questions you may have, and choose to accept or decline the hepatitis B vaccination.

Information

Hepatitis B is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness. It results from infection with the hepatitis B virus. Health care workers who have contact with blood, infected tissue or secretions, and regular exposure to trauma, needle sticks, cuts, and abrasions are most at risk for acquiring hepatitis B. In the United States, about 5% of the general population show evidence of past or present hepatitis B infection, while up to 30% or more health care workers in high risk areas show evidence of past hepatitis B infection.

Hepatitis B vaccine is usually well tolerated. The most common side effect is soreness at the local injection site and fatigue. The vaccine is administered in 3 doses.

CONTRAINDICATIONS: Employees who are pregnant, breast-feeding mothers, have allergies to the vaccine or its components, mercury or yeast, have a fever or active infection, heart disease, Guillian-Barre Syndrome, or immune deficiency disorders will be referred to their private physician for evaluation, prior to receiving the vaccine.

POSSIBLE ADVERSE REACTIONS: Flushed face, redness, swelling, or warmth at the injection site, muscle aches, fatigue, and dizziness. Low-grade fever (less than 101 degrees F) occurs occasionally.

For more information please click here: http://www.cdc.gov/vaccines/vpd-vac/hepb/

Acceptance and Release

I have read the above information and have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and the risks of hepatitis B vaccine and consent to vaccination. I also agree to hold harmless and release GNC of any damages if I have an adverse reaction to the vaccination.

_____ _____

Signature Date

Declination

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring hepatitis B (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 to me.

_____ _____

Signature Date

If applicable, please check the appropriate box:

□ I am declining the Hepatitis B Vaccination because I have already been vaccinated and I will provide GNC with documentation.

□ I am declining the Hepatitis B Vaccination because I currently have one of the contraindications, but I would like an email reminder to reconsider the vaccine on _____(date).

HEALTH SCREEN (Part 3)

PPD Tests, Vaccine Record, and Assessment

FOR INTERNAL USE ONLY

General Information

Blood Pressure: _____ Physician Referral (if applicable): _____
Additional Comments: _____

PPD Skin Test #1

Date of Skin Test: _____ Date of Reading: _____
Mantoux: Lot #_____ Expiration Date: _____
Result: □ Positive: _____mm □ Negative: _____mm
Chest X-Ray Required: □ Yes □ No Referred to Public Health Dept. □ N/A □ Date:_____

_____ _____
PPD Skin Testor's Signature PPD Skin Testor's Name (Printed)

PPD Skin Test #2

Date of Skin Test: _____ Date of Reading: _____
Mantoux: Lot #_____ Expiration Date: _____
Result: □ Positive: _____mm □ Negative: _____mm
Chest X-Ray Required: □ Yes □ No Referred to Public Health Dept. □ N/A □ Date:_____

_____ _____
PPD Skin Testor's Signature PPD Skin Testor's Name (Printed)

Chest X-Ray

□ Not needed at this time □ Normal □ Not Normal Reviewer's Name:_____
Additional comments:_____

Hepatitis B Vaccine Record

Did employee accept the hepatitis B vaccine? □ No □ Yes Date Accepted:_____
Please fill out the record below if employee accepted the hepatitis B vaccine.

First Injection	Section Injection	Third Injection
Time Vaccinated	Time Vaccinated	Time Vaccinated
Date Vaccinated	Date Vaccinated	Date Vaccinated
Vaccine/Lot#/Exp. Date	Vaccine/Lot#/ Exp. Date	Vaccine/Lot #/ Exp. Date
Site of Injection	Site of Injection	Site of Injection
Administered By (Printed Name)	Administered By (Printed Name)	Administered By (Printed Name)
Administered By (Signature)	Administered By (Signature)	Administered By (Signature)

Health Screen Assessment

The complete health screen was reviewed on _____(date) and they are (□ Cleared □ Not Cleared) to provide or continue providing services for GNC. Additional Comments: _____

_____

_____ _____
Assessor's Signature Assessor's Name and Title (Printed)