

EMPLOYMENT APPLICATION



**SKILLED NURSING * PHYSICAL THERAPY * OCCUPATIONAL THERAPY *
SPEECH THERAPY * MEDICAL SOCIAL WORKER * HOME HEALTH AIDES**

WHERE YOU'RE LIKE FAMILY!

Altomar Home Healthcare (the "Company") is an equal opportunity/affirmative action employer. All qualified applicants will be considered without regard to age, race, color, sex, religion, nation origin, marital status, ancestry, citizenship, veteran status, sexual orientation or preference, or physical or mental disability.

EMPLOYMENT HISTORY (You may attach your resume instead)

List all employments for the past 10 years, starting with the most recent position. All information **must** be completed. You may attach a resume, but not in place of completing the required information.

Employed From / /	Employer Name	Supervisor Name	Starting Salary
Employed Until / /	Employer Address	Supervisor Phone #	Ending Salary
Job Title		Reason for Leaving	
Duties & Responsibilities			

Employed From / /	Employer Name	Supervisor Name	Starting Salary
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Employed Until / /	Employer Address	Supervisor Phone #	Ending Salary
Job Title		Reason for Leaving	
Duties & Responsibilities			

GENERAL

Yes No

May we contact your current employer for references?

If hired, will you be able to work overtime?

Will you be able to perform the essential job functions for the position you are applying for with or without reasonable accommodation?

Have you ever been convicted of a crime, excluding misdemeanors and summary offenses, which has not been annulled, expunged or seals by court?
(A yes response does **not** automatically disqualify your application.)

Do you (or an immediate family member) currently hold administrative duties and/or financial interests in a home healthcare or DME business in El Paso, Texas or New Mexico?
(A yes response does **not** disqualify your application, but further review with our conflict of interest policy may need to take place.)

CERTIFICATION & AUTHORIZATION

The above information is true and correct. I understand that, in the event of my employment by the Company, I shall be subject to dismissal if any information that I have given in this application is false or misleading or if I have failed to give any information herein requested, regardless of the time elapsed after discovery.

I authorize the Company to inquire into my educational, professional and past employment history references as needed to research my qualifications for this position. I hereby give my consent to any former employer to provide employment-related information about me to the Company and will hold the Company and my former employer harmless from any claim made on the basis that such information about me was provided or that any employment decision was made on the basis of such information. I further authorize the Company to obtain any credit and consumer check.

I understand that nothing in this employment application, the granting of an interview or my subsequent employment with the Company is intended to create an employment contract between myself and the Company under which my employment could be terminated only for cause. On the contrary I understand and agree that, if hired, my employment will be terminable at will and may be terminated by me or the Company at any time and for any reason. I understand that no person has any authority to enter into any agreement contrary to the foregoing.

If employed, I will be required to provide original documents which verify my identity and right to work in the United States under the Immigration Reform and Control Act (IRCA) of 1986. The document(s) provided will be used for completion of Form I-9.

I hereby acknowledge that I have read and agree to the above statements.

Signature

Date

PERSONAL & EMERGENCY CONTACT INFORMATION UPDATE

Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (include area code) _____

Cell Phone: (include area code) _____

Fax Number: (include area code) _____

Email Address 1 (Commonly Used/Viewed): _____

Email Address 2 (Commonly Used/Viewed): _____

Please note below in order of priority (1-6), the best way to communicate information to you in a timely manner.

Home Ph. ____ Cell Ph. ____ Cell Ph. Text ____ Email 1: ____ Email 2: ____ Fax ____

List below the name, address, and telephone numbers of at least two people that we may contact in case of an emergency:

EMERGENCY CONTACT PERSON #1:

Name: _____ Relation to You: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (include area code) _____

Cell Phone: (include area code) _____

Business Phone: (include area code) _____

Please note below in order of priority (1-3), the best way to communicate information to you in a timely manner.

Home Ph. ____ Cell Ph. ____ Business Ph. ____

EMERGENCY CONTACT PERSON #2:

Name: _____ Relation to You: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (include area code) _____

Cell Phone: (include area code) _____

Business Phone: (include area code) _____

Please note below in order of priority (1-3), the best way to communicate information to you in a timely manner.

Home Ph. ____ Cell Ph. ____ Business Ph. ____

Employee Signature: _____ Date: _____



STATEMENT OF EMPLOYABILITY

If the Department of Public Safety reports that a person has a criminal conviction of any kind, the conviction shall be reviewed by the facility to determine if the conviction may bar the person from employment in a facility under Section 250.006 or if the conviction may be a contraindication to employment.

CONVICTIONS BARRING EMPLOYMENT, 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 below regardless of date of conviction:

- (1) a conviction of practicing any health-related profession without a required license;
- (2) a conviction relating to drugs, dangerous drugs or controlled substances;
- (3) a conviction involving a health care client; or

(4) a misdemeanor or felony conviction for one of the following offenses under the Texas Penal Code:

<ul style="list-style-type: none"> (1) an offense under Chapter 19, Penal Code (criminal homicide); (2) an offense under Chapter 20, Penal Code (kidnapping and unlawful restraint); (3) an offense under Section 21.02, Penal Code (continuous sexual abuse of young child or children), or Section 21.11, Penal Code (indecenty with a child); (4) an offense under Section 22.011, Penal Code (sexual assault); (5) an offense under Section 22.02, Penal Code (aggravated assault); (6) an offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual); (7) an offense under Section 22.041, Penal Code (abandoning or endangering child); (8) an offense under Section 22.08, Penal Code (aiding suicide); (9) an offense under Section 25.031, Penal Code (agreement to abduct from custody); (10) an offense under Section 25.08, Penal Code (sale or purchase of a child); (11) an offense under Section 28.02, Penal Code (arson); (12) an offense under Section 29.02, Penal Code (robbery); 	<ul style="list-style-type: none"> (13) an offense under Section 29.03, Penal Code (aggravated robbery); (14) an offense under Section 21.08, Penal Code (indecent exposure); (15) an offense under Section 21.12, Penal Code (improper relationship between educator and student); (16) an offense under Section 21.15, Penal Code (improper photography or visual recording); (17) an offense under Section 22.05, Penal Code (deadly conduct); (18) an offense under Section 22.021, Penal Code (aggravated sexual assault); (19) an offense under Section 22.07, Penal Code (terroristic threat); (20) an offense under Section 33.021, Penal Code (online solicitation of a minor); (21) an offense under Section 34.02, Penal Code (money laundering); (22) an offense under Section 35A.02, Penal Code (Medicaid fraud); (23) an offense under Section 42.09, Penal Code (cruelty to animals); or (24) 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.
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A person may not be employed in a position the duties of which involve direct contact with a resident in the facility before the fifth anniversary of the date the person is convicted of:

- an offense under Section 22.01, Penal Code (assault), that is 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), that is punishable as a Class A misdemeanor or a felony.
- an offense under Section 37.12, Penal Code (false identification as peace officer); or
- an offense under Section 42.01(a)(7), (8), or (9), Penal Code (disorderly conduct).
- 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.



STATEMENT OF EMPLOYABILITY CONTINUED.....

• 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.

Other criminal activity based upon severity, frequency etc., may also make you ineligible for employment. All information regarding felonies, misdemeanors, etc., must be disclosed on the employment application.

*I hereby profess that I have not been convicted of any of the following crimes which are a permanent **automatic bar to employment by this agency.***

Falsification of the employment application is grounds for disqualification or termination, if employed.

Print Name: _____ Signature: _____ Date: _____

CRIMINAL HISTORY CHECK CONSENT

By execution of this document, I _____, hereby acknowledge that:

I understand that Altomar Home Healthcare, Inc. runs a criminal history check on all prospective employees and contractors who have direct contact with clients in compliance with the Texas state law and as a condition of hire.

I have been informed by ALTOMAR HOME HEALTHCARE, INC. that a criminal history check will be performed on my name as a pre-requisite for hire and/or to contract business with Altomar Home Health, Inc.

I understand that I have been employed/contracted on an emergency basis and that my employment is temporary or interim pending the results of the criminal history check.

I also understand that no offer of employment/contract is final until the criminal history check is complete.

I hereby state that I have not been convicted of a crime under the Texas Health and Safety Code.

I understand a conviction under Texas Health and Safety code 250.005 bars employment from any Texas home health agency.

I will inform this agency of all names (i.e., maiden name, aliases) that I have used in the past. Having read and understood the above statements, I give my consent to Altomar Home Healthcare to complete a criminal history check on me at this time and authorize the company to re-run my criminal history report annually during my tenure as an employee of Altomar Home Health, Inc.

Name (Print)

Date of Birth

Maiden Name &/or Aliases (Print)

S.S. #

Signature

Date



EMPLOYEE MISCONDUCT REGISTRY
NURSE REGISTRY &
O.I.G CONSENT

The State of Texas prohibits the hiring of an individual who is listed in the Employee Misconduct Registry and the Nurse Aide Registry as having abused, neglected, or exploited a resident of a facility or misappropriated a resident's property.

Before you are hired, your name will be checked against the State of Texas Employee Misconduct Registry, Nurse Aide Registry and the Office of Inspector General. If you are listed on any of these registries, you may be ineligible for employment.

Print Name: _____ Certificate or License Number (if applicable): _____

Social Security Number: _____ Date of Birth _____ Male or Female

I understand that my name will be checked and certify that I have not been listed as having abused, neglected, or exploited a resident or consumer of a facility or misappropriated a resident's or consumer's property.

By signing this you are authorizing the company to check your name against the State of Texas Employee Misconduct Registry, Nurse Aide Registry and the Office of Inspector General.

Signature: _____ Date: _____



STATEMENT OF EMPLOYABILITY/ EMPLOYEE CRIMINAL HISTORY CERTIFICATION VERIFICATION / MISCONDUCT REGISTRY/ O.I.G.

Employer to complete:

NOTE – All registries and criminal history must be checked. (1-800-452-3934 – both registries)

Employee Misconduct Registry (mark one):

- Employee is not listed on the Employee Misconduct Registry.
- Employee is listed on the Employee Misconduct Registry as unemployable.

Nurse Aide / Certified Med Aide Registry (mark one):

- Employee is not listed on the Nurse Aide Registry.
- Employee is listed on the Nurse Aide Registry but is employable. (complete nurse aide certificate information below)

Nurse Aide's-Certified Med Aide certificate number is _____ It expires _____ Status _____

- Employee is listed on the Nurse Aide Registry as unemployable.

Certification / License Verification:

- SLP, PT, OT certificate number is _____ Expiration Date _____
- LVN certificate number is _____ Expiration Date _____ (LVN 1-512-305-8100)
- R N certificate number is _____ Expiration Date _____ (RN 1-512-305-7400)

Criminal History (mark one) (run through D.P.S.)

- Employee is eligible for employment
- Employee is not eligible for employment

O.I.G. Exclusion List (mark one) (run through O.I.G. web site <http://oig.hhs.gov>.)

- Employee is not found on the exclusion list and is eligible for employment
- Employee is found on the exclusion and is not eligible for employment

Checked by _____

Date _____

See Copies Attached



Verification of Current/Previous Employment

REFERENCE CHECK ONE (1)

By signing below, you are giving Altomar HHC, Inc. permission to contact your previous/current employer to verify employee AND salary information as listed below. Please be advised, in the event that we are not able to garner salary information you may be asked to furnish a payroll history for any positions that are administrative and/or salaries above our standard rate.

Applicant Information

Employee Name: Last First Middle

Social Security #: Date of Birth:

Position:

Signature of Applicant Date

Name of Previous/Current Representative who may validate Past/Current Employment with their Company

Name of Contact: Title: Phone: Company: Address: Street Address Suite City State ZIP Code

Was the applicant an employee of your company? YES NO

What was the period of employment? START DATE: END DATE:

What was the applicant's position on the last day of employment?

Does the applicant have at least 6 months experience with pediatric clients?

What was the applicant's starting salary?

What was the applicant's ending salary?

What was the applicant's reason for leaving?

Would you rehire this applicant? YES NO

Signature Date



Verification of Current/Previous Employment
REFERENCE CHECK TWO (2)

By signing below, you are giving Altomar HHC, Inc. permission to contact your previous/current employer to verify employee AND salary information as listed below. Please be advised, in the event that we are not able to garner salary information you may be asked to furnish a payroll history for any positions that are administrative and/or salaries above our standard rate.

Applicant Information

Employee Name: Last First Middle

Social Security #: Date of Birth:

Position:

Signature of Applicant Date

Name of Previous/Current Representative who may validate Past/Current Employment with their Company

Name of Contact:

Title: Phone: ()

Company:

Address:

Street Address Suite

City State ZIP Code

Was the applicant an employee of your company? YES NO

What was the period of employment? START DATE: END DATE:

What was the applicant's position on the last day of employment?

Does the applicant have at least 6 months experience with pediatric clients?

What was the applicant's starting salary?

What was the applicant's ending salary?

What was the applicant's reason for leaving?

Would you rehire this applicant? YES NO

Signature Date



LICENSED PERSONNEL SKILLS CHECKLIST

Employee Name: _____

INSTRUCTIONS:

Using the key below, choose this number which most closely reflects your knowledge, experience, and need for teaching. Enter the appropriate number from 0-3 under each category beside each item listed.

KNOWLEDGE	EXPERIENCE	REQUIRE IN-SERVICE
0 = No Knowledge	0 = No Knowledge	0 = No Knowledge
1 = Need to Review & Learn Application	1 = Need to Review & Learn Application	1 = Need to Review & Learn Application
2 = Very Knowledgeable – Do not need to review	2 = Very Knowledgeable – Do not need to review	2 = Very Knowledgeable – Do not need to review
3 = Expert – Can Instruct	3 = Expert – Can Instruct	3 = Expert – Can Instruct

Procedure	(0-3) Knowledge	(0-3) Experience	(0-3) Require In-Service
1. Intravenous Therapy, Technique, and care of:			
a. Venipuncture			
b. Butterfly			
c. Heparin Locks			
d. Over-The-Needle Catheter			
e. Addition of Fluids to present IV			
f. Regulation of IVs			
g. Peripheral IV site care			
h. Central Venous Access (CVA) Devices – Hickman:			
(1) Drawing Blood			
(2) Site Care			
(3) Flushing			
(4) Cap Change			
i. Groshong			
(1) Site Care			
(2) Flushing			
(3) Cap Change			
j. PICC			
(1) Site Care			
(2) Flushing			
(3) Cap Change			
k. Port-A-Cath			
(1) Site Care			
(2) Flushing			
(3) Cap Change			
l. Infusion Pumps			
m. Ambulatory Fusion			
n. Administration of Blood and Blood Procedure			
2. Respiratory Care:			
a. Tracheostomy:			
(1) General Hygenic care of site			
(2) Cleaning and removal fo inner cannula			
(3) Changing trach ties			
(4) Suctioning			
(5) Change trach tube			
(6) Pharyngeal Suction			

Procedure	(0-3) Knowledge	(0-3) Experience	(0-3) Require In-Service
(7) Airway Insertion (8) Oxygen Administration a. Safety b. Mask c. Nasal Cannula (9) Nebulizer Treatments (10) Use of oral/nasal inhaler b. Ventilator (1) Assessing the Patient on a Ventilator (2) Ventilator Function/Settings (3) Draining Tubing (4) Monitor Alarm Settings (5) Manual Ventilation/Ambu Bag			
3. Foley Catherization a. Daily Catheter Care b. Irrigation c. Obtaining UA from Foley d. Insertion of Foley (urethra) male and female e. Removal of Foley Catheter (urethra) f. Insertion of Supra-pubic catheter g. Removal of Supra-pubic catheter h. Care of urostomy i. Straight Catherization j. Cath for residual k. Bladder Training l. Douche m. Sitz Bath n. Nephrostomy Tubes			
4. Administration of Medications a. Oral b. IM c. Subcutaneous d. IM-Z-Track e. Intravenous: (1) Admixtures (2) Bolus-Push f. Chemotherapy: (1) General (2) Extravenous g. TPN h. Rectal Suppositories i. Vaginal Suppositories j. Ear Drops k. Eye Drops l. Nose Drops m. Tubes System n. Narcotics o. Heparin p. Insulin q. Assessing for Side Effects Response			
5. Gastric Tubes a. NG Tube Insertion b. Mercury weighted NG Insertion c. Checking for Placement of NG d. Gastrostomy Tube Insertion e. Jejunostomy Tube f. Care of Insertion Site: (1) Gastronomy Tube (2) Jejunostomy Tube g. Enteral Feedings: (1) Pumps (2) Bolus (Syringe, Intermittent)			

Procedure	(0-3) Knowledge	(0-3) Experience	(0-3) Require In-Service
(3) Gravity (Bag)			
6. Equipment: a. O2 Mask, Nasal Cannula, Concentrator, Portable O2 b. Suction Machine c. Emerson Suction d. Gomco Suction e. Water Pik f. Glucometer, Diascan, Exactech, Accucheck, One Touch, Tracer g. IV Pumps, CAD, AVI, Pancreatic Intelligent h. Electric Bed i. Hoyer Lift j. Medication Nebulizer k. Hemovac Suction l. Alternative Pressure Mattress			
7. Safety Devices: a. Bed Rails b. Restraints c. Fire Extinguisher			
8. Patient Transfer a. 1-Man transfer b. 2-Man Transfer c. Fire Extinguisher			
9. Collection, Labeling, and Delivering Specimens: a. Clean cath urine (In & Out Cath UA/Midstream) b. Urine Cultures c. 24 Hr Urine Collection d. Stool Collection (O & P, Hemocult) e. Venipuncture for Blood (1) Vacutainer (2) Butterfly (3) Syringe and Needle f. Blood Cultures g. Sputum Cultures h. Wound Culture i. Urine & Ketodiasitix			
10. Infection Control a. Universal Precautions b. Hand washing c. Handling Body Fluids d. Disposal of Sharps e. Clean Up of spills of Body Fluids f. Disposal of contaminated (body fluid) articles g. Maintaining and environmentally Safe Work Areas h. Respiratory Isolation i. Enteric Precautions			
11. Cardiopulmonary Resuscitation a. ABCs of Resuscitation b. Duties and Responsibilities c. DNR Procedure d. Living Will or Advance Directive e. Use of Resuscitation Mask f. Heimlich Maneuver			
12. Wounds and Dressings: a. Wound Assessment b. Wound Measurement c. Wound Irrigation d. Wet To Dry Dressings e. Sterile Dressings f. Clean Dressings g. Decubitus Care h. Pressure Dressings			

Procedure	(0-3) Knowledge	(0-3) Experience	(0-3) Require In-Service
i. Ace Wrap			
j. Cast Care			
k. Compresses			
l. Use of Sheep skin and other devices			
13. Physical Assessment:			
a. Obtaining a Health History			
b. Vital Signs			
c. Apical-Radial Pulse			
d. Skin Assessment			
e. Neurological Assessment			
f. Cardiac Assessment			
g. Respiratory Assessment			
h. GI Assessment			
i. GU Assessment			
14. Miscellaneous:			
a. Intake and Output			
b. Gavage			
c. Colostomy			
(1) Care			
(2) Irrigation			
d. Ileostomy Care			
e. Indwelling Epidural Catheter			
(1) Site Care			
(2) Administration of Medication through catheter			
(3) Change of Cap			
f. Caring for Patients with AIDS			
g. Eye Irrigation			
h. Ear Irrigation			
i. Anti-Embolism Stockings			
j. Patient Teaching			
k. Care Planning			
l. Discharge Planning			
m. Case Management			
n. Post-Mortem Care			
o. Enemas			
15. Charting:			
a. Medicare Guidelines for Documentation			
b. Correction to the Medical record			
c. Transcribe Orders			
d. Documentation			
16. Accidental/Incident Reports			
17. Areas of Expertise:			
a. Medical-Surgical			
b. Oncology			
c. Pediatrics			
d. Orthopedics			
e. Neurology			
f. Obstetrics, post partum			
g. Rehabilitation			
h. Urology			
i. OTHER			

Name of Employee

Date of Employment

Supervisor Name

Date