PHYSICIANS CHOICE HEALTH SERVICES
APPLICATION FOR EMPLOYMENT

☐ Full Time
☐ Part Time
☐ Temporary

THIS FACILITY IS A EQUAL OPPORTUNITY EMPLOYER. FEDERAL AND STATE LAWS PROHIBIT DISCRIMINATION OF EMPLOYMENT BECAUSE OF RACE, COLOR, RELIGION, AGE, SEX, NATIONAL ORIGIN OR DISABILITY. NO QUESTION ON THIS APPLICATION IS ASKED FOR THE PURPOSE OF LIMITING OR EXCLUDING ANY APPLICANTS CONSIDERATION FOR EMPLOYMENT BECAUSE OF RACE, COLOR, RELIGION, AGE ,SEX, NATIONAL, ORIGIN OR DISABILITY.

DATE:________________________

If you need help filling out this application form or during any phase in the application process, please notify the person who gave you this form or another member of the Human Resources Department and every effort will be made to accomdate your needs in a reasonable amount of time.

POSITION DESIRED ____________________________

(Last Name) (First Name) (Middle Name) Phone Number

Street Address City State Zip

Issuing State____________

Social Security # ________________________ Driver's License # ________________ Exp. Date ________________

Have you ever been employed at this facility? YES____ NO_______ YEAR__________ Department ________________
Are you 18 years of age or older? YES_____ NO_______

Date of Birth ______________________ Who Referred you? ____________________
Are you more than 65 years of age? YES___ NO_____ Neighbor ____________ Newspaper Ad ____________ Agency__________
Friend ____________ Employee ____________ Name of Agency ____________
Date you can start______________________
List any relatives employed at this facility ____

EDUCATION

Schools	Name and Address of Institution	Graduated YES / NO	Degrees Received	Average Grades	Areas of Specialization
High School					
College					

MILITARY STATUS

Veteran of U.S. Armed Forces YES___ NO____

Dates : From ________________ To ____________ Rank on Entering ____________ Rank at Discharge ____________

Did you attend a professional school? YES NO

Type	Location	Period of Attendance From	To	Did You Graduate
Nursing				
Practical Nursing				
X-Ray				
Laboratory				
Other				

Licensure and Professional Activities Licensed in (State)	Registration Number	Did you Graduate
____________	____________	____________

PHYSICIANS CHOICE HEALTH SERVICES, LLC
STATEMENT OF EMPLOYABILITY

PLEASE READ THIS DOCUMENT CAREFULLY

By execution o£ this document, 1 acknowledge that I have been informed by the Human Resource Department, that a criminal history check will be performed on my name. I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that the status of my employment is temporary pending the results o£ the criminal history check.

I have not been convicted of any of the following crimes;

1. An offense under Chapter 19, Penal Code (criminal homicide);
2. An offense under Chapter 20, Penal Code (kidnapping and false imprisonment);
3. An offense under Section 21.11, Penal Code (indecency 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 a 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), or
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 42.08, Penal Code (cruelty to animals); or
24. A conviction under the laws of another state, federal law or the uniform code of military justice or an offense containing elements that are substantially similar to the elements of any offense listed by this subsection.

ADDITIONALLY

According to health and Safety Code 250.006(b), persons may not be employed in positions where Duties involve direct contact with a consumer *before the fifth anniversary* of the date the person is convicted of:

1. An offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony;
2. An offense under Section 30.02 Penal Code (burglary);
3. An offense under Chapter 31, Penal Code (theft), that is punishable as a felony;
4. 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
5. 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;
6. Section 37.12 Penal Code (false identification as peace officer); and
7. Section 42.01(a) (7), (8), or (9), Penal Code (disorderly conduct).

<u>In addition to the prohibitions on employment prescribed by Subsections (a) and (b),</u> 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:
1. Of an offense under Section 30.02 Penal Code (burglary); or
2. 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.

<u>Finally, according to health and Safety Code 250.006(d),</u> 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 offenses (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

______________________________ ______________________________
Printed Name Date

Signature of Applicant

For Agency Use Only; NAR and EMR Check <u>must be performed prior to employment</u>.

___ EMR & NAR checked by telephone (800-452-3934)
___ EMR & NAR checked online. See attached print out.
<u>(http://www.dhs.state.tx.us/program/ltc/credentialing/)</u>

___ Applicant is employable **___ Applicant is not employable**

______________________________ ______________
Verified by Agency Representative **Date**

EMPLOYMENT REFERENCES

List Most Recent Employer First

If currently employed, may we contact your present employer ? YES ____ NO ____

1. Place of Employment ______________________ Position Held ______________
Address ______________________ Name of Supervisor ______________
City ______________ State ______________ Phone Number ______________
Employment Date From: ______________ To: ______________
Name Used During Employment: ______________________ Salary: ______________
Reason for Leaving: ____

2. Place of Employment ______________________ Position Held ______________
Address ______________________ Name of Supervisor ______________
City ______________ State ______________ Phone Number ______________
Employment Date From: ______________ To: ______________
Name Used During Employment: ______________________ Salary: ______________
Reason for Leaving: ____

3. Place of Employment ______________________ Position Held ______________
Address ______________________ Name of Supervisor ______________
City ______________ State ______________ Phone Number ______________
Employment Date From: ______________ To: ______________
Name Used During Employment: ______________________ Salary: ______________
Reason for Leaving: ____

4. Place of Employment ______________________ Position Held ______________
Address ______________________ Name of Supervisor ______________
City ______________ State ______________ Phone Number ______________
Employment Date From: ______________ To: ______________
Name Used During Employment: ______________________ Salary: ______________
Reason for Leaving: ____

OTHER PERTINENT DATA

Have you been convicted of a crime other than a misdemeanor or summary offence? YES______ NO______

Years of Conviction ____

Charges____

____

____

Medical Professionals Only:

Have you ever been involved in a medical malpractice action? YES______ NO______

Explain: ____

____

____

If employment is offered, can you submit a birth certificate, social security card, certificate of U.S. citizenship or verfication of your legal right to work in the U.S.? YES_____ NO______

Employment will be contigent upon successful completion of a medical examination.

APPLICATION DISCLOSURE

Please read this statement carefully, should you have any questions, please seek assistance before signing the application. This company is an equal opportunity employer and selects individuals best matched for the job based upon job-related qualifications regardless of race, color, creed, sex, religion, national origin, age or disability. I understand that any misrepresentation, misinformation, or inaccuracy of the statements contained in this application may result in termination of my employment or withdrawal of an offer of employment. I authorize the company to investigate all information and references and to obtain any trascripts, records, or documents pertaining to my background and business experience as required to arrive at an employment decision. I also hereby release the company, its officers, employees, representatives, or agents, from any and all liability and/or damage incurred by myself in obtaining such information.

I understand that if I have a physical or mental impairment that substantially limits one or more of my major life activities or a record of such impairment, or if otherwise believe myself to be covered by the Americans with Disabilities, I can advise the company at anytime during the application, interview or hiring process about the accommodations the company could make to enable me to perform the essential functions of the job I am seeking. I understand that submission of information regarding reasonable accommodation is voluntary and that my refusal to provide it will not subject me to adverse treatment in the employment process. I further understand that information obtained by the company regarding my disability will be kept confidential except that, if hired, (1) Supervisors and Managers maybe informed regarding restrictions on my work or duties, and regarding necessary accommodations; (2) First aid and safety personnel may be informed when and to the extent appropriate, if the condition might require emergency treatment: and (3) Government officials investigating compliance with the Americans with Disabilities act may be informed, in this connection, I authorize any physician or hospital to release to the company any information that my be necessary to determine my ability to perform the essential functions of a job for which I am being considered prior to employment or during my employment with the company. If offered employment, the company may require me to take a physical examination and drug and alcohol screen, the results of which I agree can be reported to the company.

I hereby understand and acknowledge that unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the employee may resign at any time and the employer may discharge the employee at any time with or without cause. It is further understood that this "at will" cally acknowledged in writing by an authorized executive of this organization.

time I understand that this application will remain active for sixty (60) days, and if I have not been hired by that date, I must complete a new application to be considered for future employment.

Pursuant to the requirements of the fair credit reporting act. Notice is given that a consumer report or an investigate consumer report may be made in connection with my application for employment. If I am denied employment either wholly or partly, because of information that contained in a consumer report. A disclosure will be made to me of the name and address of the consumer reporting agency making such report.

I have read the above notice and understand what it means.

______________________________ ______________________________
Date Signature of Applicant

(APPLICANT - PLEASE DO NOT WRITE IN SPACE BELOW)

Date ____________________

Referring ____________________ To ____________________ Department ____________________

(Applicants Name) (Department Head) For the position ____________________

Salary Quoted Monthly ( ) Hourly( )

Experience Considered (If applicable)

Remarks ____

Interviewed by ____________________

DEPARTMENT HEAD USE ONLY

Department Head Comments:

Date ____________________ If rejected give reason ____________________

IF HIRED COMPLETE THE PAYROLL INFORMATION BELOW

Date to start work ____________________ Department ____________________

Job Title ____________________ Hours ____________________ Salary ____________________

Full time ____________________ Part time ____________________ Temporary ____________________

Criminal History Check for Unlicensed HCSSA Personnel

Agency Name ____________________ (AC) Telephone # ____________ License # ____________

Address (Street, City, State, Zip) ______________________________

A person employed in direct contact with a consumer of service must have a criminal history conviction check initiated within 72 hours of employment. They may not be considered permanently employed until 40 days have passed since the request was submitted. This does not apply to persons licensed under other state laws.

I certify that the information submitted on this form contains no willful misrepresentation and that the information given is true and correct to the best of my knowledge. I realize that this is priviledged information and should be used for the exclusive use of this agency.

Signature - Agency Representative ____________________ Date ________

Mail to: TDHS - CREDENTIALING DEPARTMENT
HCSSA Criminal History
P.O. BOX 149030 - MC Y-978
Austin, TX 78714-9030

Name (Last, First, Middle) | Maiden Name | Date Hired

Other Names (alias, married name, etc)

Date of Birth (mm/dd/yy) | Race/Ethnicity | Sex ☐ Male ☐ Female | Social Security #

Name (Last, First, Middle) | Maiden Name | Date Hired

Other Names (alias, married name, etc)

Date of Birth (mm/dd/yy) | Race/Ethnicity | Sex ☐ Male ☐ Female | Social Security #

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Other Names (alias, married name, etc)

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Name (Last, First, Middle) | Maiden Name | Date Hired

Other Names (alias, married name, etc)

Date of Birth (mm/dd/yy) | Race/Ethnicity | Sex ☐ Male ☐ Female | Social Security #

Physicians Choice Health Services Home Health

REQUEST FOR REFERENCES

Name ______________________________ Social Security #______________________________

Address (Street, City, State, Zip) ______________________________

PERSON OR INSTITUTION WE MAY CONTACT FOR REFERENCE

Name ______________________________

Address (Street, City, State, Zip) ______________________________

I have made application for employment with the above listed employer. I hereby request and authorize you to furnish the above listed employer with any information concerning my employment records, character, habits and ability. I do hereby release the addressed entity and all individuals concerned from any claims, suits, liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the gaining of such information.

____

Applicants Signature

The applicant was your employee from ______________________ to ______________________YES( ) NO ( )

Was his/her position or title ______________________________

If not, explain ______________________________

Reason for leaving ______________________________

Would you rehire ? YES( ) NO( ) . If no, give reason ______________________________

Comment(s): ______________________________

____

	Below Average	Above Average	Average	N/A
Quality of Performance	( )	( )	( )	( )
Appearance	( )	( )	( )	( )
Dependability	( )	( )	( )	( )
Attendance/Punctuality	( )	( )	( )	( )
Quality of Work	( )	( )	( )	( )

Signature/Title ______________________________ Date ______________________________

Physicians Choice Health Services Home Health

REQUEST FOR REFERENCES

Name ____ Social Security #________________________________

Address (Street, City, State, Zip) ____

PERSON OR INSTITUTION WE MAY CONTACT FOR REFERENCE

Name ____

Address (Street, City, State, Zip) ____

I have made application for employment with the above listed employer. I hereby request and authorize you to furnish the above listed employer with any information concerning my employment records, character, habits and ability. I do hereby release the addressed entity and all individuals concerned from any claims, suits, liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the gaining of such information.

____

Applicants Signature

The applicant was your employee from ___________________________ to ________________________YES( ) NO ( )

Was his/her position or title ____

If not, explain ____

Reason for leaving ____

Would you rehire ? YES( ) NO( ) . If no, give reason ____

Comment(s): ____

____

	Below Average	Above Average	Average	N/A
Quality of Performance	( )	( )	( )	( )
Appearance	( )	( )	( )	( )
Dependability	( )	( )	( )	( )
Attendance/Punctuality	( )	( )	( )	( )
Quality of Work	( )	( )	( )	( )

Signature/Title ____ Date ________________________________

Employee Acknowledgment

Confidentiality 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, he/she should consult with their supervisor.

Drug Testing Policy: 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. Employees who have direct contact with clients may be subject to reasonable-suspicion testing when the agency or its client has reason to believe that drug or alcohol problem exists or a violation of the policy has occurred. The agency may perform random drug testing on an employee with 24 hour notice to the employe.

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.

Non-Solicitation/ Illegal Remuneration: Agency does not reimburse or provide incentives to employees, physicians, durable equipment providers, family or other health professional for patient referrals for home health services .

Workers Compensation: Agency does not provide workers compensation insurance. In the event of an emergency or injury contact agency management for instructions. If the emergency is life threatening, proceed to the nearest hospital. Contact the agency as soon as possible. It is required to complete an incident report for agency records.

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 process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

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

PHYSICIANS CHOICE HEALTH SERVICES, LLC

EMPLOYEE STATEMENT OF CONFIDENTIALITY

I, the undersigned, understand the importance of observing strict confidentiality policies. Therefore, I agree not to discuss/release any information obtained within the agency regarding any PHYSICIANS CHOICE HEALTH SERVICES, LLC client, there medical record, or any client's condition with any individual not directly, associated with PHYSICIANS CHOICE HEALTH SERVICES, LLC nor with HYSICIANS CHOICE HEALTH SERVICES, LLC employees who are not directly associated with that client. I also agree that any information that is released regarding the client or the client's record will only be done with proper authorization and/ or with established agency policy for the release of the information.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies and that any breach in the aforementioned policies will result in implementation of the disciplinary procedure up to and including possible immediate dismissal from employment at PHYSICIANS CHOICE HEALTH SERVICES, LLC.

______________________________ __________________________

Employee's Signature Date

______________________________ __________________________

Supervisor's Signature Date