Application for Employment

Please Print

Equal access to programs, services, and employment is available to all persons. Those applicants requiring reasonable accommodations to the application and/or interview process should notify a representative of Home & Hospital Medical Personnel, Inc.

Date of Application ______________________ **Position(s) applying for** _________________________

Name ____
Last First Middle

Address ____
Street City State Zip Code

Primary Phone # ____________________ ***Can you receive texts?** ________ **Secondary Phone #** ___________________

Date of Birth ________________________ **Social Security #** ______________________

How did you hear about Home & Hospital? ____

Have you ever been employed here before? ____

Are you legally eligible for work in this country ……………………………………………………...Yes ☐ No ☐

What date are you available to start work? ____

Type of employment desired……………………………………………………… **Full Time** ☐ **Part Time** ☐

Hours/Shifts/Days preferred____

Are you able to meet the attendance requirements of this job? ……………………………………..Yes ☐ No ☐

Have you been convicted of a crime in the past seven years? ………………………………………..Yes ☐ No ☐

If yes, please explain____

Conviction will not necessarily be a bar to employment. Each instance and explanation will be considered in relation to the position for which you are applying.

Employment History

Provide the following information for your past three employers, assignments, or volunteer activities, starting with the most recent.

From:	To:	Employer	Telephone
Job Title		Address	
Immediate Supervisor & Title		Summarize the nature of work and job responsibilities	
Reason for leaving		Hourly Rate/Salary: Start $ __________ Per __________ Final $ __________ Per __________	

From:	To:	Employer	Telephone
Job Title:		Address	
Immediate Supervisor & Title		Summarize the nature of work and job responsibilities	
Reason for leaving		Hourly Rate/Salary: Start $ __________ Per __________ Final $ __________ Per __________	

Skills and Qualifications

Summarize any training, skills, licenses, and/or certificates that may qualify you as being able to perform job-related functions in the position for which you are applying.

Educational Background

Name & Location	Year Completed	Did you graduate?	Course of Study
High School			
College		Major Degree	
Other			

References

Name	Telephone #	Years known

Emergency Contact(s)

Name	Relationship	Telephone #

I understand that if I am employed, any misrepresentation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate discharge from the Home & Hospital Medical Personnel, Inc.'s service, whenever it is discovered.

I give Home & Hospital Medical Personnel, Inc. the right to contact and obtain information from all references, employers, educational institutions and to otherwise verify the accuracy of the information contained in this application. I hereby release from liability Home & Hospital Medical Personnel, Inc. and its representatives for seeking, gathering and using such information and all other persons, corporations or organizations for furnishing such information.

Home & Hospital Medical Personnel, Inc. does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by local, state or federal law.

The application is current for only 60 days. At the conclusion of this time, if I have not heard from Home & Hospital Medical Personnel, Inc. and would still like to be considered for employment, it will be necessary to fill out a new application.

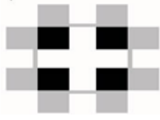
If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice. Home & Hospital reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as required by law. This application does not constitute an agreement or contract for employment for any specified period or duration. I understand that no representative of Home & Hospital Medical Personnel, Inc. other than an authorized officer has the authority to make any assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer.

I understand that it is this company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the ADA.

I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization.

I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

***Signature of Applicant ____________________________________ Date _____________________**



799 Bloomfield Ave #210
Verona, NJ 07044
P: (973) 857-9200
F: (973) 857-3061

TO BE COMPLETED BY APPLICANT:

APPLICANT NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

DATES OF EMPLOYMENT POSITION(S) HELD

REASON FOR LEAVING

I have applied for a position with Home & Hospital Medical Personnel, Inc. Please complete and return this evaluation for me. I hereby authorize you to disclose any and all information concerning my employment with your firm to Home & Hospital Medical Personnel, Inc. I Understand this is in accordance with all Federal and State laws.

/ /

SIGNATURE OF APPLICANT DATE (Mo/Day/Yr)

TO BE COMPLETED BY FORMER EMPLOYER:

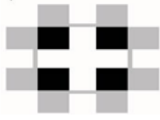
The applicant named above has applied for a position with Home & Hospital Medical Personnel, Inc. and has listed you as a previous employer. We would appreciate your assistance in verifying this applicant's employment and in evaluating his/her job performance so we will be able to maintain our high standards. All information provided will be held in strictest confidence. Thank you.

1. Does the information above correspond with your records..…....................... Yes No
2. Position Held ____________________
3. Would you rehire this applicant.. Yes ☐ No ☐
4. Is there any reason, Medical or Other, that would interfere with this applicant performing his/her job.. Yes ☐ No ☐
5. Reason for termination ____________________

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
ATTENDANCE				
PUNCTUALITY				
DEPENDABILITY				
QUALITY OF WORK				
JOB KNOWLEDGE				
ACCEPTS SUPERVISION				
PERSONAL APPEARANCE				
CONDUCT				

/ /

Information Supplied by Title Date(Mo/Day/Yr)



799 Bloomfield Ave #210
Verona, NJ 07044
P: (973) 857-9200
F: (973) 857-3061

TO BE COMPLETED BY APPLICANT:

APPLICANT NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

DATES OF EMPLOYMENT POSITION(S) HELD

REASON FOR LEAVING

I have applied for a position with Home & Hospital Medical Personnel, Inc. Please complete and return this evaluation for me. I hereby authorize you to disclose any and all information concerning my employment with your firm to Home & Hospital Medical Personnel, Inc. I Understand this is in accordance with all Federal and State laws.

/ /

SIGNATURE OF APPLICANT DATE (Mo/Day/Yr)

TO BE COMPLETED BY FORMER EMPLOYER:

The applicant named above has applied for a position with Home & Hospital Medical Personnel, Inc. and has listed you as a previous employer. We would appreciate your assistance in verifying this applicant's employment and in evaluating his/her job performance so we will be able to maintain our high standards. All information provided will be held in strictest confidence. Thank you.

1. Does the information above correspond with your records.. Yes No
2. Position Held ______
3. Would you rehire this applicant.. Yes ☐ No ☐
4. Is there any reason, Medical or Other, that would interfere with this applicant performing his/her job.. Yes ☐ No ☐
5. Reason for termination ______

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
ATTENDANCE				
PUNCTUALITY				
DEPENDABILITY				
QUALITY OF WORK				
JOB KNOWLEDGE				
ACCEPTS SUPERVISION				
PERSONAL APPEARANCE				
CONDUCT				

/ /

Information Supplied by Title Date(Mo/Day/Yr)

CLINICAL SKILL EXPERIENCE ASSESSMENT RECORD

NAME: ______________________________ DATE: ________________

In accordance with Federal, State and local governing bodies for Home Health Agencies, the following information regarding your clinical skills and assessments abilities is required in order to provide appropriate assignments for you.

Please place a check mark in the appropriate box to indicate your clinical and assessment abilities:

Box 1 – Experienced; Box 2- Needs review; Box 3- Trained Only; Box 4 – Never Done

GENERAL NURSING EXPERIENCE

Med / Surg	☐	☐	☐	☐
Labor & Delivery	☐	☐	☐	☐
Pediatrics	☐	☐	☐	☐
NICU	☐	☐	☐	☐
PICU	☐	☐	☐	☐
ER/Trauma	☐	☐	☐	☐
ICU (Med / Surg)	☐	☐	☐	☐
CCU	☐	☐	☐	☐
OR	☐	☐	☐	☐
Recovery Room	☐	☐	☐	☐
Oncology	☐	☐	☐	☐
Orthopedics	☐	☐	☐	☐
Dialysis	☐	☐	☐	☐
IV team	☐	☐	☐	☐
Code team	☐	☐	☐	☐
GYN / OB	☐	☐	☐	☐
Head Nurse	☐	☐	☐	☐
Supervisor	☐	☐	☐	☐
Administration	☐	☐	☐	☐
Burn Unit	☐	☐	☐	☐
Psychiatry	☐	☐	☐	☐
Geriatrics	☐	☐	☐	☐
Alcohol Drug Abuse	☐	☐	☐	☐

I.V. EXPERIENCE

IV Certified	☐	☐	☐	☐
Heparin Locks	☐	☐	☐	☐
Antibiotic Therapy	☐	☐	☐	☐
Intrathecal Caths	☐	☐	☐	☐
TRN	☐	☐	☐	☐

M/S EXPERIENCE

CVP Lines	☐	☐	☐	☐
Enemas	☐	☐	☐	☐
Fecal Impactions	☐	☐	☐	☐
Gavage Feedings	☐	☐	☐	☐
Insert Levine Tube	☐	☐	☐	☐
Irrig Levine Tube	☐	☐	☐	☐
O2 Administration	☐	☐	☐	☐
Isolation Technique	☐	☐	☐	☐
Reverse Isolation	☐	☐	☐	☐
Urine Testing	☐	☐	☐	☐
I & P Sheets	☐	☐	☐	☐
Postmortem Care	☐	☐	☐	☐
Suctioning	☐	☐	☐	☐
IV Medications	☐	☐	☐	☐
Chemotherapy	☐	☐	☐	☐
Diabetic Teaching	☐	☐	☐	☐
Give / Take Report	☐	☐	☐	☐
Change Duties	☐	☐	☐	☐
Cataract Care	☐	☐	☐	☐
Gastrostomy	☐	☐	☐	☐
Transfer Patient				

HOME CARE

Hospice	☐	☐	☐	☐
AIDS	☐	☐	☐	☐
Ventilators	☐	☐	☐	☐
Initial /Add to	☐	☐	☐	☐
Init Pt Assessment	☐	☐	☐	☐
Pt. Family Teaching	☐	☐	☐	☐

-OVER-

CLINICAL SKILL EXPERIENCE ASSESSMENT RECORD

Home Care (cont'd)				
Heparin Locks	☐	☐	☐	☐
TPN	☐	☐	☐	☐
TPN with Lipids	☐	☐	☐	☐
Antibiotic Therapy	☐	☐	☐	☐
Chemotherapy	☐	☐	☐	☐
Pain Management	☐	☐	☐	☐
Perenteral Pumps	☐	☐	☐	☐
CADD Pump	☐	☐	☐	☐
Enteral Pumps	☐	☐	☐	☐
Insertion N/G Tube	☐	☐	☐	☐
Enterals Pumps	☐	☐	☐	☐
Trach Care	☐	☐	☐	☐
Porta Caths	☐	☐	☐	☐
Hickman / Broviac	☐	☐	☐	☐
Caths	☐	☐	☐	☐
Peripheral Lines	☐	☐	☐	☐
Venepuncture	☐	☐	☐	☐
Insertion Foley (male)	☐	☐	☐	☐
Insertion Foley (female)	☐	☐	☐	☐
Rehabilitation	☐	☐	☐	☐
Quadri / Para	☐	☐	☐	☐
Disabled	☐	☐	☐	☐
Postmortem Care	☐	☐	☐	☐
Trach Special Diets	☐	☐	☐	☐
Dialysis	☐	☐	☐	☐
Diabetic Instruction	☐	☐	☐	☐
Suction	☐	☐	☐	☐
Gastrostomy Feeding	☐	☐	☐	☐
Stoma Care	☐	☐	☐	☐
Incident Reports	☐	☐	☐	☐
O2 Administration	☐	☐	☐	☐
Inhalation Therapies	☐	☐	☐	☐
Pentamadine Therapy	☐	☐	☐	☐

Most Work Experience In:				
Hospital	☐	☐	☐	☐
Nursing Home	☐	☐	☐	☐
Rehab	☐	☐	☐	☐
Home Care	☐	☐	☐	☐

Signature ***Date***

EMPLOYEE W-4 INFORMATION FORM

Employee Name ______________________________

Address ______________________________

____

____

Email Address ______________________________

Home # ______________________________

Cell # ______________________________

Date of Birth ______________________________

Social Security # ______________________________

Marital Status ____________________

Dependents ____________________

Date of Hire ____________________

Rate of Pay ____________________

Additional Withholdings ____________________

ALL EMPLOYEES WILL BE USING DIRECT DEPOSIT……..FILL OUT BELOW

Bank Name _______________________

Bank Account Number _______________________

Bank Routing Number ________________________

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **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.**

OMB No. 1545-0074

2014

1 Your first name and middle initial | Last name | **2 Your social security number**

Home address (number and street or rural route)

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

Note. 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. ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | 5 |

6 Additional amount, if any, you want withheld from each paycheck . . . . | 6 | $

7 I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption.

- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ | 7 |

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.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

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)

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

Please 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 eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of 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 *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
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 or national of the United States
- ☐ A Lawful Permanent Resident (Alien #) A ______
- ☐ An alien authorized to work until ______ (Alien # or Admission #) ______

Employee's Signature	Date *(month/day/year)*

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 *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

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 *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION - lattest, 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 eligible 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	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

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

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility. Document Title: ______ Document #: ______ Expiration Date (if any): ______

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 *(month/day/year)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

AUTHORIZATION FOR BACKGROUND CHECKS

After carefully reading this Background Check Disclosure and Authorization form, I authorize the Company to order my background report, including investigative consumer reports. I understand that the Company may rely on this authorization to order additional background reports, including investigative consumer reports, during my employment without asking me for my authorization again as allowed by law.

I also authorize the following agencies and entities to disclose to ADP Screening and Selection Services and its agents all information about or concerning me, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; motor vehicle records agencies; if applicable, worker's compensation injuries; all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. Workers' compensation information will only be requested in compliance with federal Americans with Disabilities Act and/or any other applicable federal, state or local laws and only after a conditional job offer is made. The information that can be disclosed to ADP Screening and Selection Services and its agents includes, but is not limited to, information concerning my employment history, earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses and substance abuse testing.

I agree the Company may rely on this authorization to order background reports, including investigative consumer reports, from companies other than ADP Screening and Selection Services without asking me for my authorization again as allowed by law. I also agree that a copy of this form is valid like the signed original. I certify that all of the personal information I provided is true and correct.

Last Name ________________________________ First ______________________ Middle ___________________

Maiden/Other Names ____ Years Used ______________________

If you live or work for the Company in California, Minnesota or Oklahoma: Check this box if you would like a free copy of your background check report: ☐

____ _____/_______/________

Signature Date: (Month/Day/Year)

If required, notarize here. When using an embossed seal,

please shade with a pencil before faxing.

Subscribed and sworn before me:

____

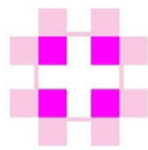
Notary Public Signature

____

Date

____

My Commission Expires



HOME & HOSPITAL
Medical Personnel, Inc.

799 Bloomfield Ave.
Verona, NJ 07044
(973) 857-9200

RN/LPN EXAM

NAME:__________________________________ DATE: _____________

1. You arrive at your adult patient's home to find him lying on the floor with no pulse and no spontaneous respirations. What is your first action?

   a. call the agency to notify them of the situation
   b. call the ambulance squad immediately
   c. call the physician for orders
   d. initiate CPR for one minute, call the ambulance and then resume CPR

2. You receive an order from the physician for Keflex 0.5gm PO BID. You have capsules available that are 250mg per capsule. How many capsules do you administer?

   a. 2 capsules
   b. 2.5 capsules
   c. 1 capsule
   d. it is impossible to administer that dosage with the capsules available

3. A geriatric patient is discharged from the hospital after having bilateral hip pinnings and receiving 2 units of whole blood. When providing home care, which of the following times should you wear gloves?

   a. empty foley bag
   b. empty bedside commode which has stool splatter
   c. to draw blood from a peripheral site
   d. Give a back rub

   (1) A, B (2) A,B, and C (3) C (4) D

4. Which of the following <u>would not</u> be a risk factor associated with coronary artery disease?

   a. elevated cholesterol
   b. hypertension
   c. emotional stress
   d. physical activity

5. You arrive at your patient's home and he greets you stating he has been bothered by epigastric discomfort all day. He is pale, diaphoretic and very anxious. Your first nursing action would be?

   a. call the physician
   b. call the ambulance squad
   c. assist patient to rest quietly and comfortably while you continue your assessment
   d. administer Maalox

6. If there is a change in a patient's condition which is not an emergency, what action should be taken?

   a. call the physician and ambulance
   b. call the physician, ambulance and agency supervisor
   c. call the patient's family
   d. call the agency supervisor

7. The pathophysiology of bronchial asthma includes:

   a. spasm of bronchial muscles
   b. edema of bronchial mucosa
   c. production of abnormal respiratory secretions
   d. dilation of terminal bronchioles
   e. filling of alveoli with exudates

(1) A only (2) A, B and C (3) All but B (4) all of the above

8. Cyanosis is detected in:

   a. nailbeds
   b. lips
   c. conjunctival
   d. circumoral pallor

(1) all of the above (2) A (3) B (4) A, B and D (5) D

9. Symptoms of Gastroesophageal Reflex are:

   a. "spitting up" vomiting
   b. irritability and posturing
   c. hematemesis, anemia
   d. poor growth, failure to thrive
   e. choking, apnea

(1) A and B (2) A, C, and D (3) A and E (4) all of the above

10. Prior to administration of each dose of Lanoxin, which of the following pulses should be assessed?

   a. brachial
   b. apical
   c. femoral
   d. pedal

11. A nurse would be correct in withholding a patient's dose of Lanoxin if the apical pulse rate goes below which of the following values?

    a. 60 beats per minute (bpm)
    b. 40 bpm
    c. 80 bpm
    d. 100 bpm

12. As a result of spinal cord injury, elasticity of blood vessels is diminished. Based on this information, the nurse should identify that the patient is at risk for which of the following nursing diagnosis?

    a. alteration in thought process related to decreased tissue oxygenation
    b. alteration in skin integrity related to immobility
    c. alteration in cardiac output related to decreased peripheral resistance
    d. alteration in cardiac output related to increased peripheral resistance

13. A patient with spinal cord injury at T5 enters a rehabilitation program which includes the use of leg braces. When applying the brace, it is essential for the nurse to consider which of the following aspects of the patient's condition?

    a. the patient cannot fully extend hip joints
    b. the patient has no sensation in the lower extremities
    c. the patient cannot move his lower extremities
    d. the patient can flex the knees to a 45 degree angle

14. When preparing to teach a juvenile diabetic about insulin, it is important for the nurse to include which of the following facts about insulin?

    a. insulin dosage is determined, primarily on the basis of food intake
    b. insulin requirements will decrease with age
    c. insulin dosage, after adolescence, can be adjusted by the person in terms of variations in physical activity
    d. insulin will have to be administered for the rest of a patient's life

15. A nurse is observing a patient for symptoms of shock. The earliest symptom of post operative shock would be obtained by measurements of which of the following?

    a. pulse rate
    b. urinary output
    c. temperature
    d. respirations

16. To detect a common untoward effect of Heparin or oral Coumadin, the nurse should assess the patient for the possible development of:

    a. generalized dermatitis
    b. hematuria
    c. urinary retention
    d. vitamin K deficiency

17. Which of the following nursing measures will be essential for a patient with a tracheostomy?

    a. detecting the need for suctioning
    b. keeping the suction apparatus on at all times
    c. removing the inner cannula each time suctioning is required
    d. changing the dressing around the tracheal opening after each suctioning

18. When initiating a patient's nasogastric tube feeding, which of the following should the nurse do <u>first</u>?

    a. check for proper tube placement
    b. keeping the patient on the left side during and after the feeding
    c. using sterile equipment for each feeding
    d. allowing the tube to remain unclamped one half hour after feedings

19. Which of the following would be symptoms of autonomic dysreflexia in a patient with a spinal cord injury?

    a. hypotension, vomiting, confusion
    b. hypertension, headache, diaphoresis
    c. hypotension, headache, diaphoresis
    d. hypertensive, vomiting, confusion

20. Which of the following is a crackling sound produced by air flowing through accumulated moisture in the respiratory tract?

    a. rhonci
    b. wheeze
    c. rales
    d. friction rub

____________________________________ __________________________

SIGNATURE DATE