P-B Health
Home Care Agency, Inc.

HOME HEALTH CARE
EMPLOYMENT APPLICATION

Name: #:____________________________________ SSN #:______________________________

Last First Middle

Current Address:____

City_________________State_________Zip Code_____________________

Home Telephone#( )_________________________Work/Alt# ( )________________________

Previous Address:____

City_________________State_________Zip Code_____________________

Position(s) Applied for:

1. ____

2. ____

Minimum Income Requirement:$____________________

Have you worked for us before?_____________If yes, when?____________________

If hired, on what date will you be available for work?_______________________________________

If driving is required of this position, do you have a reliable means of transportation?____________

Do you have a current valid MD driver's license? ☐ Yes ☐ No
Driver's license Number____

Are you currently covered by auto liability insurance? ☐ Yes ☐ No
Insurance carrier?____

Any objections to travel, if required by job?___________________

If you have alien status and are hired, can you provide written evidence of your rights to work in the US?_____

Please list any reason known to you why you might be unable to perform consistently and promptly any of the job duties.

____

____

Any objections to occasional overtime work?_______________

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Have you ever been disciplined or fired? ☐ Yes ☐ No If Yes, why? ________________________

____

Have you ever been charged or convicted of a crime, excluding minor traffic offenses?___________ If yes,

Please provide details:____

____

Is there any reason why you may not be able to accept employment, if offered, with this company? ________

If yes, please explain: ____

____

Has your professional license, if required for this position, ever been revoked?________ If yes, please explain

____

____

EDUCATIONAL BACKGROUND

TYPE OF . SCHOOL	NAME AND CITY	YEARS ATTENDED	GRADUATED	COURSE OR MAJOR
HIGH SCHOOL			☐Yes ☐ No	
JUNIOR COLLEGE			☐Yes ☐ No	
COLLEGE			☐Yes ☐ No	
POST GRADUATE			☐Yes ☐ No	
BUSINESS/TRADE			☐ Yes ☐ No	
OTHER			☐ Yes ☐ No	

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MILITARY SERVICE RECORD

Have you ever served in the Armed Forces? ☐ Yes ☐ No If Yes, why? ______________________________

Date of duty: From____To________________________________
Month Day Year Month Day Year

Rank at discharge:___________________What were your duties in the service (include special training and Duty Station) ____

____

WORK HISTORY (List *in* order, last or present Employer first}

From:	Month Year	Name of Employer:
To:	Month Year	Address/Phone:
Position Title:		Summary of Job duties:
Immediate Supervisor:		
Starting Salary:$ Ending Salary: $		Likes/dislikes about job:
Reason for wanting a job change:		
From:	Month Year	Name of Employer:
To:	Month Year	Address/Phone:
Position Title:		Summary of Job duties:
Immediate Supervisor:		
StartingSalary:$ Ending Salary: $		Likes/dislikes about job:
Reason for wanting a Job change:		

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From:	Month Year	Name of Employer:
To:	Month Year	Address/Phone:
Position Title:		Summary of Job duties:
Immediate Supervisor:		
Starting Salary:$ Ending Salary: *$*		Likes/dislikes about job:
Reason for wanting a job change:		

May we contact the employers listed on *the* previous pages? __ If not, please indicate which one(s) you *do not* wish us to contact.

1. ______________________________
2. ______________________________
3. ______________________________

Are there any other experiences, skills or qualifications which you feel are relevant to this job that have not already been mentioned? ______________________________

____

____

I hereby certify that the answers given by me to all the questions contained in this application form are true and correct. If employed by the company, I will comply with all the rules and regulations of the company. I agree to submit to a physical examination (if required) and authorize anyone to give this Company any credit information they have regarding me, whether or not is on their records. I hereby release them and the company from all Liability for any damage whatsoever for issuing same. If upon investigation, anything in this application is found to be untrue or if I do not pass the physical examination (if required) I understand I will be subject to dismissal.

______________________ ______________________

Date Signature

Chief Executive Officer
Jackie D. Balley, R.N.

P-B Health Home Care Agency, Inc..
4701 Mt. Hope Drive, Ste B,
Baltimore, Maryland 21215
410 235-1060 Fax 410 235-1309
TTDY 800-735-2258 Website www.p-bhealth.com

Chief Financial Officer
Matthew H. Balley, *Esq.*

I, ____ give my consent to release information pertinent to my employment to P-8 Health Horne Care Agency, Inc. Social Security Number is ------------------ .

Signature of Applicant____ **Date**________________

Reference Requested From:
Company: ____

Address: ____

____

Attention of:____
Phone Number:____
The period of employment was from____________________to________________(Employment Dates)

Sir/Madam,
The applicant *listed* above has applied for a position at P-8 Health Home Health Care Agency, Inc. and has given us permission to ask you for a reference to allow us to thoroughly screen this applicant. Please complete the form below. We appreciate your cooperation.

LEGEND: 1-POOR 2-AVERAGE 3-ABOVE AVERAGE 4-EXCELLENT

CONFIDENTIAL REPORT	**1**	**2**	**3**	**4**
Quality of Work				
Quantity of Work				
Ability to Work Under Pressure				
Technical Skills/Knowledge-Performance of Skills				
Health-Physical; Energy; Endurance, Defects				
Health-Emotional Adjustment Objectivity. Emotional Maturity, Tolerance. Stability				
Personality-Poise, Tact, Adaptability, Culture, Ability to Cooperate; Accept Guidance and Ability to Get Along with Others				
intelligence-Alert in Grasping Ideas, Education				
Character-Integrity, Loyalty, Sincerity. Reliability				
Leadership Ability				
Professional Interest-Promise and Capacity for Development				

Would you be willing to re-hire this applicant?________________________________
Did applicant give proper notice when terminating employment?____________________

Signature____________________________________ **Date** ____________________________

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Chief Financial Officer
Matthew H. Balley, *Esq*

I, ______________________________ give *my* consent to release information pertinent to my employment to P-B Health Home Care Agency, Inc. Social Security Number is ----------------.

Signature of Applicant ______________________________ **Date** ______________

Reference Requested From:
Company: ____

Address: ____

____

Attention of: ____
Phone Number: ____
The period of employment was from ______________ to ______________ (Employment Dates)

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Quality of Work				
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Technical Skills/Knowledge-Performance of Skills				
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Health-Emotional. Adjustment Objectivity Emotional Maturity. Tolerance Stability				
Personality-Poise, Tact, Adaptability, Culture, Ability to Cooperate, Accept Guidance and Ability to Get Along with Others				
intelligence-Alert in Grasping Ideas Education				
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Would you be willing to re-hire this applicant? ______________________________
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Matthew H. Balley, £sq.

NAME: ____

PHONE NUMBERS:

PRIMARY:___________________________

PAGER: __________________________

CELLULAR:___________________________

DAYS AVAILABLE:

MONDAY___ _ TUESDAY___ WEDNESDAY ___ _

THURSDAY ___ FRIDAY ___ _ SATURDAY___ SUNDAY___ _

WHAT AREAS WILL YOU DO VISITS?

____

____

Authorization For Release of Personal Record Information

Date:__________

PLEASE PRINT CLEARLY

Name: First________________Middle:_____________Last:_______________

Social Security Number:_________________________

I hereby authorize and request any present or former employer, school, police department, and financial institution, *division* of motor vehicles or other persons or agencies having knowledge about me to furnish First Advantage with any and all information in their possession regarding me, in connection with an *application* for employment. I am willing that a photocopy of this authorization be accepted with the same authority as the original. According to the Fair Credit Reporting Act, *I* am entitled to know if employment was denied based on information obtained by *my* prospective employer, and to receive, upon written request, a disclosure of the public record information and the nature and scope of the investigating report. A request for disclosure should be made to First Advantage, 480 Quadrangle Drive, Suite A, Bollingbrook, IL, 60440. Tel: 1-844-244-4756. *I* hereby acknowledge that I have read the above statement and fully understood it.

Signature___________________________Date_______________

Phone Number:__________________________

Date of Birth MM/DD/YYYY (for identification):____________________

Are you currently employed? □ Yes □ No

Can your present employer be contacted for reference-checking purposes? □ Yes □ No

Other names used:

Dates used from: to:____

Dates used from: to:____

Current full address (Number, Street, City, State, Zip):

____

Former Address (In the past seven years) use a separate page if needed:

____

____

Driver License Number:______________________________State:.________________

Name of the highest school attended:.____________________________________

Address ____

P-B HEALTH HOME CARE AGENCY, INC.
NURSE PERFORMANCE CHECKLIST

Name ____________________ Date ________

RESPONSIBILITY, SKILL OR PROCEDURE	I HAVE NEVER DONE	I FEEL COMPETENT PERFORMING	DEMONSTRATED PERFORMANCE (INITIAL & DATE)	COMMENTS
HANDWASHING				
BODY MECHANICS				
VITAL SIGNS				
BAG TECHNIQUE				
CPR (CERTIFICATION)				
EMERGENCY USE OF ADRENALIN				
ASSESSMENT OF: CARDIOPULMONARY SYSTEM				
RESPIRATORY SYSTEM				
GASTROINTESTINAL SYSTEM				
GENITOURINARY SYSTEM				
HEAD AND NECK				
NEUROLOGICAL SYSTEM				
MENTAL STATUS				
INTEGUMENTARY SYSTEM				
MUSCULOSKELETAL SYSTEM				
CARE OF PATIENT REQUIRING IV THERAPY IV CERTIFICATION				
INSERTING IV CATHETER				
INSERTING BUTTERFLY				
INSERTING HEPARIN LOCK				
MAINTAINING HEPARIN LOCK				
CHANGING IV FLUIDS				
CALCULATING FLOW RATE				
ADDING MEDICATION TO IV FLUIDS				
ADMINISTERING IV DROP MEDICATIONS				
OPERATING IV CONTROLLER				
OPERATING IV PUMP				
ADMINISTERING IV PUSH				
ADMINISTERING IV HEPARIN				

RESPONSIBILITY, SKILL OR PROCEDURE	I HAVE NEVER DONE	I FEEL COMPETENT PERFORMING	DEMONSTRATED PERFORMANCE (INITIAL & DATE)	COMMENTS
CARING FOR IV SITE				
CHANGING IV TUBING				
ADMINISTERING IV NARCOTICS				
HYPERALIMENTATION				
CARING FOR PATIENTS WITH CENTRAL VENOUS CATHETER				
CARING FOR PATIENTS WITH HICKMAN/BROVIAC CATHETER				
CARING FOR PATIENTS WITH GROSHONG CATHETER				
CARING FOR IMPLANTED ACCESS PORTS				
CARING FOR IMPLANTED INFUSION PUMPS				
CARING FOR AMBULATORY INFUSION PUMPS				
CARING FOR PATIENTS RECEIVING ANTINEOPLASTIC DRUGS				
PAIN MANAGEMENT				
CARING FOR THE DYING PATIENT				
CARING FOR THE PATIENT WITH AIDS				
USE OF DOPPLER				
PATIENT WITH PACEMAKER				
ASSESSMENT AND INTERVENTION FOR ANAPHYLATIC SHOCK				
INSERTING ORAL AIRWAY				
USING AMBUBAG				
INSERTION OF NG TUBE				
NG LAVAGE				
NG GAVAGE				
INSERTION OF GASTROSTOMY TUBE				
CARE OF GASTROSTOMY TUBE				
GASTROSTOMY FEEDINGS				
ORAL HYGIENE				
GENERAL POSTOPERATIVE CARE				
HEMOVACS				
DRAINS				
REMOVING SUTURES				
CLEANSING WOUNDS				
STERILE GLOVING				
DRY STERILE DRESSINGS				
WET TO DRY DRESSINGS				
MAINTAINING MOIST DRESSINGS				

RESPONSIBILITY, SKILL OR PROCEDURE	I HAVE NEVER DONE	I FEEL COMPETENT PERFORMING	DEMONSTRATED PERFORMANCE (INITIAL & DATE)	COMMENTS
DUODERM				
STOMAHESIVE				
OCCLUSIVE DRESSINGS				
ANTIMICROBIALS				
MOISTURIZERS				
POUCHING WOUNDS				
WOUND IRRIGATIONS				
CARING FOR PATIENTS WITH BURNS				
CARING FOR PATIENTS WITH OSTOMIES: COLOSTOMY CARE				
COLOSTOMY IRRIGATION				
ILEOSTOMY CARE				
ILEAL CONDUIT CARE				
TRACHEOTOMY CARE				
REINSERTION OF TRACHEOTOMY TUBES				
SUCTIONING: OPERATING SUCTION MACHINE				
NASO-ORAL SUCTIONING				
TRACH SUCTIONING				
PROVIDING PERCUSSION AND POSTURAL DRAINAGE				
PROVIDING NEBULIZER				
CARING FOR PATIENTS ON VENTILATOR				

HOME HEALTH AIDE SKILLS CHECKLIST
(Self-Appraisal of Learning Needs)

HHA Name:__________________________________ Date:____________________

The following information will help the home health aide (HHA) instructor to better provide for individual learning and special classes and evaluate the orientation program.

ATTENTION: This will be a 2 day process and will include skills checklist. Orientation will continue throughout probationary period.

				Supervised		Comments
Please check appropriate response	Can safely perform w/out supervision	Need demonstration and/or practice	Need basic instruction	Demonstrated and/or practiced	Instructed	Competency demonstrated y N
BASIC HHA SKILLS						
Hand washing technique						
Apply Infection control theory to: equipment bag						
Equipment						
Personal clothing						
Personal Health						
Bed Bath						
Sponge Bath						
Tub bath						
Tub bath with tub bench						
Shower						
Shower with bench						
Back rub						
Identify pressure points						
Bed positioning: Side lying						
Prone {back lying)						
Supine(front laying)						
Use of trochanter rolls						
Use of foot board						
Use of draw sheet						
Mouth core: Brush teeth						
Brush dentures						
Mouth care for unconscious patient						
Haircare: Comb/brush						

HOME HEALTH AIDE SKILLS CHECKLIST
(Self-Appraisal of Learning Needs)

Please check appropriate response	Can safely perform w/out supervision	Need demonstration and/or practice	Need basic Instruction	Demonstrated and/or practiced	Instructed	Competency demonstrated y N
Shampoo/set						
Use of shampoo tray						
Shaving: With electric razor						
With safety razor						
Nail care: Clean, file fingernails						
Soak, file toenails						
Assist with clothing: Bedfast patient						
Wheelchair patient						
Bed making: Unoccupied						
occupied						
Use of bedpan: Regular						
fracture						
Use of a urinal: Male						
Use and care of portable commode						
Routine catheter care: Foley catheter						
Care/changing of overnight drainage						
Perinea! Care						
Vital signs: Weight						
Oral temperature						
Rectal temperature						
Axillary temperature						
Pulse						
Respirations						
Use of body mechanics						
Use of transfer belt						
Range-of-motion exercise						
"Stand-by" ambulation						
Assisting with canes						
Assisting with walkers						
Assisting with crutches						
Transfers: To/from bath bench						
To/from wheelchair						
Wheelchair to bed						
Wheelchair to toilet						
Wheelchair to tub/shower						

HOME HEALTH AIDE SKILLS CHECKLIST
(Self-Appraisal of Learning Needs)

Please check appropriate response	Can safely perform w/out supervision	Need demonstration and/or practice	Need basic instruction	Demonstrated and/or practiced	Instructed	Competency demonstrated y N
Basic nutrition/simple meal preparation						
Offering fluids to patients						
Care of patient's environment: Clean bathtub						
Clean shower						
Clean sink						
Clean toilet						
Clean eating area						
Wash dishes						
Do laundry						
CPR {cardiopulmonary resuscitation)						
Charting/observing skills						
Basic communication ski/ls: Active listening						
Nonverbal communication						
Interdisciplinary team communication						
ADVANCED HHA SKILLS						
Catheter care: Condom catheter						
Care/changing of leg bag						
Measuring Intake/output						
Simple dressing changes (clean technique)						
Colostomy care: Change bag						
Skin care						
Basicdecubitusulcercare: positioning to relieve pressure areas						
Wash with soap/water						
Air dry skin/ulcer						
Use/care of Hoyer lift						

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Chief Executive Officer
Jackie D. Bailey, RN

Chief Financial Officer
Matthew H. Bailey, Esq.

Employee Physical Examination Form

To be completed by a licensed physician.

Employee name:______________________________________

Is the employee in adequate physical condition to perform the duties of the job description? If answered no please elaborate. Yes___ No___

____

____

Does the employee *have* any current or future weight lifting restrictions: Yes___ NO __
If answered yes please elaborate.

____

____

Tuberculin Vaccine

Date given:_______________ Date Read:____________

Results:____________mm _______Negative --- Positive

Chest X-ray:

Date of Chest X-ray:__________________

-- No evidence of active tuberculosis

__ Chest x-ray abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed *above.* The individual should be referred to a physician or health department for further evaluation.

Certification:

This is to certify that I have examined_________________________________
And I feel he/she is in adequate health to perform home health duties without any physical limitation. I attest that the information provided on this form is true.

______________________ ______________________
Physician Name Practice Address

______________________ ______________________
Physician Signature Date

I understand that this examination is only a brief screening where only limited areas are checked to determine if I am physically able to perform the duties of my position and this Is not to be considered as a diagnostic physical examination.