ROYALE CARE, INC.

AN EQUAL OPPORTUNITY EMPLOYER: ***(Royale Care, Inc.)***
We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital, or veteran status, sexual orientation, or other legally protected status.

APPLICATION FOR EMPLOYMENT

Position Applying for: ☐SW ☐RN ☐HHA ☐OFFICE STAFF
Type of Employment: ☐FULL-TIME ☐PART-TIME ☐TEMPORARY ☐ON-CALL
Time of Availability: ☐MORNINGS ☐NIGHTS ☐WEEKENDS
Hours of Availability: _____

Basic Information

Name *(Last, First Middle Initial)*: _____
Date of Birth: _____ Social Security Number: _____-_____-_____
Address: _____
City/State: _____ Zip Code: _____
Home Telephone: _____ Mobile: _____ Other: _____
Desired Start Date of Employment: _____ Are you willing to travel? ☐Yes ☐No
Are you authorized to work in the United States on an unrestricted basis? ☐Yes ☐No

Personal Information

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married

In Case of an Emergency, Please Notify:

Name: _____ Relationship: _____
Home Telephone: _____ Alternative: _____

Educational History

Type of Degree Earned: ☐High School Diploma ☐G.E.D. ☐College ☐Grad. School
Additional Training: _____ Diploma/Degree? ☐Yes ☐No
Nursing School *(if applicable)*: _____
City/State: _____ Zip Code: _____
Dates Attended: _____ To: _____

I hereby certify that all information provided above is true and correct to the best of my knowledge. By signing below I authorize Royale Care Home Health to investigate and verify the information.

Signature of Applicant: _____ Date: _____

For Office Use Only

Person Conducting Interview: _____ **Date:** _____
Title: _____
Comments:
_____
_____

Employment History

Company/Client's Name: ____
Job Title: ___________________________ Supervisor: ___________________________
Address: ____
City/State: _______________________________________ Zip Code: _____________
Start Date: ___________________________ End Date: ___________________________
Starting Pay: _____________ Ending Pay: _____________
Duties Performed: ____
____
Reason for Leaving:____
Comments: ____
____

Company/Client's Name: ____
Job Title: ___________________________ Supervisor: ___________________________
Address: ____
City/State: _______________________________________ Zip Code: _____________
Start Date: ___________________________ End Date: ___________________________
Starting Pay: _____________ Ending Pay: _____________
Duties Performed: ____
____
Reason for Leaving:____
Comments: ____
____

Company/Client's Name: ____
Job Title: ___________________________ Supervisor: ___________________________
Address: ____
City/State: _______________________________________ Zip Code: _____________
Start Date: ___________________________ End Date: ___________________________
Starting Pay: _____________ Ending Pay: _____________
Duties Performed: ____
____
Reason for Leaving:____
Comments: ____
____

License Verification Form

Employee Name: _____ Discipline: _____

Social Security #: _____-_____-_____

State of Massachusetts

License #: _____ Status: _____

For Office Use Only

Verified By: ☐ Automated System ☐ Verbal Contact *(If verbal, complete the following. If not, skip.)*

Spoke With: _____ Title: _____

Verified By: _____ Date: _____

Title: _____

Comments: _____

_____

APPLICANT'S STATEMENT

I understand and agree that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service if I have been employed. Furthermore, I understand that this is an "At Will employment" and just as I am free to resign at any time, the employer reserves the right to terminate my employment at any time, with or without cause, and without prior notice. I understand that no representative of the employer has the authority to make assurances to the contrary.

I give the employer the right to investigate all references and to secure additional information about me, if job-related. I hereby release from liability the employer and its representatives for seeking such information, and all other persons, corporations, or organizations for furnishing such information.

_____ _____

Signature of the Applicant Date

Interviewer's Comments:

Signature of the Interviewer: _____

Reference Form

The undersigned, having applied for a position with our company, hereby authorizes you to release any information necessary relating to employment. This hereby releases your organization unconditionally from all liability for damage whatsoever that might result from furnishing this information.

Section I: *(To be completed by Applicant)*

Name:_____ Company's Name: _____

Position:_____ Supervisor's Name:_____

Telephone: _____ Fax: _____

Dates Employed: From_____ To _____

I acknowledge filing an application with Royale Care Home Health Services and authorize the release of information from my former employer.

Applicant Signature: _____ Date: _____

Section II: *(Supervisor, please confirm information in Section I and complete Section II.)*

Is the Applicant's position title correct? ☐Yes ☐No _____
(if no, please correct information)

Are the dates of employment correct? ☐Yes ☐No _____
(if no, please correct information)

Is this employee eligible for rehire? ☐Yes ☐No or ☐Conditional

_____
(if no/conditional, please explain)

Section II: Evaluation of Performance

Job knowledge/Technical skills:	☐Excellent	☐Good	☐Fair	☐Poor
Quality of work:	☐Excellent	☐Good	☐Fair	☐Poor
Ability to work with others:	☐Excellent	☐Good	☐Fair	☐Poor
Initiative:	☐Excellent	☐Good	☐Fair	☐Poor
Punctuality/Attendance:	☐Excellent	☐Good	☐Fair	☐Poor

Additional Comments: _____

_____

Information Verified by: _____ Title: _____

Reference record completed by *(Authorized Representative)*: _____

Title: _____ Date: _____

Reference Form

The undersigned, having applied for a position with our company, hereby authorizes you to release any information necessary relating to employment. This hereby releases your organization unconditionally from all liability for damage whatsoever that might result from furnishing this information.

Section I: *(To be completed by Applicant)*

Name:_____ Company's Name: _____

Position:_____ Supervisor's Name:_____

Telephone: _____ Fax: _____

Dates Employed: From_____ To _____

I acknowledge filing an application with Royale Care Home Health Services and authorize the release of information from my former employer.

Applicant Signature: _____ Date: _____

Section II: *(Supervisor, please confirm information in Section I and complete Section II.)*

Is the Applicant's position title correct? ☐Yes ☐No _____
(if no, please correct information)

Are the dates of employment correct? ☐Yes ☐No _____
(if no, please correct information)

Is this employee eligible for rehire? ☐Yes ☐No ☐Conditional

_____
(if no or conditional, please explain)

Section II: Evaluation of Performance

Job knowledge/Technical skills:	☐Excellent	☐Good	☐Fair	☐Poor
Quality of work:	☐Excellent	☐Good	☐Fair	☐Poor
Ability to work with others:	☐Excellent	☐Good	☐Fair	☐Poor
Initiative:	☐Excellent	☐Good	☐Fair	☐Poor
Punctuality/Attendance:	☐Excellent	☐Good	☐Fair	☐Poor

Additional Comments: _____

_____

Information Verified by: _____ Title: _____

Reference record completed by *(Authorized Representative)*: _____

Title: _____ Date: _____

CONFIDENTIALITY STATEMENT

Disclosure of confidential information gained through your employment by Royale Care Home Health Services is stated as an act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient's illness, family, financial condition or personal peculiarities is strictly confidential. When a patient's history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Royale Care Home Health Services Representative)

Date: _____

Name (Last Name): _____

EMPLOYEE CONFIDENTIALITY STATEMENT

I, _____, hereby agree and pledge that I will honor and respect the
(Applicant's Name, Please Print)
privacy and confidentiality of the agency, their clients and business associates. I will not divulge any information of any type obtained through my services as an employee of Royale Care Home Health Services. I agree not to discuss nor release any information obtained within the agency regarding any Royale Care Home Health Services clients, their medical record or any client's condition with any individual not directly associated with Royale Care Home Health Services, nor with Royale Care Home Health Services employees who are not directly associated with that client. I also agree that any information that is released regarding the client or client's record will only be done with proper authorization and/or in accordance with established agency policy for the release of the information: this includes, but is not limited to: the client's identity, description, medical condition, or addresses, the agency or their business associates, financial status or condition, or any and all commercial or private transactions of the agency.

My signature on this document indicates that I understand and I am aware of, and agree to abide by the aforementioned policies and that any breach will have significant consequences which may include suspension or termination of employment and/or civil prosecution.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Royale Care Home Health Services Representative)

Date: _____

Name (Last Name): _____

UNIVERSAL PRECAUTIONS

(OSHA BLOODBORNE PATHOGENS, SECTION 1910.1030 OF TITLE 29, CODE OF FEDERAL REGULATIONS)

I, _____, am aware and understand that due to my occupation, I am
(Applicant's Name, Please Print)
at risk for exposure to blood or other potentially infectious materials. Therefore, I have been given proper instruction on OSHA regulation and requirements. I also understand and I am aware of Universal Precautions and know that as a requirement of my job description I will practice Universal Precautions as described in my job description.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Royale Care Home Health Services Representative)

Date: _____

Name (Last Name): _____

IN-SERVICE REQUIREMENT

It is the policy of Royale Care Home Health Services at each licensed employee or independent contractor attends a minimum of four in-service hours per year. This is best accomplished by doing one (1) in-service every three (3) months.

Royale Care Home Health Services offers a variety of in-services throughout the year. You will be notified of scheduled in-services by memo in your paycheck. OSHA, Infection Control, and Tuberculosis are required annually. These courses must be home care focused. Should you attend an in-service elsewhere (i.e. hospital, nursing home, and/or other agencies), we will gladly accept a copy of your attendance record/certificate and will credit you with that in-service requirement.

By signing below, you acknowledge and understand that you must comply with the above requirement to remain in an “Active Status” with Royale Care Home Health Services.

Print Name: _____

Signature: _____

Date: _____

Name (Last Name): _____

DECLINATION OF MANTOUX

I, _____, have submitted or will submit documentation of a PPD test
(Applicant's Name, Please Print)
and results of said test. If an employee has a known history of having had a Positive Tuberculin test the Mantoux method, he/she may decline the Mantoux test. He/she must agree to give the agency documentation of a negative chest X-Ray within the past 12 months.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Royale Care Home Health Services Representative)

Date: _____

Name (Last Name): _____

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. It is strongly suggested that I be vaccinated for HBV. I understand that I may decline the vaccination and I also understand that not being vaccinated; I continue to at risk for acquiring and remain susceptible to HBV, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated with the HBV vaccine, I can receive the vaccination series at no charge to me.

Royale Care Home Health Services has explained to me that I continue to be at risk for HBV until such time that I am immunized.

Print Name: _____

Signature: _____

Date: _____

Discipline: _____

I have received my immunization: ☐Yes ☐No

Date of immunization: _____

City/State: _____

I am declining my immunization: ☐Yes ☐No

Reason for Declination: _____

_____

Authorized Signature: _____ Title: _____

(Royale Care Home Health Services Representative)

Date: _____

Name (Last Name): _____

PERMISSION FOR PPD TEST

I, _____, voluntarily take the PPD test intradermally as a screening
(Applicant's Name, Please Print)
method for tuberculosis. I understand that a PPD test must be administered and read annually. A chest X-Ray must be done every five years as a pre-requisite for employment at Royale Care Home Health Services.

I release Royale Care Home Health Services of any liability. I confirm that I have/have not had a PPD test within the last year; an I have no known allergy to the PPD test.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
(Royale Care Home Health Services Representative)

Date: _____