Application for Employment

KLA Medical Services

5820 Veterans Pkwy Suite 208

Columbus, GA 31904

(706)-320-0230

Please Date: _____

Name: _____ **S.S.#:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

How long have you lived at this address? _____

Are you 18 years or older? _____ **Position desired:** _____

Are you presently able to perform all the duties of the position?

_____

_____

If no, please explain:

_____

_____

Please Select the position and hours you are seeking:

Full Time ☐ **Part Time** ☐

Daytime hours ☐ Evening hours ☐ **Weekday Hours** ☐ Weekend Hours ☐

Have you ever been convicted, plead no contest, or been shown by credible evidence to have committed a criminal offense, including but not limited to crimes of dishonesty, breach of trust, robbery, embezzlement, forgery, abuse, neglect, sexual assault, exploitatiohn, or deprivation of any person to serious injury as a result of intentional or grossly negligent misconduct?

Education History

High School: _____ Location: _____

Highest grade completed: _____ Attended from: _____ to _____

College or University: _____ Location: _____

Degree or Diploma received: _____

Vocational School: Location: _____

Certification Received: _____

Emergency contact name and number: _____

Date of Birth: _____

Date of Hire (to be completed by employer): _____

Employment History

(List at least your last 5 years of work experience, if you have worked less than 5 years list all previous employers)

Employer:_____ Phone:

Address:_____

State:_____ City:_____

Position:_____ Zip: _____

Supervisor's Title:_____ Supervisor:_____

Employed from: _____ to ____ Duties:_____

Ending Salary:_____

Reason for leaving:_____

May we contact?_____

Employer:_____

Address:_____ Phone:_____

State: _____ City:_____

Position: _____ Zip: _____

Supervisors Title:_____ Supervisor:_____

Employed from: _____ to _____ Duties: _____

Ending Salary:_____

Reason for leaving:_____

May we contact?_____

Employer:_____ Phone:_____

Address:_____ City:_____

State: _____ Zip: _____

Position: _____ Supervisor:_____

Supervisors Title:_____ Duties: _____

Employed from: _____ to _____

Ending Salary:_____

Reason for leaving:_____

May we contact?_____

Personnel References

Name: _____ Address: _____

Phone #:_____ How long have you known this person?_____

Name:_____ Address:_____

Phone#:_____ How long have you known this person?_____

Please indicate training or relevant experience that you have:

☐ First Aid Course Date:_____

☐ CPR Certified Date:_____

☐ Home Health Aide Training __ __ __ Date:_____

☐ Non-Paid experience for a person with illness or disability Date:_____

☐ Certified Nursing Assistant Date:_____

☐ Personal Care Assistant Date:_____

Please list any other relevant training or certifications:

Home Health Aide & Personnel Support Aide Checklist

	Have performed for client	I have received training	I have work experience	I need training
Ambulation Transfer	☐	☐	☐	☐
Positioning	☐	☐	☐	☐
Bed Bath Grooming	☐	☐	☐	☐
Dental Care	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Skin Care	☐	☐	☐	☐
Shaving	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Caring for Quadriplegic	☐	☐	☐	☐
Caring for Hemiplegics	☐	☐	☐	☐

	Have Preformed	Received Training	Have Work Experience	Need Training
Feeding Disabled	☐	☐	☐	☐
Vital Signs	☐	☐	☐	☐
Infection control	☐	☐	☐	☐
Home Management	☐	☐	☐	☐
Home Safety	☐	☐	☐	☐
Home Sanitation	☐	☐	☐	☐
Proper nutrition	☐	☐	☐	☐
Foot Care	☐	☐	☐	☐
Care of the elderly Care of convalescing	☐	☐	☐	☐
Meal prep. Meal serving	☐	☐	☐	☐
Transport service	☐	☐	☐	☐
Accompanying errands	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐
Med. Emergencies	☐	☐	☐	☐
Transferring w/Hoyer lift	☐	☐	☐	☐
Pt. w/ catheter	☐	☐	☐	☐
Pt w/ feeding tube	☐	☐	☐	☐
Medication Assistance	☐	☐	☐	☐
Suctioning	☐	☐	☐	☐
Pt. on ventilator	☐	☐	☐	☐
Use of adaptive equipment	☐	☐	☐	☐
Operation of wheelchair	☐	☐	☐	☐
Pt. with a wound	☐	☐	☐	☐
Range of motion	☐	☐	☐	☐
Condom Catheter	☐	☐	☐	☐
Assist therpeutic Exercise	☐	☐	☐	☐
Working with Mentally Challenged	☐	☐	☐	☐

If we consider you for employment do we have your permission in obtaining a motor vehicle report (MVR) and criminal history check?

Yes ☐ ***No*** ☐

Signature

Date

KLA Medical Services, Inc.

Employee Agreement

- I hereby understand that by signing this form, I am available for temporary work assignments with this agency. I will be notified of these assignments as they become available
- I understand that I will receive instructions for each assignment and that any client may refuse my services without notice.
- It is further understood that taxes are taken out of my check and that this agency shall provide a W-2 tax form at the beginning of the year.
- By signing this form, I do hereby agree that the following conditions are grounds for being moved to inactive status
- My signature at the bottom of this form indicates a full understanding of KLA Medical Services, Inc. guidelines and procedures and states that I am willing to accept and implement these.

<u>Ground for removal to inactive status:</u>

1. Sleeping on the work site
2. No show/ No call! You must notify this office 24 hours in advance for any excused absence. (doctors excuse is required)

<u>DO NOT CALL THE CLIENT. YOU MUST CONTACT THE OFFICE (706)-320-0230</u>

3. Excessive call-outs/tardiness
4. Unprofessional conduct
5. Alcohol/ Drug abuse during assignment. All applicants are subject to initial and random drug testing.
6. Theft by taking
7. Falsification of records (Including notes and time) and incomplete records
8. Failure to maintain current licensure or credentials.
9. Failure to adhere to the client Bill of Rights
10. Abuse or misuse of the property of KLA Medical Services, Inc. or any client.

Employee Signature:_____ Date:_____

KLA Medical Services, Inc.

Dress Code

1. Scrubs shall be worn at all times when on assignment. Which includes name tags. Shorts are not permitted. Capri's are acceptable.
2. Clean shoes with rubber soles shall be worn. May wear tennis shoes.
3. Long hair must be secure and pulled back.
4. No heavy or excessive perfume or makeup is permitted.
5. No excessive jewelry to be worn.
6. Contractor must maintain proper grooming and personal hygiene at all times.
7. Nails must be kept clean and short without excessive polish or decorations.

Conduct

1. Contractor shall never accept or solicit money or gifts from any client.
2. No personal business or personal phone calls are permitted while on duty. Family and friends are not permitted at work site. No talking on cell phones while in the client's home. Please put your phone on vibrate or leave in car until assignment is complete.
3. Smoking is prohibited at client's home.
4. In case of emergency notify the office immediately!!
5. If required, Employee must stay with client until relief arrives. Never leave the client alone under any circumstances. Unless otherwise noted.
6. A termination notice must be received (7) days prior to leaving any assignments. Failure to do so will constitute any monies due to be held for (2) weeks.
7. Notes and time cards are to be turned into this office no later than 4:00pm each Monday of every week. Failure to do so will cause a delay in payment until the following pay period. NO EXCEPTIONS!
8. Employee must attend all mandatory in services.
9. The client must sign all time cards in designated place.
10. Any breech of agency or client confidentiality will result in immediate termination.

Employee Signature:_____ Date:_____

KLA Medical Services, Inc.

Confidentiality Statement

I understand the responsibilities concerning confidentiality information are as follows:

1. Agency personnel will not engage in unauthorized discussion or release of information concerning client, agency personnel and agency business.
2. Only personnel involved in the care/ service or supervision of care/ service on specific clients will have access to client information.
3. Clients are not to be discussed by clinical or non-clinical agency personnel outside of the clinical setting.
4. The client's chart is not to be released to any other individual(s) without written release of information signed by the client/ representative.
5. Client information whether in the billing, clinical record or computer will be protected.
6. Client-identifying information from reports, memos, and data collection forms shall be removed.
7. Agency personnel will limit client information discussed on cellular phones to cases of emergencies where urgent exchange of information is necessary.
8. All written/ printed client information will be disposed of by tearing or shredding prior to disposal in a trash receptacle.
9. Agency personnel will not engage in any discussion concerning agency personnel or agency business that is confidential and/or may be detrimental to the public image of the agency.
10. Breach of the confidentiality policy may result in disciplinary action up to and including termination.

Employee/CAN/PCA signature:_____ Date:_____

Supervisor signature:_____ Date:_____

KLA Medical Services, Inc.

Abuse/Neglect Statement

I _____, have never been shown by credible evidence (e.g. a court or jury, a department investigation, or other reliable evidence) to have abused, neglected, sexually assaulted, exploited, or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidence by an oral or written statement to this effect obtained at the time of application.

CNA/PCA Signature:_____ Date:_____

KLA Medical Services, Inc.

Section: Human Resources- Job Description

Title: Home Care Aide

Reports to: Assistant Administrator

Job Qualifications:

1. High school diploma and CNA preferred.
2. Able to read and write and carry our directions in the English language.
3. Able to pass a written competency test which will include but not limited to the following areas:
   A. Methods of assisting to achieve maximum self-reliance
   B. Principles of nutrition
   C. Meal preparations
   D. Principles of the aging process
   E. Emotional problems of illness
   F. Procedures for maintaining a clean, healthful, and pleasant environment
   G. Recognizing changes in the client's condition that should be reported
   H. Work of the agency and the health care team
   I. Ethics and confidentiality
   J. Record keeping according to the policies of the agency
4. Demonstrate maturity and a sympathetic attitude toward the care of the sick
5. Possesses current driver's license
6. Satisfactory background and driver's license check
7. Current CPR card.

Working Conditions

Will work in client's residence in varying conditions. May have exposure to blood fluids and infectious diseases. Will drive extensively and be subjected to the weather. Must be able to lift up to 50lbs including moving client's.

Duties

1. Taking client's vital signs
2. Assist client with bed bath/shower according to the care plan
3. Assist client's with:
   A. Personal hygiene
   B. Self-administration of medications
   C. Dressing and other ADL's as needed
   D. Toileting as needed
   E. Nutrition
4. Utilizes equipment such as Hoyer lift, wheelchair, bait belt, walker, cane, crutches
5. Observes clients for changes in conditions and reports noted changed to supervisor
6. Utilizes safe body mechanics
7. Follows agency policies and procedures relative to infection control
8. Follows agency guidelines for all paperwork including submitted required documentation in a timely manner
9. Attends agency meetings and in-service programs
10. Performs other duties as assigned

I have read the above job description/requirements and duties as listed. I understand the job requirements and agree to accept and carryout these responsibilities and other duties assigned.

Employee's Signature:_____ Date:_____

Supervisor's Signature: _____ Date:_____

KLA Medical Services, Inc.

Consent for Drug Screening Test

I _____, have applied for employment, I consent to random drug testing. I also understand that at any time during my employment, I consent to random drug testing. I also understand that if I test positive, I will be terminated at that time. Furthermore, if I am on any prescription medication that may result in a positive drug test, I will provide KLA Medical Services, Inc. with proof of this prescribed medication.

I hereby authorize any facility that KLA Medical Services, Inc. recommended to perform this said screening, and to release the results to KLA Medical Services, Inc. for further evaluation. I release any facility or person(s) conducting the screening from any liability pertaining to this procedure.

Applicants Name:_____

Applicants Signature:_____ Date:_____

KLA Medical Services, Inc.

Hepatitis B Vaccine Immunization Informed Consent

I understand that there is no guarantee that the vaccination will be effective or that the vaccine will be free from all side effects. I understand that Hepatitis B Vaccine does not provide immunity for other forms of Hepatitis. I further understand that I should seek the advice of my physician before taking the vaccine if I have had a fever in the past 48 hours, if I am pregnant, nursing a baby, or if I am allergic to yeast.

Employee/CNA/PCA Signature:_____ Date:_____

(I have received the Hepatitis B Vaccination series)

An employee/CNA/PCA who chooses not to accept the vaccine must sign the following statement of declination of Hepatitis B Vaccinations. The statement can only be signed by the employee/CNA/PCA following appropriate training regarding Hepatitis B, Hepatitis B vaccination, the efficacy, safety, method of administration and benefits of vaccination.

I understand that due to my occupational exposure to blood, or other potentially infectious materials, I may be at risk of contracting the Hepatitis B Virus (HBV). I have been given the opportunity to be vaccinated for Hepatitis at this time. I understand that by declining this vaccine I continue to be at risk of contracting Hepatitis B, a serious disease. I understand that I can request and receive the Hepatitis B Vaccination at a later date.

Employee/CNA/PCA Signature:_____ Date:_____

KLA Representative:_____ Date:_____

KLA Medical Services, Inc.

July 5, 2017

I _____, will notify the office immediately if I come into contact with Tuberculosis or Hepatitis.

Employee/CNA/PCA Signature:_____ Date:_____

KLA Medical Representative:_____ Date:_____