

Assured & Associates

Personal Care of Georgia

8687 Hospital Drive, Suite 103 Douglasville, GA 30134 • Phone: 678-391-0140; Fax: 877-797-3730

Employment Application for C.N.A

Last Name	First	Middle	Maiden
Present Address (Number and Street)			Apt. # (if applicable)
City		State	Zip Code
How long at this address?	Email Address	Driver's License Number	
Home Phone	Cell Phone	Fax #	
Previous Address (Number & Street)		City	State Zip Code
How long at this address?		Are you 18 years or older?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Position Applied for	Salary Desired (be specific)	Foreign Language(s) spoken	
<input type="checkbox"/> C.N.A <input type="checkbox"/> Other _____			

Are you a citizen of the United States? Yes No
 If no, do you have the legal right to work in the US?..... Yes No
 Have you ever been employed by Assured & Associates?..... Yes No
 Do you have any family member(s) currently working for Assured & Associates? Yes No

Days/hours available to work:

Any time _____ Monday _____ Tuesday _____ Wednesday _____
 Thursday _____ Friday _____ Saturday _____ Sunday _____

How many hours can you work weekly? _____ Shift preference: Day Night

EMERGENCY CONTACT INFORMATION			
Name	Relationship	Phone #	Second Phone #

Applicant - Do Not Write below this line – For Office Use Only

FOR OFFICE USE ONLY
Date of Hire:

Employment desired: PRN (as needed) Part-time Full-time

EDUCATION

Type of School	Name of School	School Address	Number of Years Completed	Major & Degree
High School				
College				
Business or Trade School				

5 Years Work History (required)

Name of Business	Address	Position	Supervisor's Name	Reason for Leaving
Length of Employment		Salary	Telephone No	
Begin:	End:			

Name of Business	Address	Position	Supervisor's Name	Reason for Leaving
Length of Employment		Salary	Telephone No	
Begin:	End:			

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Length of Employment		Salary	Telephone No	
Begin:	End:			

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Length of Employment		Salary	Telephone No	
Begin:	End:			

Name of Business	Address	Position	Supervisor's Name	Reason for Leaving
Length of Employment		Salary	Telephone No	
Begin:	End:			

I certify that information contained in this application is true and complete. I understand that false information may be grounds for not hiring me or for immediate termination of employment at any point in the future if I am hired. I authorize the verification of any or all information listed above.

Applicant Signature _____

Date _____

An application form sometimes makes it difficult for an individual to adequately summarize a complete background. Use the space below to summarize any additional information necessary to describe your full qualifications for the specific position for which you are applying.

List two references other than relative or previous employers

Name		
Address)		
Home Phone	Cell Phone	

Name		
Address)		
Home Phone	Cell Phone	

Job Description for C.N.A

The C.N.A is responsible for the operation of the private home care provider providing private home care services to patients and their families.

Duties Include:

- Reading and recording temperature; oral, axillary or rectal pulse, respiration, weight & blood pressure.
- Activity: ambulation, Assist – wheel chair/ walker/cane/mobility assist/ROM-active/passive
- Positioning – encourage/assist to turn every 2 hours
- Maintaining a clean, safe and healthy environment
- Bed, sponge, tub, shower bathing partial/complete, assist bath – chair and facial care
- Shampooing in sink, tub/shower/brush/other
- Nail care as needed (cleaning and filing) – **No Nail Clipping**
- Shave as needed
- Mouth care daily
- Assisting with toileting and eliminations
- Assist with medications
- Food preparation daily, feeding daily, limits/encourage fluids
- Light housekeeping as needed: bedroom/bathroom/kitchen/change bed, dusting, sweeping, mopping
- Clean range, clean countertops/table
- Laundry: wash clothes and iron as needed, change linen as needed
- Correspondence as needed, bills as needed
- Transportation as needed
- Errand as needed
- Assess food and other supplies
- Grocery shopping
- Equipment care
- Provides personal care services per client service plan, state/federal rules, regulation, and/or standards.
- Observes, reports and documents changes and any observed problems in client's status. Understands basic elements of body functioning and reports changes in client's body functions.
- Recognizes emergency situations and implements appropriate emergency procedures per agency protocol.
- Follows agency procedures with regard to infection control, handling of hazardous wastes, and safety measures.
- Attends a requirement of position and agency policies, as required by Assured & Associates Personal Care of Georgia.
- Inform Assured & Associates Personal Care of Georgia of known exposure to tuberculosis hepatitis or any other communicable diseases.
- **Patient Status Change** - It is the responsibility of each employee to promptly notify Assured & Associates Personal Care of Georgia, Inc. of any change in client's status. Employee is required to notify Agency immediately any time your client requires a hospital visit or is admitted to the hospital in order to obtain proper authorization for the caregiver to remain with the client. Caregiver is never to leave a patient if taken to the Emergency Room or is not yet admitted to the hospital. Prior to leaving patient at hospital an additional phone call is required to Agency for specific instruction(s).

Failure to abide by the Patient Status Change Policy will result in termination of employment with Assured and Associates.

Applicant's Signature

Date _____

Medical History

Please complete the following questions by ticking the appropriate box. If the answer is “yes,” give details including (i) date, (ii) amount of time lost from work/school, (iii) treatment, as appropriate.

Have you ever suffered from any of the following illness:

	YES	NO	If Yes, please give details
Visual defects/eye conditions (including color-blindness)			
Hearing defects/ear conditions			
Severe anxiety, depression, other psychiatric disorder			
Paralysis or other neurological disorder			
Fainting attacks, blackouts, epilepsy or fits			
Recurrent headaches, migraine			
Vertigo, giddiness or tinnitus			
Heart disease, high blood pressure			
Asthma, bronchitis, tuberculosis or other chest disease			
Peptic ulcer or other digestive or bowel disorder			
Liver disorder			
Kidney or bladder problems			
Gynaecological problems			
Recurrent backache, arthritis, rheumatism			
Any blood disorder			
Eczema, dermatitis, other skin conditions			
Diabetes, thyroid or other gland problems			
Hay fever, allergies to drugs, animals etc.			
Any recurrent infections			
Any impairment of immunity to infection			
Varicose veins causing trouble			
Hernia			
Any alcohol or drug related problem or illness			
Any other medical condition, physical or mental, not mentioned above			

Have you

Ever undergone a surgical operation or been admitted to hospital for any reason?			
Had more than 20 days sickness absence in the past 2 years?			
Ever been, or are a Registered Disabled Person?			
Suffered from an Industrial Disease / Accident?			
Had a chest X-ray in past 12 months – If so, state place/ date/result			

Present Health Status

Are you currently attending a doctor?			
Are you at present on any medication or treatment prescribed by a doctor?			
Are you a smoker? If so, please give details			
Do you drink alcohol? If so, how many units per week? (NB 1 unit is ½ pint of beer or 1 medium glass of wine)			

Medical History continued on back

Medical History continued

	YES	NO	If Yes, please give details
Do you have any eyesight defects other than those corrected by glasses?			
Do you have any hearing problems?			
Do you have any defect of speech or communication problem?			
Do you have any physical disability necessitating special aids, or requirements for access to premises?			
Do you have any other relevant health problems?			
What is your height? _____ ft _____ ins or _____ m (without shoes)			
What is your weight? _____ st _____ lbs. or _____ kgs			

Declaration

1. I declare that, to the best of my knowledge, the information I have given is correct.
2. I understand that I may be required to attend a medical examination
3. I understand that failure to disclose relevant information or giving false information may result in termination of my employment.

Signature _____ Date _____

Assured & Associates

8687 Hospital Drive, Suite 103 • P.O. Box 1312, Douglasville, GA 30133 • Phone (678) 391-0140, Fax (877) 797-3730

AUTHORIZATION RELEASE FORM

I hereby AUTHORIZE and request any law enforcement agency to furnish bearer with criminal history and identify check information in their possession regarding me in connection with my employment in a critical position. I am willing that a photocopy of this authorization be accepted with the same authority as the original. I understand this AUTHORIZATION is to be part of the written employment application which I signed. **By signing this authorization, I also acknowledge there will be a MINIMUM CHARGE OF \$15 that will be deducted from my pay.**

LAST NAME			FIRST			MIDDLE				
DATE OF BIRTH (mm/dd/year)			SOCIAL SECURITY NUMBER			HOME PHONE NUMBER				
OTHER NAMES YOU HAVE USED						BUSINESS OR CELL PHONE				
CURRENT ADDRESS: STREET NUMBER AND NAME										
CITY			STATE			ZIP CODE			HOW LONG	
PREVIOUS ADDRESS: STREET NUMBER AND NAME										
CITY			STATE			ZIP CODE			HOW LONG	
Have you been background checked in the State of Georgia previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please note date (approximate): _____										
Since your 18 th birthday, have you been convicted of a felony or felony-reduced-misdemeanor conviction by any court? (You may omit conviction or a misdemeanor while under age 18, if the record was sealed, minor traffic violations for which the fine imposed was \$400.00 or less, any office that was settled in Juvenile court or was referred to the youth authority.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate date, location and explanation: _____ _____										
Have you ever been convicted of a crime under another name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state name: _____										
DRIVER'S LICENSE NUMBER			STATE OF ISSUE			EXPIRATION DATE				

SEE ADDITIONAL NFORMATION ON BACK

I hereby certify that all statements on this application are true and correct to the best of my knowledge and belief. I understand that Assured & Associates Personal Care of Georgia, Inc. solicits this information so as to be informed of my previous record and character. I understand that my employment with Assured & Associates Personal Care of Georgia, Inc. depends upon successful completion of criminal background investigation. If employed, I understand that any falsification, misrepresentation or omission of facts of this record may be considered as cause for release or dismissal.

I hereby authorize Assured and Associates, U.S. Info Search, and their designated agents and representatives to conduct a review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes and for future preparation of a consumer report or investigative consumer report for purposes of retention, promotion or reassignment unless revoked in writing. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: Verification of social security number; current and previous residences; employment history including all personnel files; education including transcripts; character references; credit history and reports; criminal history records from any criminal justice agency in any or all federal, state, country jurisdictions; birth records; motor vehicle records to include traffic citations and registration; workers compensation for employment; and any other public records or to conduct interviews with third parties relative to my character, general reputation, personal characteristics or mode of living. I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to U.S. Info Search or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. I hereby release U.S. Info Search the Social Security Administration, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from liability to the extent permitted by law for damages of whatever kind, which may, at any time, result to me, my heirs family, or associates because of compliance with this authorization and request to release. If an investigative consumer report is conducted I understand that I have the right to request additional information about the nature of the report and a copy of the report by calling U.S. Info Search.

NOTICE TO CALIFORNIA, MINNESOTA AND OKLAHOMA APPLICANTS

Under California, Minnesota, and Oklahoma law, the consumer reports we order on you is defined as investigative consumer reports. These reports may contain information on your character, general reputation, personal characteristics and mode of living. Under California, Minnesota, and Oklahoma Civil Code, you may view the file maintained on you by U.S. Info Search. during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at U.S. Info Search in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification. I want to receive a free copy of any investigative consumer report requested on me by signing my initials on the following line:

Initials _____

Print Name: _____

Applicant's Signature: _____

Date _____

Affidavit of Non-Abuse

I _____ hereby swear that 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 evidenced by an oral or written statement to this effect obtained at the time of application.

Furthermore, I understand that if these statements are found to be untrue, my employment with Assured & Associates will be immediately terminated.

Applicant's Signature

Date _____

Case Confidentiality & Security Contractual Agreement

I, _____, The employee, agree that during or after a 2 year term of this employment, the Employee shall not solicit nor be employed by the same Clients introduced to them by Assured & Associates. By soliciting any of its clients/accounts or by being employed to our Clients will result in the employee being liable for an amount not less \$15,000.00 payable to Assured & Associates.

I recognize the rights of Assured and Associates, as my employer and agree not to work for any current or former Assured and Associates client directly or through any other person or entity for the time period described in and including all other terms in our written agreement (on file at Assured and Associates) during Assured and Associates service provision and following termination of Assured and Associates, as the service provider.

Employee agrees that during or after the term of this employment, not to reveal confidential information, or trade secrets to any person, firm, corporation, or entity. Should Employee reveal or threaten to reveal this information, the Company may pursue any remedies/steps it has to against the Employee for a breach or threatened breach of this agreement, including the recovery of damages/loss from the Employee's action.

Applicant's Signature

Date _____

Policy & Procedure to Avoid Conflict

1. If asked by family to leave – I must notify the Agency Director, Supervisor or designee.
2. Document accordingly if possible and leave quietly.
3. Notify police if they have not been called by family already – get police report and case #.
4. If time is appropriate, take report and copy of notes to office.
5. If time is not appropriate, bring to office as soon as possible on the next day.

If you are threatened by bodily harm, leave the home and call police immediately.

Applicant's Signature

Date _____

Service Contract

Assured and Associates is offering you the opportunity to work with our client on a PRN or "As Needed Basis".

Should your Client expire, or wish to discontinue your service because of your lack of professionalism, conduct or behavior you may be re-assigned should there be another opening.

If there are no other openings your name may go back on the availability list. I understand that it is my responsibility to contact the staffing coordinators and advise them of my availability from time to time in order to be considered for future assignments.

Applicant's Signature

Date _____

Statement of Understanding

I understand that it is mandatory that I must carry out my assignment by completing all scheduled shifts assigned to me. If I am unable to make a scheduled shift for any reason, I must notify the staffing agent, supervisor or designee as soon as possible or a minimum of four (4) hours prior to the start time of the scheduled shift.

I understand that any falsification of my time sheet is grounds for immediate dismissal by Assured & Associates Personal Care of Florida, LLC.

I have read and understand this statement.

Applicant's Signature

Date _____

Unemployment Benefits/W4

I understand that all employees are required to pay federal taxes. I understand that a portion of my income will be deducted every paycheck to pay this tax. By signing below I acknowledge that all information submitted on the W4 form is correct. I also understand that if I do not fill out a W4 form to allow taxes to be withheld, I cannot seek unemployment benefits from employer if my assigned work should end. I also understand that Assured and Associates will try to place me on another assignment if the current case I am working terminates due to reason beyond my control.

Applicant's Signature

Date _____

Authorization for Drug Test

Pursuant to O.C.G.A. 34-9-14 Title 34. LABOR AND INDUSTRIAL RELATIONS CHAPTER 9. WORKERS' COMPENSATION ARTICLE 11. DRUG-FREE WORKPLACE PROGRAMS, I hereby authorize and request any representative of Assured & Associates (eg: a physician, a physician's assistant, a registered professional nurse, a licensed practical nurse, a nurse practitioner, or a certified paramedic who is present at the scene of an accident for the purpose of rendering emergency medical service or treatment, a person certified or employed by a laboratory certified by the national Institute on Drug Abuse, the College of American Pathologists, or the Georgia Dept. of Community Health), to perform a drug test from specimen(s) which is/are taken from me.

I will accept that this is to be part of the employment application.

I understand the types of testing an employee, job applicant, student attending our training center, or in their employment may be required to submit to, including reasonable suspicion, random or other basis used to determine when such testing will be required, and the actions the employer may take against an employee, job applicant, student attending our training center, or in their employment on the basis of a positive confirmed test result. The employer shall inform an employee, job applicant, student attending our training center, or in their employment in writing of such positive test result, the consequences of such results, and the options available to same. If testing is conducted based on reasonable suspicion, the employer shall promptly detail in writing the circumstances which formed the basis of the determination that reasonable suspicion existed to warrant the testing. A copy of this documentation shall be given to the employee upon request and the original documentation shall be kept confidential by the employer pursuant to Code Section 34-9-420 and retain by the employer for at least one year.

I understand that anyone who receives a positive confirmed test result may contest or explain the result to the employer within five working days after written notification of the positive test result.

I understand if the employee has caused or contributed to an on the job injury which resulted in a loss of worktime, the employee must submit to a substance abuse test.

I understand if the employee, job applicant, student attending our training center, or in their employment refuses to submit to a drug test certain consequences may apply up to and including termination. Refusal to submit to drug testing or yielding a positive result is a clear violation of Company policy.

All information, interviews, reports, statements, memoranda and test results, written or otherwise, received by the employer through a substance abuse testing program are confidential communications, but may be used or received in evidence, obtained in discovery, or disclosed in any civil or administrative proceeding, except as provided in subsection (d) of O.C.G.A. 34-9-420. Subsection (d) notates that nothing contained in this Article 11 shall be construed to prohibit the employer or laboratory conducting a test from having access to employee test information when consulting with legal counsel when the information is relevant to its defense in a civil or administrative manner.

Applicant's Signature

Date _____

Confidentiality Statement

I have been formally instructed in maintaining the confidentiality of the medical information.

I have been advised that except as needed to conduct the business of the medical information may not be discussed with anyone either inside or outside the office.

It is my understanding that such discussion is cause for dismissal.

Applicant's Signature

Date _____

Orientation Acknowledgement

I have been oriented to Assured & Associates Personal Care of Georgia and its Policies and Procedures and all aspects of care pertaining to this Agency.

I have been provided the opportunity to document and validate the skills required for this position.

Inform Assured & Associates Personal Care of Georgia of known exposure to Tuberculosis Hepatitis or any other communicable disease.

Assured & Associates employees involved with direct care or supervision of direct care workers of clients in their homes, are mandated reporters according to state law and shall be familiar with and be able to recognize a situation of possible abuse, neglect emergency or exploitation or likelihood of serious physical harm to persons receiving services. The employee of Assured & Associates needs to contact the office immediately.

Employee Orientation

Please **initial** each line after reading.

Written Policies and Procedures Regarding:

- Scope of Services: _____
- Types of Clients: _____

“Client’s Rights and Responsible” form _____

Complaint Procedure _____

Assigned Duties _____

Job Description / Service Plan _____

Acknowledgement of Procedure for reporting client progress and problems to supervisor _____

Acknowledgement of Procedures for handling emergencies _____

Acknowledgement of the employee’s responsibility to report known exposure to TB and Hepatitis to the employer _____

Acknowledgement that a minimum of twelve (12) hours of annual training will be conducted _____

I certify that there is no credible evidence (i.e., 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 evidenced by an oral or written statement to this effect, obtained at the time of this application.

Applicant’s Signature

Date _____
Application Date

Personal Code of Ethics

All employees and volunteers of Assured & Associates are considered professional and as such, will abide by the following code while performing services for the agency:

Employees and volunteers will:

1. not use the client's car for personal reasons.
2. not consume the client's food or beverage.
3. not use the client's telephone to make personal calls
4. not discuss religious or political beliefs with the client
5. not accept gifts or financial gratuities (tips) from client or client's representative.
6. not discuss personal problems with the client.
7. not loan money or any other item to client or client representative
8. not borrow money or any other item from client or client representative
9. not will not sell gifts, food, or other items to or for client or client representative
10. not purchase any items for the client unless specifically directed in the care plan
11. not bring other visitors (i.e., children, friends, relatives, pets) to client's home
12. not smoke in the client's home
13. not report for duty under the influence of alcoholic beverage or illegal substances
14. not sleep in client's home
15. not remain in the client's home after services have been rendered and completed
16. adhere to the dress code for Assured & Associates
17. not contact client's case manager; insurance adjuster; lawyer; or family member
18. call the office at least 6 hours prior to your shift, when you cannot make it in to work.

By signing below, I agree to follow the code of ethics established for Assured & Associates. I understand that failure to abide by the code of ethics or any other code of ethics not listed above, will result in termination of employment with Assured & Associates.

Applicant's Signature

Date _____

Assured and Associates

CONFIDENTIAL/NON COMPETE AGREEMENT

Employee/Contractor acknowledges that in order to perform the services called for in this Agreement it shall be necessary for Company to disclose to Employee/Contractor certain Trade Secret(s) that have been developed by Company at great expense and that have required considerable effort of skilled professionals. Employee/Contractor further acknowledges that the deliverables will of necessity incorporate such Trade Secrets. Employee/Contractor agrees that he/she shall not disclose, transfer, use, copy, or allow access to any such Trade Secrets to any employees or to any third parties, excepting those who have a need to know such Trade Secrets consistent with the requirements of this Agreement and who have undertaken an obligation of confidentiality and limitation of use. In no event shall Employee/Contractor disclose any such Trade Secrets to any competitors of Company.

As used herein, the term "Trade Secret(s)" shall mean any scientific or technical data, information, design, process, procedure, formula, or improvement that is commercially valuable to the Company and not generally known in the industry. The obligations shall survive this Agreement and continue for so long as the material remains a Trade Secret(s).

Employee/Contractor shall not disclose the nature of the effort undertaken for Company or the terms of this Agreement to any other person or entity, except as may be necessary to fulfill Employee/Contractor's obligations hereunder.

Employee/Contractor shall not at any time use Company's name or any Company trademark(s) or trade name(s) in any advertising, publicity in, consult or be contracted by any similar without the prior written consent of Company.

This agreement shall apply, not only to Assured and Associates, Inc. but the other companies that are owned by Assured and Associates. This includes:

1. Assured and Associates Training Center, Inc.
2. J&N Leasing, Inc.
3. Assured and Associates Personal Care of Florida, Inc.

Employee/Contractor agrees that the Company, for valuable consideration (included as a part of the agreed compensation), Employee/Contractor received and accepted compensation to not compete with company and to protect Company's trade secrets hereafter. Employee/Contractor shall not accept employment of a similar nature to the position held with Assured and Associates, Inc. and related companies at the time of termination with a competing company located within a 25 square mile radius of the company or in the counties of Carroll, Coweta, Heard, Spalding, Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale.

Applicant's Signature

Date _____

Assured and Associates

Personal Care of Georgia

8687 Hospital Drive, Suite 103; Douglasville, GA 30134; Phone: 678-391-0140; Fax: 877-797-3730

Employment Verification

Company Name _____

Phone Number _____ Fax Number _____

Contact Person's Name _____ Title _____

To Whom It May Concern:

I, _____ authorize **Assured and Associates** to check my references regarding past employment. I understand that I have the right to make a request regarding the nature and scope of the report.

Signature _____ Date _____

Former Employer fills information below this line

Assured and Associates would appreciate the following information:

Employed From: _____ To: _____

Salary/hourly rate: _____

Is this person eligible for rehire? Yes No

Explain: _____

Company Name: _____

Address: _____

Signature: _____

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Is this person eligible for rehire? Yes No

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Company Name: _____

Address: _____

Signature: _____