EXCEL HEALTH CARE SERVICES
Drug free workplace and an Equal Opportunity Employer

HUMAN RESOURCES DEPARTMENT
3901 Calverton BLVD, Suite 430
Calverton, MD 20705
Phone: (301) 572-3940
Fax: (301) 572-8128

EMPLOYMENT APPLICATION

AVAILABILITY

You will be expected to be available for scheduling during the times you've listed below.

Position applying for	Available start date:	Desired pay:	Years of Experience:
Do you have reliable transportation ☐ Yes ☐ No	What's the distance you're willing to travel?		

Desired Schedule: ☐ Full-time ☐ Part-time ☐ PRN	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	Start End	Start End	Start End	Start End	Start End	Start End	Start End

PERSONAL INFORMATION

Please complete all sections

Last Name	First Name		Middle Name	
Address		City	State	Zip
Date of Birth	SSN #		Sex	Race
Primary Telphone: ☐ Mobile ☐ Home ☐ Work	Secondary Telephone: ☐ Mobile ☐ Home ☐ Work		Email Address:	

EMPLOYMENT HISTORY

List all employment, starting with your most recent position. Failing to provide all information for each employer may result in the rejection of your application. **May we contact your recent employer? Yes ☐ No ☐**

Employer	Dates From	To	Position / Title
Address			Duties Performed
City State Telephone			
Supervisor	Hourly Rate / Salary Starting	Final	
Reason for Leaving			

Employer	Dates From	To	Position / Title
Address			Duties Performed
City State Telephone			
Supervisor	Hourly Rate / Salary Starting	Final	
Reason for Leaving			

Have you ever been discplined, terminated, asked to resign by any employer because of dishonesty, negligence or theft?
☐ **Yes** ☐ **No** If yes, please explain:_____

EDUCATION & BACKGROUND

Type of school	Name and Location of School	Degree / Area of Study	Number of Years Completed	Graduated ? (Check one)
High School	Name City State			☐ Yes ☐ No
College	Name City State			☐ Yes ☐ No
Other	Name City State			☐ Yes ☐ No
Special Skills / Courses				

By lisiting a language you're consenting that you're flunet in reading, speaking & writing those language(s):

Primary Language	Secondary Language

CRIMINAL CONVICTION

Have you ever been convicted of a felony? ☐ Yes ☐ No
Date (s) / Nature of Offenses (s):

Have you ever been convicted of a misdemeanor involving weapons, abuse, theft, dishonestly and / or violence? ☐ Yes ☐ No
Dates (s) / Nature of Offenses (s) / Sentence Imposed:

MISCELLANEOUS

Are you legally autorized to work in the United States? ☐ Yes ☐ No		Are you at least 18 years of age or older? ☐ Yes ☐ No	
How were you referred to EHCS ?	List the names of friends or relatives now employed by EHCS:		
Have you ever been employed by EHCS before? ☐ Yes ☐ No	Dates Employed	Position	Supervisor
Have you worked in an Assisted Living Facility before? ☐ Yes ☐ No If yes, how many years? (Please indicate)			

REFERENCES Please provide the name and information of business colleagues and / or former managers only.

Name	Address	Telephone	Relationship/Title	Years Known

EMERGENCY CONTACT This information is to facilitate contact in the event of an emergency only

Full Name	Address	Telephone	Relationship

PLEASE READ THIS STATEMENT CAREFULLY

CONFLICT OF INTEREST

I acknowledge that I have read the company policy statement concerning conflict of interest and I hereby declare that neither I, nor any other business to which I may be associated, nor, to the best of my knowledge, any member of my immediate family has any conflict between our personal affairs or interests and the proper performance of my responsibilities for the company that would constitute a violation of that company policy. Furthermore, I declare that during my employment, I shall continue to maintain my affairs in accordance with the requirements of said policy.

_____ _____
SIGNATURE OF APPLICANT DATE

RELEASE OF INFORMATION

I hereby authorized all prior employers, schools, credit bureaus, Social Security Administration. Law enforcement agencies and investigative agencies give **Excel Healthcare Services** any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, concerning my qualifications for the position applied for. I release to **Excel Healthcare Services** and all its employees from all liability for any damage that may result from furnishing information to **Excel Healthcare Services**, I also release to **Excel Healthcare Services** and all its employees from all liability for any damage that may result from reliance on the information furnished. I understand that if a consumer investigative report is requested, I have the right under the Fair Credit Reporting Act to request in writing, within a reasonable time, a complete and accurate disclosure of the nature and scope of the investigation. This written request should be addressed to the location where this application is filed.

_____ _____
SIGNATURE OF APPLICANT DATE

CONFIDENTIAL AGREEMENT

I agree that, except at the request and for the benefit of Excel Healthcare Services I will not disclose to anyone or use for my own purposes any of Excel Healthcare Services confidential or proprietary information, either during or after my employment. I understand and agree that Excel Healthcare Services bidding, costs, pricing and marketing information and techniques, customer names and information, and employee name and information are confidential and proprietary to Excel Healthcare Services.

_____ _____
SIGNATURE OF APPLICANT DATE

EMPLOYMENT PROBATION

I agree to carry out the designated responsibilities to the best of my ability. I have read the position description. I am aware there is a conditional period of 3 months prior to permanent employment.
I certify that I have given true, accurate and complete information on this form to the best of my knowledge. I authorized investigation of statements made in this application and understand that false information may be grounds for denial of my position and/or dismissal if I am employed

_____ _____
SIGNATURE OF APPLICANT DATE

POLICY STATEMENT

It is our policy to provide equal opportunity for all qualified applicants regardless of race, religion, color, age, sex, national origin, and physical or mental disability. All application will be kept active for six months from receipt. These lines/procedures are necessary in ensuring a successful career with Excel Health Care Services.

- Licensed personnel and Aides must always carry their license and current CPR and First Aid cards.
- Please arrive to work on time. However, emergencies do happen and if you are going to be late please call the office. If you are going to be absent, call the office immediately.
  DO NOT CALL CLIENT.
- Upon arrival please **CLOCK IN** and **CLOCK OUT** before leaving client residence if clocking is required. You will be informed.
- **HOURS PAID** will be based on hours received from ISAS report system.
- Dress appropriately to all assigned jobs or as directed by the agency/client. Please emphasize personal hygiene and modesty as far as jewelry and makeup are concerned.
- In case of emergency in the client's home – call 911 and immediately call the agency.
- Do not ask or accept any gift/money from your client.
- No personal telephone calls while on duty and no calls of personal nature should be received while on duty. Phone usage is not permitted at work place.
- **WORK SCHEDULES** are available at the beginning of each month. Please notify the office at least one week before the schedule is available if you intend to take any day off. If it is an emergency, call the office immediately, the Agency will need a letter from you upon return. **VIOLATION OF THIS POLICY MAY RESULT IN TERMINATION OF CONTRACT.**
- While still under the employment of Excel Health Care services, you are not authorized to accept any employment/contract that may be offered to you by your client.
- Always treat the client with utmost respect. If there is any problem with a nurse or client, please report to your supervisor immediately. Refrain from engaging in an argument with the client.
- Every caregiver is responsible for completing the Activity of daily Living log (ADL).
- Any desired schedule changes must receive prior approval from your supervisor.
- Excel HealthCare Services employees are paid on a bi-weekly basis every year. In addition, direct deposit of your payroll check is available.
- It is the policy of EHCS to administer fair and reasonable methods of disciplinary action for those employees whose job performance or behavior does not meet the standards of professional performance outlined by the agency.
- EHCS staff is expected to maintain a professional, relationship in the home. If a situation arises that present an ethical dilemma, including theft, sexual harassment, bribery, falsification of time sheets, or fraternization involving the patient, his/her family, or staff, should be reported immediately to the Staff Coordinator or the Agency Administrator. EHCS will conduct an internal investigation that may include disciplinary action up to termination.
- Please be professional and courteous to everyone. For all questions and concerns please call an EHCS representative during regular business hours.

- EHCS strives for staff retention and hopes that all employees will continue services with the agency. In the event an employee can no longer continue services with EHCS, they are requested to submit a two week notice to allow for continuity of patient care.
- EHCS complies with all federal and state laws governing employment practices in Maryland.
- EHCS employs individual on a need basis and may terminate an employee at any time without reason. Any infraction of the Maryland Nurse Practice Act will lead to termination.
- A federal regulation, known as the "**HIPPA**" Privacy Rule requires that we provide a detailed notice in writing of our privacy practices. The HIPPA notice requires us to address many things, including the protection of health information that identifies a patient, how we may use and disclose protected health information, the right of patients to have their health information protected, and the right to file a complaint if there is a violation of their privacy.
- EHCS has taken every precaution to protect every patient's health information. As an employee of EHCS you are requested to follow all state and federal regulations that govern health information. At any time, you are not allowed to disclose any information prior consent of the DON or Administrator.
- Always remember that as an agency representative, many eyes will be on you. Please do not assume anything, if unsure of what to do in a given situation, ask your supervisors.
- **The following three trainings MUST be completed within 30 days of hire:**
    1. **Infection Control** **2. Abuse and Neglect** **3. Reporting and Documenting**
- If you are on a PRN position, this means that your employment with EHCS is TEMPORARY. You will only be called to fill in as needed or until we find a full time position for you depending on a successful 3months probation period.

Employee Name: _____

Employee Signature: _____

Date:_____

TRANSPORTATION/ESCORT POLICY

Personal Vehicle, Use of by Employees to Transport Patients

PURPOSE:

To ensure that all policies and procedures in effect within the organization adhere to industry and business standards of practice for the provision of care, treatment and services.

POLICY

1. Excel Health Care Services (EHCS) does not have automobile insurance coverage for employees using their personal vehicles for carrying out duties for Excel Health Care Services.

2. EHCS prohibit the transportation of clients. However, Caregivers may accompany clients (if family member is transporting or if alternate transportation arrangement is made). if client needs assistance with ADLs during transport or at the point of destination, caregiver will provide assistance.

3. Caregiver may escort clients to grocery, medical appointments, church and other specific places as indicated on the care plan. Anything to the contrary the agency must be notified for approval.

4. Caregivers are not to drive the client's vehicle while performing services. EHCS does not provide company vehicles for transportation of clients or employee personal use.

5. EHCS does not reimburse employees for mileage for transporting clients.

6. Should there be an accident while transporting Excel Health patients/clients and the patients/clients are injured, the owner of the vehicle is liable for the injured passengers.

Signatures

I have read and understand the terms and conditions of this policy and agree to comply with them.

_____	_____	_____
Employee Name	Employee Signature	Date

Physician's Statement

This form must be completed by a physician, physician assistant, or nurse practitioner.

Personal Data

Name_____ Social Security Number_____

Address_____

City_____ State_____ Zip Code_____

Phone_____Cell_____

Medical Release Authorization

I _____ do hereby authorize_____ to
Patient Name *Physician Name*
release any information acquired during medical examination, relevant to employment with Excel Healthcare Services.

Immunization Records **Excel Healthcare Services must receive a copy of the results of all vaccinations, and or chest x-ray reports (if applicable) before employee is hired for the purpose of home health staffing. Vaccination dates, not titers, are required for home health staffing only.**

	Date	Results	Immune
Hepatitis Vaccine 1	_____		
Hepatitis Vaccine 2	_____		
Hepatitis Vaccine 3	_____		
Polio Vaccine	_____		
MMR Vaccine	_____		
Diptheria-Tetanus (DT) Vaccine	_____(*required every 10 years)*		
T.B. Skin Test (PPD)	_____	Neg.☐ Pos.☐	_____MM
Chest X-ray (only if PPD pos.)	_____		
BCG Vaccine	_____	Yes ☐	No ☐

(vaccine given in foreign countries for TB, not given in USA)

Physical Examination

Temp _____ Pulse _____ Respirations _____ Blood Pressure _____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to function without any physical limitations or weight lifting restrictions as a healthcare professional.

Physician Name (please print)_____ License Number_____

Physician Address_____

City/State/Zip Code_____ Phone_____

Physician Signature_____ Date_____

Excel HEALTHCARE SERVICES
A trusted name in Healthcare Services

Caregiver Position Agreement

CAREGIVER POSITION SUMMARY STATEMENT

SIGNATURE PAGE

This need to be signed by employee and filed off in employee file.

I have read and understood everything stated thereof. A copy of the agreement was given to me.

Signing on behalf of The Caregiver and agreeing to accept all its accountabilities and being bound by the terms of this agreement is:

Caregiver Signature: _____

Caregiver Printed Name: _____

Date: _____

HEPATITIS B

Employee Information:

Name: _____ Date: _____

Address: _____

A. I have elected to voluntarily be vaccinated with Hepatitis B vaccine requested by the Agency. I have received vaccine information regarding risk associated with this vaccination.

B._____ I have completed the Hepatitis B vaccination series on _____ and will provide medical documentation to the Agency.

C._____ I have elected to voluntarily decline the vaccine at this time.

D._____ I have completed the Hepatitis B vaccination in the past and will provide medical documentation of vaccination.

Employee Signature: _____ Date: _____

Agency Representative:_____ Date: _____

Hepatitis B Declination Statement

If C is checked above, please read and sign below:

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. I have been requested to be vaccinated with hepatitis B vaccine; however, I decline hepatitis B vaccination at this time.

I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can still receive the vaccination series.

Name: _____

Employee Signature: _____

Date: _____

EMPLOYMENT REFERENCE FORM

[* - fill in the required]

*Name of Employer: _____ *Position: _____

*Address: _____

*Department: _____ *Supervisor: _____
*Phone: (____) _____-_____

The person whose signature appears beneath mine has applied to Excel Healthcare Services for employment and has submitted your name as a former employer for reference purposes. The serious nature of our responsibility to our clients is such that any consideration of the individual by Excel Healthcare Services is dependent upon receipt of satisfactory references. We would, therefore, appreciate your cooperation in replying to the questions below. Please be assured that your response will be kept in the strictest confidence. Thank you in advance for this courtesy.

_____
Agency Rep.

I hereby authorize you to fulfill the above request for information.

_____
Applicant's Signature/Date

*Applicant's Name_____ *Social Security #: _____

*Position held in your employ:_____ *Unit/Area worked:_____

*Employment dates: From_____ *To: _____

Did applicant resign or was he/she terminated_____ Eligible for rehire? Yes ☐ No ☐

*Reason for leaving_____

Was this a travel assignment? Yes ☐ No ☐

PERSONAL EVALUATION:	**VERY GOOD**	**SATISFACTORY**	**FAIR**	**POOR**
Quality of work				
Flexibility				
Attitude				
Emotional Stability				
Adaptability to work under pressure				
Dependability / Attendance / Punctuality				
Cooperation / Ability to get along with others				

Comments: _____

_____

_____

CHARACTER REFERENCE VERIFICATION
[* - fill in the required]

*Applicant Name: _____ *Position: _____

*Character Reference Name: _____ *Phone: (____) _____-_____

Please answer all questions and provide additional information as requested

1) Are you related to the applicant? □ Yes □ No If yes, please explain: _____
2) How many years have you known applicant? _____
3) In what context have you known applicant (supervisor, colleague, friend, etc) _____

_____

Please answer all questions to the best of your knowledge

4) Have you ever had to question the applicants reputation for:
   a. Honesty □ Yes □ No □ Don't know
   b. Trustworthiness □ Yes □ No □ Don't know
   c. Diligence □ Yes □ No □ Don't know
   d. Reliability □ Yes □ No □ Don't know
   e. Good character □ Yes □ No □ Don't know
   f. Maturity □ Yes □ No □ Don't know

Please indicate your overall recommendation for this applicant

□ highly recommended □ Recommended, but with reservations

□ Recommended □ not recommended

For Internal Use Only

Results: _____

Date Checked: _____/_____/_____ *by Phone* □ *by Mail* □ *by Fax* □

Signature: _____ *Date:* ___/____/____

PLEASE PRESENT THIS WHEN YOU GO TO DO THE CRIMINAL BACKGROUND CHECK

COMPANY NAME: EXCEL HEALTH CARE SERVICES

COMPANY ADDRESS: 3901 CALVERTON BLVD, SUITE 430 CALVERTON, MD 20705

CATEGORY: ADULT DEPENDENT CARE

AUTHORIZATION CODE: **0500126583**

EMAIL: EXCELHEALTH@COMCAST.NET

VENUE FOR *CRIMINAL BACKGROUND CHECK*

Address: Grand Mission Consult LLC –
7515 Annapolis Road suite 203 Hyattsville MD 20784
Phone: 301-429-0525

Address: Biometrics Identity Verification System
5010 Sunnyside Avenue, Suite 300 Beltsville, MD 20705
Phone: 301-477-3210

PLEASE PRESENT THIS WHEN YOU GO TO DO THE CRIMINAL BACKGROUND CHECK

COMPANY NAME: EXCEL HEALTH CARE SERVICES

COMPANY ADDRESS: 3901 CALVERTON BLVD, SUITE 430 CALVERTON, MD 20705

CATEGORY: ADULT DEPENDENT CARE

AUTHORIZATION CODE: **0500126583**

EMAIL: EXCELHEALTH@COMCAST.NET

VENUE FOR *CRIMINAL BACKGROUND CHECK*

Address: Grand Mission Consult LLC –
7515 Annapolis Road suite 203 Hyattsville MD 20784
Phone: 301-429-0525

Address: Biometrics Identity Verification System
5010 Sunnyside Avenue, Suite 300 Beltsville, MD 20705
Phone: 301-477-3210