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 LPN/RN

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?
	❑ Yes ❑ No

Position Applied for	Professional License Number	Date Professional License Expire
❑ LPN ❑ RN ❑ Other_____		

Salary Desired (be specific)	Foreign Language(s) spoken

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 - <u>Do Not</u> 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:			

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:			

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

If needed, please use blank paper for additional comments.

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**	

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 ⋄ Douglasville, GA 30134 ⋄ Phone: 678-391-0140, Fax 877-797-3730

Evaluation / Medical / Surgical Unit Clinical Skills Checklist

Level of Proficiency: **A** = Theory, no practice **B** = Intermittent experience
C = One-two years' experience **D** = Two plus years' experience

SKILLS	A	B	C	D
Care of Patients:				
Patient Controlled Analgesia (PCA)				
Colostomy				
Ileostomy				
Aneurysms				
Isolation				
Femoral-popliteal bypass				
Thoracic surgery				
Carotid endarterectomy				
CVA				
Spinal cord injury				
Craniotomy				
DT's				
Overdose				
Burns				
GI bleeding				
AIDS				
ARDS				
Near Drowning				
Cardiovascular:				
Heart sounds				
Blood Pressure Interpretation				
12-Lead EKG				
Basic arrhythmia interpretation				
Lead placement				
Doppler				
Heart sounds / murmurs				
Pulses / circulation checks				
Pacemaker				

SKILLS	A	B	C	D
Assessment:				
Cardiovascular				
Respiratory				
GI				
GU				
Nutritional status				
Mental status				
Muscoskeletal				
Neurological				
Integumentary				
Pain				
Psychosocial status				
Wound care				
Lab values				
Vital signs				
Effects / side effects medication				
Drug / drug interactions				
Drug / food interactions				
Endocrine:				
Preparation of Insulin				
Administration of Insulin				
Site rotation for injection				
Signs & symptoms of hypo/hyperglycemia				
Urine testing				
Blood testing				
Foot and skin care				
Exercise / activity / rest				
Sick day routine				
Care of patient with Addison's disease				

Evaluation / Medical / Surgical Unit Clinical Skills Checklist *(continued)*

Level of Proficiency: **A** = Theory, no practice **B** = Intermittent experience
C = One-two years' experience **D** = Two plus years' experience

SKILLS	A	B	C	D
Wound Care:				
Wet to dry dressing				
Packing				
Debridement				
Sterile dressing changes				
Burns				
Pressure sores				
Staging decubitus ulcers				
Irrigation				
Occlusive dressing				
Infectious Diseases:				
Interpretation of blood count				
Care of the patient with AIDS				
Care of the patient with Hepatitis				
Fever Management				
Isolation				
Universal Precautions				
Blood Borne Pathogen				
Disposal of Hazardous Waste				
Particulate Respirators				
IV Therapy:				
Administration of blood				
Packed red blood cells				
Whole blood				
Plasma				
Cryoprecipitate				
Drawing blood from central line				
Drawing venous blood				
Starting IV's				
Peripheral line				
Central line dressing				

SKILLS	A	B	C	D
IV Therapy: (continued)				
Broviac				
Groshong				
Hickman				
Portacath				
Quinton				
Heparin lock				
Oncology:				
Pain control				
Nutritional status				
Reverse isolation				
Bone marrow transplant				
Inpatient chemotherapy				
Inpatient hospice				
Leukemia				
Pain Management:				
Care of patient w/ epidural anesthesia				
IV conscious sedation				
Narcotic analgesia				
Patient controlled analgesia				
Patient teaching				
Family teaching				

Specialty Experience:

- ❑ Medical _____ years
- ❑ Surgical _____ years
- ❑ OB/GYN _____ years
- ❑ Orthopedics _____ years
- ❑ Telemetry _____ years
- ❑ Neugology _____ years
- ❑ Oncology _____ years
- ❑ Transplant _____ years
- ❑ Rehabilitation _____ years
- ❑ HIV _____ years
- ❑ Other_____

Have Experience With:

- ❑ Computerized charting systems
- ❑ Medication administration systems

Signature (required) _____

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?..... ❑ Yes ❑ No

If yes, please note date (approximate):_____

Since your 18th 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.)..... ❑ Yes ❑ No

If yes, please indicate date, location and explanation: _____

_____

Have you ever been convicted of a crime under another name?..... ❑ Yes ❑ No

If yes, state name: _____

DRIVER'S LICENSE NUMBER	STATE OF ISSUE	EXPIRATION DATE

SEE ADDITIONAL INFORMATION 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 hearby 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 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.

_____ Date_____

Applicant Signature

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.

_____ Date_____

Applicant Signature

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.

_____ Date_____

Applicant’s Signature

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 Georgia.

I have read and understand this statement.

_____ Date_____

Applicant Signature

Unemployment Benefits/W4

I understand that under Georgia State law all employees are required to pay state and 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 the state and or 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.

_____ Date_____

Applicant Signature

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.

_____ Date_____

Applicant's Signature

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.

3

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

_____ Date_____

Applicant's Signature

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.

_____ Date_____

Applicant Signature

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, LLC.

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.

_____ Date_____

Applicant Signature

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: _____

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: _____