Medical Directories Application for Employment

Personal Information

Last Name	First Name	Middle Initial	Social Security Number	DOB
Address			Apt. Number	
City	State	Zip Code	Phone Number ( )	Cell Number ( )
Years at present address	Previous Address If less than 2 years			
Position on Applying for	Date you can start work		Salary Desired	
How did you hear about Medical Directions?				

Education

School Level	Name and Location of School	Years attended	Did you graduate?	Diploma received
High School				
High School				
Vocational, Trade or Business				

SPECIAL TRAINING OR SKILLS

Personal Information

Name		Date Started	Date Left	May I Contact (Yes or No)
Address	City		State	Zip Code
Job Title	Current Salary	Supervisor's Name and Title		Phone Number ( )
Description of work				
Reason for leaving				

Previous Employers (Please provide two)

Name		Date Started	Date Left	May I Contact (Yes or No)
Address	City		State	Zip Code
Job Title	Current Salary	Supervisor's Name and Title		Phone Number ( )
Description of work				
Reason for leaving				

Name		Date Started	Date Left	May I Contact (Yes or No)
Address	City		State	Zip Code
Job Title	Current Salary	Supervisor's Name and Title		Phone Number ( )
Description of work				
Reason for leaving				

Military Service

Branch of Service	Date of Discharge	Rank at time of Discharge
Honorable Discharge (Yes or No) If No, please explain		

Have you been convicted of a Felony within the last 5 year? _____ Yes _____ No	If yes, please explain below. It will NOT necessarily exclude you from employment.

I CERTIFY THAT THE INFORMATION I PROVIDED IN THIS APPLICATION TO BE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT IF EMPLOYED, ANY STATEMENTS FOUND TO BE FALSE WILL BE GROUNDS FOR TERMINATION.

I AUTHORIZE THE INVESTIGATION OF ALL STATEMENTS, REFERENCES, AND EMPLOYERS LISTED ABOVE. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT PERSONAL OR OTHERWISE AND RELEASE THE COMPANY OR INDIVIDUAL FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM THE RELEASE OF THIS INFORMATION.

I ACKNOWLEDGE THAT MY EMPLOYMENT AT MEDICAL DIRECTIONS MAY BE TERMINATED AT ANY TIME AND FOR ANY REASON BY THE COMPANY OR ME.

DATE ***SIGNATURE***

INTERVIEWED BY	DATE	ELIGIBLE FOR EMPLOYMENT	START DATE	SALARY RANGE
COMMENTS			MANAGERS SIGNATURE	

MEDICAL DIRECTIONS
RN/LPN/COMPETENCY CHECKLIST

Please fill in the blank with the number that most accurately describe your experience in each clinical area.

0 No/minimal experience
1 6 months to 1 year experience
2 1 year to 3 year experience
3 >3 years experience

Telemetry_____
PACU_____
Gynecology_____
Psychiatry_____
Nephrology_____
Home Health_____
Charge RN_____
Nursery_____
Geriatrics_____
NICU_____
Labor/Delivery_____
Orthopedics_____
Cardiology_____
Rehabilitation_____
ENT_____
Neurology_____
Pediatrics_____
Operating Room_____
Emergency Room_____
Postpartum_____
PICU_____
Oncology_____
Gastroenterology_____
Med/Surg_____

Please fill in the blank with the number that most accurately describes your skill level when providing care to patients with the following health conditions or performing the following tasks:

0 Minimal to no experience, needs supervision
1 Moderate experience, can perform with minimal supervision
2 Very experienced, can perform with minimal supervision
3 Able to supervise others

Starting IV therapy_____
Infusion pump_____
Medications via IV push_____
Venipuncture_____
Administration of Blood/Blood products_____
Injections (IM, Sub-Q, Z-tracks) _____
Hemodialysis_____
Diabetic Teaching_____
Accuchecks_____
Diabetic Ketoacidosis_____
Hypoglycemia_____
Wound management_____
OR Scrub Tech_____
OR Circulator_____
HIV/AIDS_____
Drugs/ETOH Dependency_____
Chest tube management_____
Ventilator_____
Pulse Oximetry_____
Interpretation of ABG's_____
Oral suctioning_____
Nasotracheal suctioning_____
Isolation techniques_____
Chemotherapy_____
Physical assessment_____
Feeding patients_____
Assessment of neuro signs_____
Pacemakers_____
Interpretation of arrhythmias_____
Cardiac arrest/CPR_____
Gastrostomy tube_____
Storms care_____
Bowel obstruction_____
GI Bleed_____
Renal Failure_____
Foley catheter insertion/care_____
Suprapublic catheter care_____
Shunts and Fistulas_____
TPN/Hyper alimentation_____
Self-Breast Exam_____
Assist with GYN/PAP Exam_____
Assessment progression of labor (exp.
Pre-op patient_____
Post-op patient_____
Medication administration_____
Patient teaching_____
Management of hickman, broviac, groshong catheters_____
Knowledge of normal lab values_____
Management of Oxygen Therapy_____

I affirm that the information I provided in the above assessment of my skills and competency is accurate and I will perform only those tasks/assignments I am competent to complete.

Employee Name _____ Date_____

Medical Directions

Job Description/LPN

Summary: Responsible for delivery of nursing care to patients as directed by the Physician's plan of treatment.

Responsible to: Director of Clinical Services

Position Requirements:

1. Graduate of a state approved class/CAN Certificate
2. Successful completion of Nurse Aide Competency Test
3. 12 Months experience
4. Current CPR card
5. Current PPD

Job Duties:

Assists doctors and nurses in general care and treatment of patients; measures doses and administers medications; documents medications using appropriate forms; performs narcotic counts; checks and may administer intravenous medications; reports changes in patients to doctors; ensures that restraints are applied correctly; transcribes doctors medications orders; dispenses certain medications in doctors absence; takes and charts temperatures, pulses and respirations; performs simple nursing treatments; monitors general patient needs including personal hygiene; reports on patient conditions and behavior; keep the unit safe and healthy; administers enemas or suppositories; orients patients concerning medications and their use; may perform emergency first aid; performs related duties as required

Employee Signature_____Date_____

Medical Directions

Job Description/RN

Summary: Responsible for establishing, monitoring and delivering nursing care to patients as directed by the Physician's plan of treatment.

Responsible to: Director of Clinical Services

Position Requirements:

1. Graduate of a state approved class/CAN Certificate
2. Successful completion of Nurse Aide Competency Test
3. 12 Months experience
4. Current CPR card
5. Current PPD

Job Duties:

Assists doctors and nurses in general care and treatment of patients; measures doses and administers medications; documents medications using appropriate forms; performs narcotic counts; checks and may administer intravenous medications; reports changes in patients to doctors; ensures that restraints are applied correctly; transcribes doctors medications orders; dispenses certain medications in doctors absence; takes and charts temperatures, pulses and respirations; performs simple nursing treatments; monitors general patient needs including personal hygiene; reports on patient conditions and behavior; keep the unit safe and healthy; administers enemas or suppositories; orients patients concerning medications and their use; may perform emergency first aid; performs related duties as required

Employee Signature_____Date_____

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . .	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	**2 Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

U.S. Department of Justice

Immigration and Naturalization Service — Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE. It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification

To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt.#	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A _____)
- ☐ An alien authorized to work until _____

(Alien # or Admission # _____)

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification

To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s).

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification

To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

This form was electronically produced by National Production Services Staff

Employee Direct Deposit

No More Extra Trips To the Bank

To request Direct Deposit of your paycheck, read and complete the following authorization agreement, and give it to your payroll department. If you are eligible to participate, they set you up on Direct Deposit.

Please deposit my entire net pay into the account specified below.

Circle One: **Checking** **Saving**

Account #: _____

Routing / Transit #: _____

Attach a void check, bank letter, or specification sheet. Deposit tickets are NOT accepted.

EMPLOYEE INFORMATION

Name: _____

Social Security # (Required): _____

Home Address: _____

City: _____

State: _____ Zip: _____

AUTHORIZATION

I authorize my employer; MEDICAL DIRECTION, (hereinafter Company) to deposit my pay each payday directly into account. In the event that the Company deposit funds erroneously into my account, I hereby authorize the Company to debit my account for an amount not to exceed the original amount of erroneous credit.

Any dispute arising out of or in correction with this agreement, if not otherwise resolved, shall be determined by arbitration in Cleveland, Ohio, in accordance with the Rules of the American Arbitration Association, and it's the expressed desire of both parties that the prevailing party be awarded the costs and attorney's fees and that the award be entered as a judgment in any jurisdiction in which non-prevailing party does business

This authorization will remain in full force and effect until the Company and the Bank have received written notice from me of its termination in such time and in such manner as to afford the Company and Bank a reasonable opportunity to act on it.

Employee Signature_____ Date_____

Medical Directions

I have completed the Health Safety and Infection Control Training Module. This program is designed to keep employees fully informed on infection control techniques, universal precautions, personal protectives equipment, infectious waste in the home, communicating hazards, tuberculosis exposure control, Hepatitis B vaccine, employee safety, body mechanics and fire safety.

I have reviewed the materials and studied the contents. I am aware that I can receive the Hepatitis B vaccine when I work in care that poses a risk for exposure.

New employees must check one of the two (2) options below. You are not required to check this off if you have already done so before.

- ❑ I accept Hepatitis B vaccination. I will make arrangements with my supervisor to obtain the vaccine on agency time and free of charge.

- ❑ 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 given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline the 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 liver 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 receive the vaccination series at no charge to me.

I am further aware that I must receive a TB screening upon initial employment, annually and after an exposure to TB. I also understand the transmission of HIV, along with the laws and issues affecting the case of people with HIV/AIDS. Anytime I have questions, I will talk with the Branch Manager and /or Home Care Supervisor or Case Manager

I understand that a review of this material is required on an annual basis.

_____ _____

Employee Name - Please Print Date

_____ _____

Employee Signature Date

_____ _____

Signature of Witness Date

Medical directions, Inc
Reference Form

Employee Name_____ SS#_____

Previous Employer Information

Name _____

Address _____

City _____ State _____Zip_____

Supervisor (name/Title) _____

Date of employment _____Position Held _____

I (print name) _____ am applying for employment with Medical Directions. I have given them permission to contact you for a reference. Please provide them with information requested. By signing below, I authorize the release of all information pertaining to my employment and release the above named company from all liability damage that may result form the utilization of such information.

Employee Signature _____ Date _____

Please evaluate _____ in following areas

Category	Above Average	Satisfactory	Need Improvement	Poor
Quality of work				
Interest & Enthusiasm				
Attendance				
Personal Appearance				
Ability to work with staff member				
Ability to relate to patients				
Punctuality				

Additional comments_____

_____

Supervisor's Signature _____ Date _____

Thank You for your assistance.

Substance Abuse Policy

It is our policy to prohibition the workplace unlawful possession, use or distribution of controlled substances, illegal drugs and alcohol. Violation of this policy will result in disciplinary action including termination of employment. In accordance with the Drug-Free Workplace Act, as a condition of employment, all employees must comply with this policy.

We require mandatory drug/alcohol testing of all employees, we also conduct random tests when the safety of our clients may be in question. Such tests may be deemed necessary based on observed inconsistent or erratic behavior that constitutes a health or safety hazard to other employees or clients

Since the Drug-Free Workplace Act requires that companies be able to document the notification and receipt of this policy, please sign at the bottom.

Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of the policy on Substance Abuse. I do understand the provisions of the policy, and will comply with all aspects of the policy.

Employee
Signature_____Date_____