Application Required Documents

APPLICANT'S NAME: _____

DATE: _____

It is a requirement that all pre-applicants provide the necessary documentation before completing an application for employment:

1. Nursing License for Maryland .....
2. CPR Certificate .....
3. Social Security Card .....
4. Current TB Clearance (PPD or Chest X-Ray) .....
5. Criminal Background C heck .....
6. Driver's License or ID Card .....
7. One on One interview Date .....
8. How were You referred .....
9. Date of Hire .....
10. First Aid .....
11. Start Date .....

APPLICATION FOR EMPLOYMENT

PERSONAL IMFORAMTUION

NAME (LASTNAME FIRST) SOCIAL SECURITY NO.

PRESENT ADDRESS APT. NO. CITY ZIP

PERMANENT ADDRES APT. NO. CITY ZIP

ARE YOU 18 YEARS OR OLDER? PNONE NO.

❑ YES ❑ no

DESIRED EMPLOYMENT

POSITION STATE DATE DESIRED SALARY

ARE YOU CURRENTLY EMPLOYED?

❑ YES ❑ NO

MAY WE INQUIRE OF YOU CURRENT EMPLOYER?

❑ YES ❑ NO

CURRENT EMPLOYER TELEPHONE

NAME OF YOUR LAST SUPERVISOR

EVER WORKED FOR THIS COMPANY BEFORE

❑ YES ❑ NO

WHO REFERRED YOU TO Saint Gabriel Health Care Services

❑ FRIEND ❑ EMPLOYEE ❑ ADVERTISMENT

GOVERNMENT PLACEMNET AGENCY

❑ INTERNET ❑ OTHER, SPECITY:

_____

EDUCATION

LEVEL	NAME AND LOCATION OF SCHOOL	NO. OF YEARS ATTENDED	DID YOU GRADUATE	MAJOR
ELEMENTARY SCHOOL				
HIGHT SCHOOL				
COLLEGE/UNIVERSITY				
PROFESSIONAL				
TRAINING				

EMPLOYMENT HISTORY

List your last two (2) employers, assignments of volunteer activities, including experience. Explain any gap in employment in the comments section below.

SAINT GABRIEL HEALTH CARE SERVICES

EMPLOYEE FILE CHECKLIST

Employee Name: _____ Date of Hire: _____

		Initial	Date	Credential Exp. Date
1.	Completed Application	_____	_____	_____
2.	References	_____	_____	_____
3.	Job Description (RN, LPN, Personal Care Aid)	_____	_____	_____
4.	CJIS Criminal Background Check (Agency's CJIS Authorization)	_____	_____	_____
5.	Copy of Social Security Card	_____	_____	_____
6.	Copy of Driver's License or Birth Certificate	_____	_____	_____
7.	Current First Aid Certification	_____	_____	_____
8.	Current CPR Certification	_____	_____	_____
9.	MD Board of Nursing Verification of credentials (RN, LPN, C.N.A., C.M.A., Med. Technician)	_____	_____	_____
10.	Employment Agreement	_____	_____	_____
11.	Initial Skills Assessment (Written)	_____	_____	_____
12.	Initial Skills Demonstration (Observed)	_____	_____	_____
13.	Work Permit/Authorization (if applicable)	_____	_____	_____

Staff person responsible for obtaining required information:

_____ _____

Print Name Date

_____

Signature

Termination Date: _____

FACE TO FACE INTERVIEW

Name COMPLETE: ☐ PENDING: ☐

CERTIFICATION/LICENSE RN ☐ LPN ☐ CNA ☐ CMT ☐ HHA ☐

Date of Hire

SKILLS ASSESSMENT YES: ☐ NO: ☐

REFERENCES YES: ☐ NO: ☐

Character Date Checked: _____

YES: ☐ NO: ☐

Employment Date Checked: _____

INTERVIEW NOTES

FINGERPRINTING YES: ☐ NO: ☐

Date Checked: _____

HEALTH SCREEN YES: ☐ NO: ☐

TB YES: ☐ NO: ☐

Hep B Vaccination YES: ☐ NO: ☐

ORIENTATION YES: ☐ NO: ☐

CPR YES: ☐ NO: ☐

FIRST AID

TRANSPORTATION Private: ☐ Public: ☐

COMMENTS: _____

Interviewed by: _____

Date: _____

SAINT GABRIEL HEALTH CARE SERVICES

VERIFICATION OF PREVIOUS EMPLOYMENT

To:
Company Name:
Address:
Phone No:

App li cant's Name:
Position Applying For:
Employed From: to:

I hereby authorize Saint Gabriel Health Care Services to contact all past employers and other individuals, agencies or entities concerning the information I have supplied and waive, release and hold harmless such individuals; agencies or entities from any claims arising from the information they may supply Saint Gabriel Health Care Services

Applicant's Signature Date

_____ _____

The above applicant has applied for employment with us. Your evaluation will be greatly appreciated.

Staff Recruiter Date

_____ _____

TO BE COMPLETED BY EMPLOYER

Job Title:
Reason for Leaving: _____ _____ ____ ____ __ Are applicant's personal qualifications, skills and personal habits such as to render him/her a desirable employee?
Yes No Would you rehire? Yes No: _____

EVALUATION

	Excellent	Good	Fair	Poor
Quality of Work	❑	❑	❑	❑
Attendance/Punctuality	❑	❑	❑	❑
Cooperation	❑	❑	❑	❑
Performance Under Pressure	❑	❑	❑	❑
Ability to Work Independently	❑	❑	❑	❑
Personal Appearance	❑	❑	❑	❑

CHARACTER REFERENCE VERIFICATION

NAME: _____ (First) _____ (Middle) _____ (Last)

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

CHARACTER REFERENCES

NAME: _____ (First) _____ (Middle) _____ (Last)

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

NAME: _____ (First) _____ (Middle) _____ (Last)

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

NAME: _____ (First) _____ (Middle) _____ (Last)

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

_____ Date

Employee Signature

_____ Date

Agency Staff Signature

SAINT GABRIEL HEALTH CARE SERVICES.

Hepatitis B Immunization Consent Declination

Please check one:

Yes, I want to receive the Hepatitis B vaccine.

I read the information given to me about Hepatitis B virus and Hepatitis B vaccine and I had the opportunity to ask question My questions were answered.

I want to participate in the vaccination program. I understand this includes three injections at prescribed intervals over a 6-month period. I understand that there is no guarantee that I will become immune to Hepatitis B and that I might experience adverse side effect as the result of the vaccination.

	Date Given	Lot # Administered by	Next Date Due
1st Dose			
2nd Dose			
3rd Dose			

No, I don't want to receive the Hepatitis B Vaccine.

I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring Hepatitis B Virus (HBV). I was given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at an increased risk of acquiring Hepatitis B, a serious disease.

If in the future I want to be vaccinated with the Hepatitis B vaccine, I understand that I can receive the vaccine series at no charge to me.

_____ Employee Name

_____ Facility

_____ City, State, Zip

_____ Address

_____ Telephone Number

_____

_____ Signature

_____ Date

Privacy Act Statement:

SAINT GABRIEL HEALTH CARE SERVICES.

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_____ Employee Name

_____ Facility

_____ City, State, Zip

_____ Address

_____ Telephone Number

_____

_____ Signature

_____ Date

Privacy Act Statement:

SAINT GABRIEL HEALTH CARE SERVICES

CAREGIVER CONSENT FORM

Caregiver's Information: (Last name)

(Middle initial)

(First name)

Date of Birth

Social Security Number:

Telephone:

Home Address:

(Street address) (City/State/Zip code)

I hereby consent to provide care for clients of Saint Gabriel Health Care Services and I hereby acknowledge consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confi am mentally capable of giving informed consent to the provision of the care and am not subject to duress or ur influence.

I hereby acknowledge and understand that, by singing this voluntary caregiver consent for, I am giving infor to provide Saint Gabriel Health Care Services unless the action or omission of Saint Gabriel Health C continues willful or want on misconduct upon singing this agreement, I agree that

I will not be employed any client from Saint Gabriel Health Care Services without the due consent of Saint Health Care Services preserves the right to sue the caregiver for up to
$10,000.00 if care giver is employed directly or indirectly by client.