

Mother Earth Healthcare Services Inc

APPLICATION FOR EMPLOYMENT

Date: _____

PERSONAL INFORMATION

Full Name: _____

Social Security No: _____

Present Address: _____

City: _____ State: _____ Zip: _____

Phone No: _____ Pager No: _____

Permanent Address: _____

Notify in case of an emergency:

Name: _____

Address: _____

Phone No: _____

Are you 18 years or older? YES NO

Have you ever been convicted of a felony? YES NO

If YES, please explain: _____

Please note that we are required by Texas law to perform a Criminal Conviction History Check on all Unlicensed personnel and are prohibited from permanently employing any person whose check reveals certain past criminal convictions.

Referral Source:

Friend (Name): _____ Relative (Name): _____

Newspaper: _____ Walk-in: _____

Employment Agency: _____

Other: _____

EMPLOYMENT RECORD

Are you currently employed? YES NO

WE ROUTINELY CONTACT AN APPLICANT'S CURRENT EMPLOYER FOR REFERENCE CHECKS. WOULD We routinely contact an applicant's current employer for reference checks. Would this pose any particular difficulty for you?

YES NO

If YES, please explain: _____

LIST PREVIOUS EMPLOYMENT INFORMATION:

Current or Last Employer

Dates Employed From: _____ to _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for Leaving: _____

Previous Employer

Dates Employed From: _____ to _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for leaving: _____

Previous Employer

Dates Employed From: _____ to _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for Leaving: _____

Please explain all periods of unemployment: _____

Have you ever been terminated from employment? YES NO

If YES, please explain: _____

Use this space to give us other information about your personal qualities, work style, interpersonal skills or communication skills which would assist us in placing you:

REFERENCES

NAME	ADDRESS	PHONE	YEARS KNOWN
1			
2			
3			

PRE-EMPLOYMENT MEDICAL HISTORY AND MOBILITY EVALUATION

SECTION 1: APPLICANT INFORMATION STATEMENT (TO BE READ BY APPLICANT)

Before an offer of employment can be made, the section below must be completed.

Mother Earth Healthcare Services Inc, is an equal opportunity employer who affirmatively seeks to employ qualified handicapped individuals. The following evaluation will assist us in efforts to reasonably accommodate our work environment to your needs.

SECTION 2: MEDICAL HISTORY

a. State any physical defects or limitations that you have:

b. Employment for the company requires all employees to be fit to perform any physical activities related to that job, as well as to appear regularly and on time for work as assigned. In that regard, do you have any of the following ailments?

- | | |
|---|---|
| <input type="checkbox"/> NA | <input type="checkbox"/> HEART TROUBLE |
| <input type="checkbox"/> BACK TROUBLE | <input type="checkbox"/> HERNIA |
| <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> TRICK JOINTS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> DIFFICULTY BENDING | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> DIZZINESS/BLACKOUTS | <input type="checkbox"/> ALCOHOL ADDICTION |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> DRUG ADDICTION |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> ANY COMMUNICABLE DISEASE |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | |

Describe any checked answers. List any prescribed medications you are now using:

Please Review and Sign

In making application for employment:

I certify that the information in this application is true and complete for all practical purposes. It may be verified by the facility or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the facility or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate discharge without recourse.

I understand that an investigative report may be made by a consumer reporting agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I understand that I will receive notice that such report has been requested, and that I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

I understand and agree that if I am offered employment by the facility, my employment will be for no definite term and that either I, or the facility will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the facility.

I understand, if I am an unlicensed person who has face-to-face patient/client contact, that the agency will perform a criminal history check per State Regulations as well as a check of the Nurse Aide Registry and Employee Misconduct Registry. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in DADS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Department of Aging and Disability Services (DADS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All DADS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, **unemployable**.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant Signature: _____

Date: _____

Mother Earth Healthcare Services Inc

EMERGENCY CONTACT FORM

Employee Name: _____
Home Address: _____
Home Phone: _____
Home Fax: _____
Cell: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____
Relationship: _____
Address: _____
Telephone Numbers: Home: _____
Work: _____
Other: _____
Family Doctor: _____
Office Phone: _____
Hospital of Choice: _____
Allergies: _____

Mother Earth Healthcare Services Inc

UNIVERSAL PRECAUTIONS

Because the infectious status may not be known for every client, it is important to prevent exposure to the blood and body fluids of all patients. This approach will limit any potential HIV/HBV exposures.

All health care workers should routinely use appropriately barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient are anticipated.

Gloves must be worn for touching blood and body fluids, mucous membranes or non-intact skin of all clients and for handling items or surface soiled with blood or body fluids. Gloves must also be worn for performing venipuncture and during vascular access procedures and should be changed after contact with each patient. Hands must be washed immediately upon removal or damaging of gloves.

Masks face shields and protective eyewear should be worn during procedures that are likely to generate droplets of mucous membranes of the mouth, nose and eyes. Long sleeve fluid repellent disposable gowns and/or aprons should be worn and removed immediately if contaminated with blood or other body fluids.

All sharp items should be considered potentially infectious and handled with extraordinary care. Used needles are not to be recapped, broken or purposely bent. All needles and sharps shall be placed in puncture resistant containers.

OSHA RISK EXPOSURE

CATEGORY I: Tasks that involve exposure to blood, body fluids or tissue.

All procedures or other job-related tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids or tissue or a potential for spills or splashes of them, are Category I Tasks. Use of appropriate protective measures is required.

CATEGORY II: Tasks that involve no exposure to blood, body fluids or tissue, but employment may require performing unplanned Category I Tasks.

The normal work routine involves no exposure to blood, body fluids or tissues but exposure or potential exposure may be required as a condition of employment. Appropriate measures should be readily available to every employee engaged in Category II Tasks.

EMPLOYEE ACKNOWLEDGEMENT STATEMENT

I have read the above and have been instructed in the techniques of universal precautions and the Mother Earth Healthcare Services Inc, exposure control plan for bloodborne pathogens. If I choose to disregard the above standards, I realize I am doing so against Mother Earth Healthcare Services Inc, policy and OSHA standards.

I understand the potential dangers of recapping needles and of the failure to take adequate precautions to prevent or decrease the risk of exposure to blood and body fluids.

I also understand infractions of this policy will result in disciplinary action against me ranging from verbal counseling to termination.

Employee Signature

Date

Mother Earth Healthcare Services Inc

EMPLOYEE TB SYMPTOM SURVEY

Date: _____

Annual Update: Y or N

Employee/Contractor Name: _____

Address: _____

City, State, & Zip: _____

Phone Number: _____

Date of Birth: _____ Social Security No: _____

(PARENTAL CONSENT IS REQUIRED FOR ALL PERSONS UNDER 18 YEARS OF AGE)

The purpose of the PPD (Purified Protein Derivative) Intradermal Skin Test is to aid in the detection and diagnosis of Tuberculosis or the Exposure to Tuberculosis.

PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS

- | | | |
|---|-----|----|
| 1. Have you ever had the disease Tuberculosis (TB)? | YES | NO |
| 2. Have you ever had a positive reaction to a TB skin test? | YES | NO |
| 3. Have you ever had an allergic reaction to a TB skin test? | YES | NO |
| 4. Have you ever been immunized against TB with BCG or other? | YES | NO |
| 5. Have you ever received any of the medications used in the treatment of TB? | YES | NO |
| 6. Have you taken steroids during the last 4 weeks? | YES | NO |
| 7. Have you had a viral infection during the last 4 weeks? | YES | NO |
| 8. Have you had any type of vaccine during the last 4 weeks? | YES | NO |
| 9. Are you pregnant? | YES | NO |
| | YES | NO |

Circle YES or NO to any of the following symptoms you have had persistently:

Productive Cough	YES	NO
Weight Loss	YES	NO
Lethargy	YES	NO
Night Sweats	YES	NO
Coughing Up Blood	YES	NO
Loss of Appetite	YES	NO
Weakness	YES	NO
Fever	YES	NO

[] To the best of my knowledge, the above answers are true.

This skin test will not be valid until the results are reported to and recorded in the employee personnel file. All employee health records are kept confidential.

Employee signature: _____

Date: _____

Mother Earth Healthcare Services Inc

HHA MISCONDUCT REGISTRY AND EMR VERIFICATION FORM

Name: _____ Date of Hire: _____

SS #: _____ Certificate #: _____

For Office Use Only

Reported/Verified Certificate #: _____

Certificate Active? YES NO

EMPLOYEE MISCONDUCT STATUS:

HHA in Good Standing? YES NO

Name found on Misconduct Registry? YES NO

Abuse, Neglected or Exploited a Client or Customer? YES NO

Misappropriated a Client or Customer's Property? YES NO

Verified by:		Date Verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	

Mother Earth Healthcare Services Inc

EMPLOYEE REFERENCE CHECK

TO:

Company: _____

ATTN: _____

TITLE: _____

PHONE: _____

FAX: _____

FROM:

Mother Earth Healthcare Services Inc

9821 Summerwood Circle #1701

Dallas, TX 75243

Rene Andoh

Administrator

469-349-9828

TO BE FILLED OUT BY APPLICANT:

I have made application for employment with the above listed employer. I hereby request and authorize you to furnish the above listed employer with any information concerning my employment record, character, habits and ability. I do hereby release the addressed entity and individuals concerned from any claims, suits and liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the giving of such information.

Name while employed: _____

Social Security No: _____

Dates of Employment: _____ to _____

Hire Position: _____ Dept.: _____

Salary: \$ _____ Immediate Supervisor: _____

End Position: _____ Dept. _____

Salary: \$ _____ Immediate Supervisor: _____

Signature: _____

TO BE FILLED OUT BY PREVIOUS EMPLOYER:

Was the applicant employed by your company? YES NO

Is all the information stated above correct? YES NO

If not, what is correct? _____

What were the applicant's responsibilities? _____

Please rate the applicant's performance in the following areas:

PTHC0709

Mother Earth Healthcare Services Inc

REFERENCE REQUEST

Date: _____

Check method of gathering referenced data: [] Verbal [] Mail

Name of person giving reference: _____

Facility: _____

The individual named below is applying for a position as: _____
and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance: _____
Name of Company Representative

Applicant Release

Applicant: _____
Last First Middle Maiden

Position Held: _____

SSN#: _____ Dates Employed: From _____ to _____

I hereby release from all liability the company or person completing this form and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

Applicant Signature _____ Date _____

1) Please confirm the applicant's employment. From _____ to _____

2) Please comment on the applicant's attributes using the following scale:
4=Excellent 3=Good 2=Fair 1=Poor N/A= Not applicable

Quality of work:	_____	Cooperation:	_____
Knowledge & Skills:	_____	Competence:	_____
Reliability & Attendance:	_____	Supervisory ability & capacity:	_____
		Grooming:	_____

3) Please indicate specialty areas in which applicant has had experience: _____

4) Please indicate any special considerations necessary when giving assignments to this individual: _____

5) Is applicant eligible for rehire? [] Yes [] No If, No, why not? _____

Please attach additional Comments.

PTHC0709 Signature _____

Position/Title _____

Date _____

Mother Earth Healthcare Services Inc

PERSONAL CARE ATTENDANT TEST

1. **When the blood circulation of elderly personal generally improves when their:**
 - A. Clothing is kept clean
 - B. Liquid intake is increased
 - C. Room temperature is kept around 70 degrees F
 - D. Activity is increased

2. **A normal axillary (under the arm) temperature is?**
 - A. 92
 - B. 91
 - C. 97.6
 - D. 105

3. **The universal sign of choking is:**
 - A. Jumping
 - B. Sneezing
 - C. Doing nothing
 - D. Hands at throat

4. **The loss of fatty tissue is a normal part of the aging process that makes the elderly more likely to develop which of the following conditions:**
 - A. Pressure ulcers
 - B. Fractured hips
 - C. Skin cancers
 - D. Constipation
 - E. All of the Above

5. **In giving foot care to a patient who has Diabetes Mellitus, the nursing assistant should NOT take which of these actions?**
 - A. Clean the toenails
 - B. Cut the toenails
 - C. Soak the patient's feet for 5 minutes in a warm basin of water
 - D. Put lotion on the patient's feet after drying them

6. **The Nursing assistant finds Mr. Rose sitting up in bed and vomiting bright red blood into an emesis basi
Which of these actions should the nursing assistant take FIRST?**
 - A. Elevate the head and knee rest of Mr. Rose's bed
 - B. Stay with Mr. Rose and call for help
 - C. Go to the desk and ask for the nurse in charge to call mr. Rose's doctor
 - D. Remove the emesis basin from Mr. Rose's view and empty it

7. **Person with Parkinson's Disease frequently do not eat as much food as they need to maintain their weight at a normal level because:**
 - A. They have difficult in chewing and swallowing
 - B. They have no sense of smell or taste
 - C. They have no appetite
 - D. They are unaware of the importance of maintaining their weight, and are looking for ways to attract attention

8. **A patient is near death and does not respond to verbal request. The patient is incontinent of urine and feces. When providing the care of this patient, the nursing assistant should assume that the patient:**
 - A. Has no pain
 - B. Will not be aware of being touched
 - C. Can hear
 - D. Would prefer that the room be darkened

9. **Skin care is provided to patients to increase circulation**
A. TRUE
B. FALSE
10. **Soft restraints are only recommended for children**
A. TRUE
B. FALSE
11. **Standard precautions are not necessary unless a patient has HIV**
A. TRUE
B. FALSE
12. **If a patient in on fluid I & O, solid stool is also measure for output.**
A. TRUE
B. FALSE
13. **In CPR, ambu-bag ventilations are more effective than mouth-to-mouth.**
A. TRUE
B. FALSE
14. **While giving a bed bath to a patient with a Nasogastric (NG) tube, the tape should be replaced daily with new adhesive tape.**
A. TRUE
B. FALSE
15. **A patient with a colostomy drainable pouch should have their appliance changed daily for proper skin ca**
A. TRUE
B. FALSE
16. **A normal blood pressure is 120/80**
A. TRUE
B. FALSE
17. **The second set in CPR is to check for pulse.**
A. TRUE
B. FALSE
18. **To log roll a patient means to roll them as a unit, keeping their back in a straight line.**
A. TRUE
B. FALSE
19. **When performing two-man CPR, the compressor usually calls for the change.**
A. TRUE
B. FALSE
20. **When performing two-man CPR, the compressor usually calls for the change.**
A. TRUE
B. FALSE
21. **An overhead bar and trapeze is frequently used with recovering stroke patients.**
A. TRUE
B. FALSE
22. **While performing one man CPR on an adult, the compression to ventilation ratio is 10:2.**
A. TRUE
B. FALSE

23. Hand washing is the first line of defense in controlling infection.
- A. TRUE
 - B. FALSE
24. When lifting a heavy object, you should always bend from the waist, keeping your knees locked.
- A. TRUE
 - B. FALSE
25. The purpose of the Heimlich maneuver is to induce a bowel movement.
- A. TRUE
 - B. FALSE
26. If a patient stops breathing, you should immediately call for help, stay with the patient, and start CPR.
- A. TRUE
 - B. FALSE
27. Following surgery, patients are able to ambulate to avoid blood clots in their legs which could lead to a clot in their lungs.
- A. TRUE
 - B. FALSE
28. Patient on oxygen and being transported to X-Ray, may be transported without oxygen as long as oxygen is immediately hooked up upon arrival the X-ray department.
- A. TRUE
 - B. FALSE
29. A pulse rate of 60 to 100 is considered normal for an adult
- A. TRUE
 - B. FALSE
30. According to standard precautions, soiled linen should be placed in a red plastic bag marked isolation.
- A. TRUE
 - B. FALSE
31. Emesis is included in the calculation of fluid I & O
- A. TRUE
 - B. FALSE
32. Normal respirations for an adult are 30-45 breath per minute.
- A. TRUE
 - B. FALSE
33. A patient on berets for a period of time frequently will be dizzy when first ambulating.
- A. TRUE
 - B. FALSE
34. When ambulating a patient with a foley catheter, the drainage bag should always be secured above the level of the bladder.
- A. TRUE
 - B. FALSE
35. Alzheimer's patients frequently have difficulty sleeping during the night.
- A. TRUE
 - B. FALSE
36. The Hoyer lift is not a safe method to move a patient from bed to a chair.
- A. TRUE
 - B. FALSE

37. There are numerous types of restrains, chemical, environmental and physical.

A. TRUE

B. FALSE

38. A paraplegic patient can be taught to transfer themselves from the bed to a chair with the aid of a transfer board.

A. TRUE

B. FALSE

39. In figuring calculations one ounce is 45cc's

A. TRUE

B. FALSE

Name:

Date:

SCORE:

Mother Earth Healthcare Services Inc

ATTENDANT ORIENTATION CHECKLIST

The following orientation will be used for all full-time, part-time & per-diem workers.

I	Introduction	DATE	INITIALS
	About the Agency	_____	_____
	What Attendants Do	_____	_____
	Organizational Structure/ Who you report to	_____	_____
	Communication	_____	_____
	Confidentiality / HIPAA	_____	_____
	Emergency Preparedness	_____	_____
II	Exposure Control/Standard Precautions		
	Standard Precautions/OSHA/ Hazardous Waste/Infection Control/HIV		
	Hand Washing	_____	_____
	Safety	_____	_____
III	Human Resource Policies		
	Dress Code	_____	_____
	Evaluation Policy	_____	_____
	TB (according to agency policy)	_____	_____
	Hepatitis Consent/Declination	_____	_____
	On The Job Injury	_____	_____
	Pay Schedule	_____	_____
	Employee Illness	_____	_____
	Inclement Weather	_____	_____
	Progressive Discipline Policy	_____	_____
	Employee Grievance Procedure	_____	_____
	Non-Discrimination Policy	_____	_____
	Illegal Remuneration	_____	_____
	Fraud and Abuse	_____	_____
	Abuse, Neglect and Exploitation	_____	_____
IV	Attendants		
	Situations Attendants must report to Supervisor	_____	_____
V	General Policies and Procedures		
	Client Supplies	_____	_____
	Agency Paperwork	_____	_____
	Schedules/Timeframes	_____	_____
	Out-of-Hospital DNR/Advanced Directives	_____	_____
	Client Rights, Rights of the Elderly	_____	_____

Employee Signature

Date

Employee Printed Name

Human Resource Director Name/Signature & Date