

RP HOME CARE PERSONNEL APPLICATION

Personnel Category: ()RN ()LPN ()C.N.A. ()HHA ()PT ()OT ()ST ()ECE/SI Other: _____

Name: _____ () Female () Male

Address: Street: _____ **City:** _____ **Zip:** _____
Are you 16 years of age or older? Yes No **Social Security #:** _____-_____-_____

Telephone #: () _____ **Alternate #:** () _____ **Cell #:** () _____

E-mail Address: _____

Emergency Contact Name: _____ **Relationship:** _____
Day Phone #: () _____ **Evening Phone #:** () _____

Referred By: _____

HAVE YOU EVER BEEN CONVICTED OF ANY LAW VIOLATION OTHER THAN A MINOR TRAFFIC VIOLATION? () YES () NO If yes, Please explain: _____

I attest that I have *never* been convicted of any law violation other than a minor traffic violation. In addition, I have never been, nor am I currently involved in, any illegal proceedings involving any form of abuse/offenses. I understand I am required to have a Child Abuse Clearance, Adult Abuse Clearance (Delaware), Criminal History Check and FBI check when indicated. All clearances must be received by RP Home Care within 30 days of my hire. I understand that if any records received contradict the statement above, it may result in termination of employment or contractual relationship.

Has your license ever been revoked, suspended, limited or not renewed or your clinical privileges at any institution ever been revoked, suspended, reduced, limited, voluntarily surrendered or not renewed?

() Yes () No () N/A

Have any liability suits or claims ever been filed against you? () Yes () No () N/A

Are you presently employed? () Yes () No

EDUCATION	SCHOOL NAME/LOCATION	# YEARS ATTENDED	DID YOU GRADUATE?	MAJOR
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORESPONDENCE SCHOOL				

License/Certifications: RN LPN C.N.A PT OT ST ECE/SI MSW Other: _____

Number: _____ **State:** _____ **Number:** _____ **State:** _____
Number: _____ **State:** _____ **Number:** _____ **State:** _____

RNs, LPNs, Therapists ___I am CPR certified. Expir. Date: _____ ___I will become CPR certified within 45 days of hire.

Foreign Languages: – Please List: _____

WORK HISTORY: List last three positions, most recent first.

DATES (MONTH/YEAR) FROM: _____ TO: _____	COMPANY NAME/ADDRESS	POSITION/TITLE	SALARY/EARNINGS
SUPERVISOR NAME:		TELEPHONE #:	REASON FOR LEAVING:
DATES (MONTH/YEAR) FROM: _____ TO: _____	COMPANY NAME/ADDRESS	POSITION/TITLE	SALARY/EARNINGS
SUPERVISOR NAME:		TELEPHONE #:	REASON FOR LEAVING:
DATES (MONTH/YEAR) FROM: _____ TO: _____	COMPANY NAME/ADDRESS	POSITION/TITLE	SALARY/EARNINGS
SUPERVISOR NAME:		TELEPHONE #:	REASON FOR LEAVING:

PROFESSIONAL REFERENCES

NAME:	ADDRESS:	TELEPHONE #:	YRS. EMPLOYED

HEALTH INSURANCE: ELIGIBLE EMPLOYEES ONLY

As an employer, we offer health insurance to all employees who work at least **TWENTY HOURS OR TEN VISITS PER WEEK WITHIN 45 DAYS FROM THE START OF EMPLOYMENT** or the employee must wait until the next open enrollment period (open enrollment is August for coverage in September).

- I am interested in receiving information for health insurance.
- I am not interested in health insurance at this time.

HEPATITIS B VACCINE: EMPLOYEES ONLY

___ **ACCEPTANCE:** I choose to receive the Hepatitis B vaccine at this time. I understand I will not be charged for the vaccine.

Signature: _____ Date: _____

___ **DECLINATION:** I choose to decline the Hepatitis B vaccine because I have previously received the vaccine or have chosen to not receive the vaccine. 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.), a serious disease. If I choose to accept the vaccine in the future, I understand that, as a RP Home Care employee or contractor, I can receive the vaccination at no charge.

Signature: _____ Date: _____

___ **INSERVICE:** I have received Hepatitis B information and know I can contact the office at any time with questions or to request personal protective equipment.

SKILLS/EXPERIENCE CHECKLISTS: CHECK ALL THAT APPLY

RNs/LPNs	Adult	Peds	Newborn	STORK WATCH RNs	No Exp.	Some	Extensive
TRACH CARE (TEST REQUIRED)				Use of fetal stethoscope			
VENTILATOR CARE (TEST REQUIRED)				Use of fetal doppler			
BOWEL/BLADDER TRAINING				Perform non-stress test and evaluate fetal strip			
CENTRAL LINE CARE				Determine uterine fundal height: antenatal			
IV SITE CARE				Determine uterine fundal height: postpartum			
VENIPUNCTURES				Teaching fetal kick counts.			
PULSE OXIMETER				Teach uterine self palp			
RESP/INHALATION TREATMENT				Gestational Diabetes Clients			
DIABETIC TEACHING				Pregnancy Induced Hypert. Clients			
PEDIATRICS (TEST REQUIRED)				Pre-Term Labor Clients			
HHAs/CNAs	Adult	Peds	Newborn				
TRANSFER BOARD () HOYER LIFT ()				Apnea Monitoring			
FOLEY CATHETER CARE				Infant with Reflux			
COLOSTOMY CARE				Assist with breast feeding			
FEEDING TUBE CARE				Baby-Heel sticks for labs			
VITAL SIGNS				Neonatal phototherapy			
CHILD CARE				Synagis			
NEWBORN CARE							
PT	Adult	Peds	Newborn	OT	Adult	Peds	Newborn
DEVELOPMENTAL DELAY				DEVELOPMENTAL DELAY			
GROSS MOTOR ASSESSMENT				FINE MOTOR ASSESSMENT			
FUNCTIONAL ASSESSMENT				FUNCTIONAL ASSESSMENT			
ASSIST. DEV./POSITION EQUIP.				SENSORY INTEGRATION			
ROM (PROM, AROM, AAROM)				SSIST. DEV./POSITION EQUIP.			
MUSCLE RE-EDUCATION/TONE				ROM (PROM, AROM, AAROM)			
GAIT TRAINING: 2 POINT				MUSCLE RE-EDUCATION/TONE			
3 POINT				ADL TRAINING			
4 POINT				SPLINTING			
TRANSFER: STAND PIVOT				TRANSFERS: STAND PIVOT			
SLIDE BOARD				SLIDE BOARD			
HOYER LIFT				HOYER LIFT			
BED MOBILITY/POSITIONING				BED MOBILITY/POSITIONING			
CHEST PERCUSSION/VIBRATION				FEEDING PROGRAMS			
ST	Adult	Peds	Newborn	ECE/SI	Adult	Peds	Newborn
DEVELOPMENTAL DELA				DEVELOPMENTAL DELAY			
DYSPHAGIA/FEEDING				COGNITION			
DYSARTHRIA				RECE/SIPTIVE LANGUAGE			
VOICE/FLUENCY				EXPRESSIVE LANGUAGE			
COGNITION				SOCIAL/EMOTIONAL SKILLS			
RECEPTIVE LANGUAGE				HANNAN TRAINING			
EXPRESSIVE LANGUAGE				INFANT MASSAGE			
NUTRITIONIST				MEDICAL SOCIAL WORK			
CALORIC INTAKE				SOCIAL HISTORY			
FLUID INTAKE				NEEDS ASSESSMENT			
24 HOUR RECALL				RESOURCE ASSESSMENT			
PROTEIN REQUIREMENTS							
TRAINING/EDUCATION							

WORK PREFERENCES

() Full Time () Part Time () Per Diem () Contract Hours Per Week Desired: _____ Travel Time to Work: _____

() Visits () Shifts __Days __Evenings __Nights Days Available: _____

() Public Transportation: () Car Desired Geographical Areas: _____

CHECK/VOUCHER DESIGNATION: EMPLOYEES ONLY

You may have your paycheck or direct deposit voucher mailed to your home or retained in the office for pick-up. Indicate your preference by completing the following section. Please note that the Request for Direct Deposit form must be completed and returned before a voucher can be issued/distributed.

I wish to have my paycheck/direct deposit voucher: () MAILED TO MY HOME ADDRESS
 () PICKED-UP AT THE ___ SPRING HOUSE OFFICE ___ NEWCASTLE OFFICE

If I am unable to pick up my paycheck/direct deposit voucher, I authorize it to be released to: _____

RELATIONSHIP: _____ (PROPER ID MUST BE PRESENTED AT THE TIME OF CHECK RELEASE)

SUBMIT ALL CHANGES IN WRITING. ALLOW AT LEAST ONE PAYROLL CYCLE (2 WEEKS) FOR CHANGES.

I certify that I have read and understand all information on this application and will comply with the terms indicated. In addition, I hereby certify that the information I have provided on this application is accurate and true. Any discrepancies will serve as cause to discontinue employment/contract consideration and/or termination. I authorize RP Home Care to obtain and/or verify any information provided.

Signature: _____ **Date:** _____

Employees Only (Not applicable for Independent Contractors): During or after my employment with RP Home Care, I agree not to engage in any activity or relationship that would not be in the best interest of RP Home Care or to take any action that would jeopardize the confidentiality of RP Home Care information, either verbal or written.

Specifically, I agree to the following:

1. If I orient to a case or facility assignment for RP Home Care and decline the assignment, I will maintain confidentiality of the client's information and will not work for that client for another agency for a minimum of 90 days.
2. I will not work for or with any client introduced to me through RP Home Care for a period of at least (6) six months after my leaving RP Home Care. In addition, I will not accept employment with a RP Home Care client or former client for the same period of (6) six months if they change services to another agency or provider.

Signature: _____ **Date:** _____

DO NOT WRITE BELOW THIS LINE: OFFICE USE ONLY

File check list

Job Description		Child Abuse Check
Resume		Adult Abuse Check
Bachelor's Degree		Criminal History Check/FBI
License (CNA or Professional)		Physical ___ Drug Screen
License Confirmation		Mantoux 1 ST ___ 2 ND ___ Chest Xray
References/Service Letters		CPR Card
HIPAA Agreement		First Aid
Certificate of Insurance		Inservices (Bloodborne Pathogens, Fire Safety, Client Rights, Pain, HIPAA)
Handbook/Orientation Acknowledgement		Workers Comp Acknowledgement
I-9 Form		Tests: Standard Trach Vent Peds OB/SW Psych
W-4 Form		Bonus Form
Direct Deposit Form		

INTERVIEW REPORT	1 = Exceeds Expectations	2 = Meets Expectations	3 = Needs Assistance	4 = Below Expectations	NA
Professional Appearance					
Communication Skills					
Attitude					
Confidentiality/Client Rights					
Timeliness					
Care Coordination					
Documentation					

WOULD YOU HIRE/OFFER A CONTRACT FOR THIS APPLICANT? ___ Yes ___ No

Signature

Date

RP HOME CARE REFERENCE REQUEST

1

Applicant: Please fill out the top of the form (2) two references required upon being hired.

Reference: Please fill out the rest of the form & either fax to 215-540-0756 or mail back to us at:
RP Home Care, P.O. Box 906 Spring House, PA 19477.

*******APPLICANT TO COMPLETE*******

Applicant please complete name signature, social security #, position, and date ONLY!

PRINT NAME: _____ Social Security #: _____
 Signature: _____ Position Applied for: _____
 Maiden Name: _____ Date Signed: _____

**I hereby give permission for you to release employment information requested below to
RP Home Care.**

***** **INDIVIDUAL PROVIDING REFERENCE TO COMPLETE** *****

Info. Given by: _____ Phone Number: _____
 Relationship to Applicant: Employer/Supervisor Co-Worker Personal Reference

Company Name: _____ City: _____ State: _____

Known or employed from _____ to _____. Position/Capacity: _____

Is this information correct? YES NO If "NO", give correct dates: From: _____ To _____

Is it your company's policy to verify dates only? YES NO

Ages of patients cared for: Geriatric Adult Pediatric Newborn

Specialty Care or Units Worked: _____

Would you re-hire this employee? YES NO If no, give a reason _____

Please rate the applicant on the following characteristics.	1 = Excellent/Exceeds Expectations	2 = Good/Meets Expectations	3 = Below Average /Needs Assistance	4 = Poor/ Below Expectations	NA or Unable to Evaluate
Professional Appearance					
Communication Skills					
Attitude					
Confidentiality/Client Rights					
Timeliness					
Care Coordination					
Documentation: Timeliness					
Documentation: Quality					

Additional Comments:

For faxed/mailed references, please sign and date below:

Reference Signature: _____

Reference Phone Number: _____

Date: _____

RP Representative: _____ Date: _____

RP HOME CARE REFERENCE REQUEST

2

Applicant: Please fill out the top of the form (2) two references required upon being hired.

Reference: Please fill out the rest of the form & either fax to 215-540-0756 or mail back to us at:
 RP Home Care, P.O. Box 906 Spring House, PA 19477.

*******APPLICANT TO COMPLETE*******

Applicant please complete name signature, social security #, position, and date ONLY!

PRINT NAME: _____ Social Security #: _____
 Signature: _____ Position Applied for: _____
 Maiden Name: _____ Date Signed: _____

**I hereby give permission for you to release employment information requested below to
 RP Home Care.**

***** **INDIVIDUAL PROVIDING REFERENCE TO COMPLETE** *****

Info. Given by: _____ Phone Number: _____
 Relationship to Applicant: ___Employer/Supervisor ___Co-Worker ___Personal Reference

Company Name: _____ City: _____ State: _____

Known or employed from _____ to _____. Position/Capacity: _____

Is this information correct? ___YES ___NO If "NO", give correct dates: From: _____ To _____

Is it your company's policy to verify dates only? ___YES ___NO

Ages of patients cared for: ___Geriatric ___Adult ___Pediatric ___Newborn

Specialty Care or Units Worked: _____

Would you re-hire this employee? ___YES ___NO If no, give a reason _____

Please rate the applicant on the following characteristics.	1 = Excellent/Exceeds Expectations	2 = Good/Meets Expectations	3 = Below Average /Needs Assistance	4 = Poor/ Below Expectations	NA or Unable to Evaluate
Professional Appearance					
Communication Skills					
Attitude					
Confidentiality/Client Rights					
Timeliness					
Care Coordination					
Documentation: Timeliness					
Documentation: Quality					

Additional Comments:

For faxed/mailed references, please sign and date below:

Reference Signature: _____

Reference Phone Number: _____

Date: _____

RP Representative: _____ Date: _____



□ PO Box 906
 Spring House, PA 19477
 Phone: 215-643-1200
 800-355-1076
 Fax: 215-540-0756

□ 908 B New Churchman's
 Rd Extension
 New Castle, DE 19720
 Phone: 302-323-1436
 866-323-1436
 Fax: 302-323-1481

Employee Name: _____ Position: _____

SS#: _____ Birth Date: _____

PHYSICAL EXAMINATION

Essential findings deviating from normal and/or diagnosis being treated for:

Recommendations and suggestions regarding course of action or treatment:

TEST RESULTS

The 2-Step Mantoux is necessary for new employees. Both tests must be administered within one year of each other and minimally one week apart.

TEST	DATE ADMINISTERED	DATES READ	RESULTS	MM
2-STEP MANTOUX: TUBERCULIN/SKIN TEST	1.			
	2.			
CHEST X-RAY (IF SKIN TEST POSITIVE)				
SEROLOGY (IF INDICATED)				
ADDITIONAL LAB REPORTS:				

IMMUNIZATION STATUS

IMMUNIZATION	RESULTS	DATES
TETANUS		
DPT/SMALL POX		

COMMUNICABLE DISEASES

The above named person is considered free from communicable diseases. [] YES [] NO

Comments: _____

PHYSICAL STATUS/RESTRICTIONS:

Task	Restriction
Weight Restriction: Lifting	
Bending	
Standing	
Other:	

COMMENTS: _____

I confirm that the above named person [] has the above stated restrictions [] has no restrictions.

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN LICENSE#: _____ TELEPHONE #: _____