Attentive Home Health, Inc.

EMPLOYEE CHECKLIST

- ☐ Completed application
- ☐ Completed I-9 Form
- ☐ Copy of Professional license
- ☐ Resume
- ☐ Copy of Driver license
- ☐ Copy of Auto insurance
- ☐ Copy of Liability insurance
- ☐ CPR card
- ☐ Physical exam
- ☐ TB (PPD) results
- ☐ Signed employment background check requirement

Attentive Home Health Inc.

19634 Ventura Blvd Ste 111 Tarzana CA 91356
Phone: (818) 696-5011

EMPLOYMENT APPLICATION

Name: _____ Social Security Number _____

Other Names Used in Employment: _____

Address: _____

Email Address: _____

Home Phone: _____ Business Phone: _____

Position Applied for: _____

License/ Certification Number: _____ Expiration Date: _____

Driver's License Number: _____ Expiration Date: _____

To qualify for employment, you must be either (a) a citizen of the United States of America, or (b) a registered alien with government permission to work in this country. Does either statement (a) or (b) describe your status as a resident of this country? ☐ Yes ☐ No

Have you ever been fired or asked to resign? ☐ Yes ☐ No

Have you ever been convicted, fined (excluding minor traffic offenses), placed on probation, or given a suspended sentence in any court? ☐ Yes ☐ No (If "Yes" to question 11, please attach explanation)

EDUCATION

Name and address of Colleges or School Attended	Dates Attended	Major Subject or Course	Degree or Certificate Received
	From		
	To		
	From		
	To		
	From		
	To		
	From		
	To		
	From		
	To		
	From		
	To		

JOB EXPERIENCE

Job Title	Employer and Address	Duration of Work	Job Responsibilities	Reason for Leaving
		From To		
		From To		
		From To		
		From To		
		From To		

May we contact your former employer(s) for references? ☐ Yes ☐ No

Can we conduct a Criminal Background Check on you? ☐ Yes ☐ No

Please note that this agency is an equal opportunity employer and that this agency does not discriminate on the basis of sex, race, ethnicity color, or creed,

Certification of the applicant:
I certify that all statements made in this application are true and complete to the best of my knowledge. I understand that any false statement of material facts or omissions may be subject to my disqualification or dismissal.

Signature: _____ Date: _____

ATTENTIVE HOME HEALTH, INC

Disclosure and Authorization for Background Investigation

PURSUANT TO CALIFORNIA LAW

Attentive Home Health, the Company/Agency, intends to obtain information about you from an investigative consumer reporting agency ("ICRA") and/or consumer credit reporting agency for employment purposes. Such reports may include information about your character, general reputation, personal characteristics, and mode of living. The Company may also investigate information contained in the report and may also obtain criminal record report(s), work history, court records, driving record, or other information about you. The source of any investigative consumer report/credit report (as that term is defined under California Law) will be, **CLEARSTAR** (clearstar.net). The company agrees to provide you with a copy of an investigative consumer report when required to do so under California law. California civil code section 1786.22 you are entitled to find out from the ICRA what is in their file about you.

I hereby authorize Attentive Home Health, and/or any entity directed by the Agency, prior to or at any time after my employment, to obtain information about me from the above ICRA.

I hereby authorize all previous employers, educational institutions, consumer reporting agencies, and other persons or entities having information about me to provide such information to ATTENTIVE HOME HEALTH, INC. or other entities that obtain information for ATTENTIVE HOME HEALTH, INC. I further fully release ATTENTIVE HOME HEALTH, INC., it's employees, officers, directors, agents, successors, and all other parties involved in the investigation, from any claim or action for any liability whatsoever related to the process or results of this background/reference investigation.

I understand results of my background check may be used in determining whether to make me an offer of employment and other employment decisions, and that the Disclosure Authorization is not an offer for employment by the Agency or a contract with the Agency. I further understand that no representative of the Agency other than the CEO has the authority to enter into any agreement for employment for any specified period of time, or alter the Agency's At Will Employment Policy.

Applicant Signature: _____ Date: _____

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____ DOB: _____

DL# (STATE): _____

PRESENT ADDRESS:_____

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TUBERCULOSIS SKIN TEST (TST) SCREENING

REASON:

☐ New Hire ☐ 1st Step ☐ 2nd Step
☐ Annual
☐ TB Exposure

Last Name_____ First_____ MI____ Birth date____/____/____ Emp ID _____

Dept_____ Position_____ Work #_____ Home #_____

Address_____ City_____ State_____ Zip Code_____

Have you ever had a positive TST? ☐ YES ☐ NO if yes, when?_____

Have you received a live vaccine within the past 30 days? ☐ YES ☐ NO
if yes, what vaccine? ☐ Measles, Mumps, Rubella (MMR) ☐ Varicella (Chickenpox)) ☐ Other_____

Are you immune compromised or are you taking any immunosuppressant medications? ☐ YES ☐ NO

Do you <u>currently</u> have any of the following <u>chronic</u> conditions?

YES / NO		YES / NO		YES / NO	
☐	☐ Chronic cough (>3 weeks)	☐	☐ Cough up sputum or blood	☐	☐ Poor appetite
☐	☐ Chronic fatigue (>3 weeks)	☐	☐ Shortness of breath	☐	☐ Recurrent infections
☐	☐ Chronic chest discomfort	☐	☐ Unexpected weight loss		
☐	☐ Persistent low grade fever	☐	☐ Night Sweats (excluding menopause)		

Annual TST is performed to meet DHEC, OSHA, and JCAHO requirements.

- It is **<u>YOUR</u>** responsibility to have your TST read by a licensed physician (MD, DO) within 48-72 hrs and return this completed document to Attentive Home Health. You may not read your own TST.
- Your TST may show **erythema** (flat redness) or **induration** (hardened. raised area). If your skin test shows **induration, it must be read by Employee Health Services.**

I have read and understand the above instructions. I also understand that I will be given one copy of this form free of charge; hereafter there will be a charge for copies. ***I understand that I am advised to keep a copy of this form to avoid future charges.***

Signature_____ **Date**_____

<u>LICENSED PERSONNEL PLEASE COMPLETE THIS SECTION</u> **Date**

PLACED: Date_____ _____AM / PM **LA / RA** **MFT/Lot #**_____ **Exp Date** _____

By (Print Name) _____ (Title)_____ (Signature)_____

(DO NOT cover injection site with band-aid or adhesive tape as some employees may have a reaction to the adhesive.)

READ: Date_____ **Time**_____AM / PM **Results** Induration mm Erythema _____mm

By (Print Name) _____ (Title)_____ (Signature)_____

☐ Copy given to Employee, Date_____

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EMPLOYEE HEALTH EXAMINATION

I have examined (Mr. / Ms.) _____ who is applying for the position of

_____

I have found no condition that appears to prevent _____ from performing the duties of the position applied for, with the exception or possible exception of the following:

_____

_____

I have found no indication of any condition which might represent a possible hazard to the health of the patients or other employees of this facility.

_____

EXAMINATION

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Family History: Any significant illness in the family? If so, please state the illness and relationship.

Family Members	Illness	Relationship

PPD Test	Date Administered	Date Read	Result: Erythema = _____ mm Induration = _____ mm ☐ Positive ☐ Negative

PHYSICAL EXAMINATION: Report of physician

Adenopathy _____
Reflexes _____
Eyes _____
Hearing _____
Nose _____
Throat _____
Tongue _____
Teeth _____
Abdomen _____
Rectal _____

Chest: Breath Sounds _____ Resonance _____

Heart: Size _____
Murmur _____
Rhythm _____
Arteries _____

MD Signature _____ Date: _____

MD Address _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP