

APPLICATION FOR EMPLOYMENT



99 Sunnyside Blvd.
Woodbury, NY 11797

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status.

Position(s) Applied For:	Date of Application
How Did You Learn About Us? Please specify. <ul style="list-style-type: none"> <input type="checkbox"/> Advertisement _____ <input type="checkbox"/> Employment Agency _____ <input type="checkbox"/> Relative/Friend _____ <input type="checkbox"/> Inquiry (with whom did you speak?) _____ <input type="checkbox"/> Other _____ 	

Last Name		First Name		Middle Initial	
Address	Number	Street	City	State	ZIP Code
Daytime Telephone Number		Evening Telephone Number		Cell Phone Number	

Please list your professional license number and its expiration date.

If you are under 18 years of age, can you provide required proof of your eligibility to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever filed an application with Hospice Care Network before? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been employed with Hospice Care Network before? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of your friends or relatives employed here? If yes, give name and relationship.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
May we contact your present employer? If no, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you legally able to become employed in this country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of a felony? If so, please indicate details below. (A felony conviction will not necessarily bar an applicant from employment).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date available for work?	What is your desired salary range?
Are you interested in Full-time, part-time, per visit, on-call, or temporary?	
Are you currently on 'lay-off' status and subject to recall?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employment with Hospice Care Network means that you may have to travel in accordance with the agency's needs. Will you be able to travel if needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

EDUCATION

School	Name of School	Address/Telephone Number of School	Course of Study	Years Completed	Diploma/Degree
High School					
Undergraduate College					
Graduate/Professional					
Other (please specify)					

WORK EXPERIENCE

Start with your present or last job. You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities or other protected status. **PLEASE FILL OUT COMPLETELY.**

Employer	Dates Employed		Work Performed
	From	To	
Address			
Telephone Number	Hourly Rate/Salary		
	Starting	Final	
Job Title			
Contact	May We Contact?		
	<input type="checkbox"/> Yes		
Reason for Leaving	<input type="checkbox"/> No		
Employer	Dates Employed		Work Performed
	From	To	
Address			
Telephone Number	Hourly Rate/Salary		
	Starting	Final	
Job Title			
Contact	May We Contact?		
	<input type="checkbox"/> Yes		
Reason for Leaving	<input type="checkbox"/> No		
Employer	Dates Employed		Work Performed
	From	To	
Address			
Telephone Number	Hourly Rate/Salary		
	Starting	Final	
Job Title			
Contact	May We Contact?		
	<input type="checkbox"/> Yes		
Reason for Leaving	<input type="checkbox"/> No		

Comments: Include explanation of any gaps in employment.

Describe any specialized training, apprenticeship, skills and extra-curricular activities, offices held, etc.

You may exclude membership that would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status

Describe any computer skills and/or job-related training.

Note to Applicant: DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB OR OCCUPATION FOR WHICH YOU ARE APPLYING.

Are you capable of performing in a reasonable manner, with or without reasonable accommodation, the activities involved in the job or occupation for which you have applied? ___Yes ___No

PERSONAL/PROFESSIONAL REFERENCES *Do not include family members.*

Name	Phone Number	Address	Occupation
1.			
2.			
3.			

APPLICANT’S STATEMENT

I certify that answers given herein are true and complete.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an “at will” nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this “at will” employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

Signature of Applicant _____

Date

Hospice Care Network

Dear Applicant:

Hospice Care Network is regulated by the New York State Department of Health and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Should you be qualified for a position with Hospice Care Network, upon completion of a background check you may be offered employment. Prior to beginning employment and/or orientation you be required to provide the following information:

ALL EMPLOYEES:

- ✓ Health Examination for Hospice Employees (to be completed by physician).
- ✓ Evidence of Rubella Antibody Titer test or Rubella Immunization (if non-immune).
- ✓ Evidence of 2 MMR (Measles, Mumps and Rubella) vaccinations, 30 days apart, if born on or after 1/1/57 or titer tests.
- ✓ PPD skin test for tuberculosis or chest x-ray (if PPD positive).
- ✓ Copy of degree/diploma appropriate to discipline (if required for position).

PATIENT CARE EMPLOYEES:

- ✓ Evidence of completed Hepatitis B Vaccine Series or declination.
- ✓ Photocopy of signed current professional license/registration or certification.

If employment is offered, you will receive a letter of confirmation and a memo listing the items to be provided to the Human Resources Department prior to your start date. It is also a condition of employment that all new employees complete the entire orientation program for their particular discipline.

We thank you in advance for your cooperation.

Hospice Care Network

Standard Expectations of Hospice Care Network Employees

Mission Statement

Our mission is to enable persons to live with peace and dignity in a caring environment during the final stages of life by offering care and comfort both to them and to those with whom they share their lives.

We develop and provide individualized programs of care and supportive services during dying, death and bereavement that enhance quality of life by addressing physical, emotional, spiritual and social needs.

Work Schedule

The interview, hiring and orientation process involves a large investment of time and is focused on an agreed upon work schedule. The job description is discussed during the interview process as well as the employee's availability. The prospective employee documents availability in writing. All employees may be expected to work holidays and weekends. Nursing staff may also be expected to cover on-call. Employment is contingent on the flexibility of one's schedule and the ability to meet the employee's original commitment and agency needs.

Work Area

The agency cares for patients in Queens, Nassau and Suffolk Counties. While the agency will try to assign work close to the employee's place of residence, assignments may change and the needs of the agency will always be considered. Employment is contingent on the staff's flexibility in being available to work in any area needed.

Orientation

The agency pays for orientation and expects full participation and timeliness. Employees must be available for the full week of orientation. Start dates are negotiable.

Dress

The agency services diverse populations in all areas. Clothing should send a neutral message that would not prevent any patient from being able to relate to you as a professional caregiver. Clothing should not be provocative. Excessive jewelry is discouraged. Clothing should be practical and not restrict activity required by patient care.

Print Name: _____

Signature: _____

Date: _____

Hospice Care Network

Applicant _____

Position applying for: _____ MD _____ RN _____ LPN

As part of the application process, we need to determine your level of competency with regard to the medical procedures and skills listed below. Thoughtfully indicate your level of competency and add any skill that may be omitted.

Thank you for your cooperation.

Skills Assessment

Skill/Specialty	No skill	Needs Review	Independent	Comments
Administration of rectal medication				
Biliary Dressing/T Tube Care				
<u>ALTERNATE FEEDING</u>				
Change/Insert NG tube				
Change Gastric Tube				
Tube feeding - bolus method				
Tube feeding – via pump				
<ul style="list-style-type: none"> • Kangaroo Pump 				
<ul style="list-style-type: none"> • Joey Pump (portable enteral pump) 				
Disimpaction (fecal)				
Flexiseal (rectal tube to drainage system)				
<u>URINARY DEVICES</u>				
Condom/Texas catheter				
Suprapubic Catheter Change				
Foley, Female insertion				
Foley, Male insertion				
Indiana Pouch (artificial bladder)				
Intermittent Bladder Irrigation				
<u>OTHER</u>				
Glucometer				
Hoyer Lift				
Intramuscular injections				
Infusion Pumps (Region Care):				
<ul style="list-style-type: none"> • Sigma 8000+ (used for TPN generally) 				
<ul style="list-style-type: none"> • CADD PRIZM (pain PCA) 				
<ul style="list-style-type: none"> • Curlin 4000 CMS 				
Infusion Pumps (Vital Care):				
<ul style="list-style-type: none"> • CADD PRIZM (5800) 				
<ul style="list-style-type: none"> • Sabratek 6060 				
<ul style="list-style-type: none"> • Baxter pump 				

NAME _____

<u>Skill/Specialty</u>	No skill	Needs Review	Independent	Comments
<u>ACCESS DEVICE</u>				
• Peripheral IV line insertion/care				
• Midline Care/dressing				
• Care of PICC/dressing				
• Care of Groshong device				
• Care of Hickman device				
• Implanted Port				
• Spinal Catheter Care				
Nephrostomy Care				
Oxygen administration - concentrator				
Oxygen administration - tank				
Oxygen administration – wall				
Oxygen administration-liquid				
Ostomy/Stoma care				
Pain management-equianalgesic dosing				
Pleurx Catheter				
Subcutaneous injections				
Suture/Staple Removal				
Suctioning via oral, yankauer				
Tracheostomy – inner cannula				
Tracheostomy – outer cannula				
Tracheostomy care/suctioning				
Use of a sliding Board				
Ventilator patient care				
<u>WOUND CARE</u>				
• General Wound Care				
• Wet to Dry				
Additional Procedures (specify)				

PRIOR CLINICAL EXPERIENCE: (Circle any that apply and indicate years of experience)

Pediatrics _____ ICU/ER _____ Med/Surg _____ IV _____

Home Care _____ Hospice _____

Other _____

Language(s) _____

Certification in/Certified by _____

Self-Identified Learning Needs _____

Interviewer: _____

(Signature/Title/Date)

APPLICANT INFORMATION VERIFICATION AND BACKGROUND CHECK AUTHORIZATION

APPLICANT'S NAME: _____
(Please Print)

This application form is intended for use in evaluating your qualifications for employment. This is not an employment contract. **It is important that you answer all questions completely and accurately.**

In connection with my application for employment, I understand that an investigative consumer report may be requested that will include information as to my character, work habits, performance, and experience, along with reasons for termination of past employment. I understand that as directed by HCN policy and consistent with the job described, HCN or its agent may request information from public and private sources about my driving record, court record, education, credentials, credit and references. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by HCN or its agent from a consumer-reporting agency. If so, I will be notified and given the name and address of the agency or the source which provided the information.

I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, reference or insurance company contacted by HCN or its agent to furnish the information described above and hereby release any said persons, schools, companies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information.

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purpose.

Please print your full name

Please print other names you have used

Home Address

City

State

ZIP Code

Social Security Number

Date of Birth

Sex: Male Female

Check all that apply. (See reverse for definitions.)

Ethnicity: Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.)

Race: White (not Hispanic or Latino)
 Black or African American (not Hispanic or Latino)
 Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)
 Asian (not Hispanic or Latino)
 American Indian or Alaskan Native (not Hispanic or Latino)
 Two or More Races (not Hispanic or Latino)

Driver's License Number

State Issuing License

Name as it appears on License

I certify that I have read and understood the Applicant Information Verification and Background Check Authorization form and that it will made part of this application for employment.

Signature

Today's Date

UPON COMPLETION OF THIS FORM, REMOVE FROM APPLICATION, FOLD, PLACE IN ENVELOPE AND PRINT YOUR NAME ON THE OUTSIDE, GIVE TO THE HUMAN RESOURCES DEPARTMENT.
Releasefor BkgdCk1006

DEFINITIONS:

In keeping with the Equal Employment Opportunity Commission (EEOC) and the Office of Federal Contract Compliance Programs (OFCCP) revisions effective for reporting year 10/1/06 through 9/30/07.

Ethnicity: Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Race: White (not Hispanic or Latino) – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Black or African American (not Hispanic or Latino) – A person having origins in any of the Black racial groups of Africa.

Native Hawaiian or Other Pacific Islander (not Hispanic or Latino) – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Asian (not Hispanic or Latino) – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

American Indian or Alaskan Native (not Hispanic or Latino) – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community recognition.

Two or more Races (not Hispanic or Latino) – All persons who identify with more than one of the above five races.