Dear Applicant,

We appreciate your interest in employment opportunities with our agency, Total Care Nursing Services. We have served the Greater Los Angeles Area, Orange County, Ventura County, Riverside County and San Bernardino as a home health provider for over 18 years, understanding fully, how important developing a superior nursing staff is to our continued success.

Attached below you will find the **Application Documents** for you to fill-up and sign. You can return the completed application and credentials to our offices personally, or remit it via mail, email, or fax. Our contact information is below:

Total Care Nursing Services
*Attn: Human Resources*
3450 Wilshire Blvd., Suite # 1003
Los Angeles, CA. 90010
Fax: (213) 380-4046
Email: azavela@tcnshha.org

Upon receipt, your application will be reviewed by the Human Resource Department and a brief orientation will be scheduled for you at our offices. We conduct a twice a month Saturday orientation and seats are limited. Our staff will contact you upon receipt of your application and an orientation will be scheduled according to the most recent date available. We appreciate the value of your time and will make every effort to expedite your application in a timely manner.

If you have any questions, or need additional clarification, please contact me at (213) 380-1399.
As always, we are looking forward to working with you.

Ann Margaret Zavela
Extended Care Division
Operations Manager

**TOTAL CARE NURSING SERVICES**
3450 Wilshire Blvd. Los Angeles, CA. 90010
Phone: (213) 380-1399 Fax: (213) 380-4046

## REQUIRED CREDENTIALS

**Please submit copies of the following credentials together with your application forms and documents.** Any missing documents may cause a delay of your application process and orientation schedule.

*According to our Policy # 8007, all clinical staff having direct contact with patients are required by law to maintain valid licensure, certification or registration. You will be notified in ample time for provision of required documents to ensure that you and the agency are in compliance with the state, federal and agency requirements.*

| Document | Expiration Date |
|---|---|
| Professional License (RN, LVN, PT, OT, ST) | |
| CPR Card | |
| Physical Exam / MD Certification (within 2 yrs.) | |
| Drivers License | |
| Auto Insurance | |
| TB / PPD (if positive chest x-ray is required) | |
| CXR if applicable (within 2 yrs.) | |
| Professional Liability Insurance | |
| Social Security Card | |

Thank you in advance for addressing these items. Should you have any questions or need further assistance, please call us in the office at (213) 380-1399. Your employment with the agency and cooperation is greatly appreciated.

Martha Garduño, RN
Director of Patient Care Services


EOE/AA

TOTAL CARE NURSING SERVICES
3450 Wilshire Blvd. Suite 1003
Los Angeles, CA 90010

Application for Employment

## Applicant Information

| | |
|---|---|
| Name: | Position: |
| Street Address: | Home Phone/ Fax: |
| City, State, Zip: | Cell Phone: |
| DOB: | Email: |
| In case of emergency, please notify: | Phone: |

| | | | |
|---|---|---|---|
| Classification: □ RN □ LP/VN □ CNA/CHHA | | | License # |
| State Issued: | Expiration Date: | For office use only<br>License received by: | |

If hired, what date and time will you be available to start work?

Please list any other languages you speak fluently:

Do you have any impairments; physical, mental, or medical which would prevent you from performing in a reasonable manner, the activities involved in the job for which you are applying? □ Yes □ No
If yes, please describe the impairments and explain any work limitations. _____
_____

Have you ever been convicted of a felony? □ Yes □ No
If yes, describe in full. _____
_____

How did you learn about Total Care Nursing Services?

Do you have a driver's license? □ Yes □ No If yes, Drivers License #_____

Do you have insurance? □ Yes □ No If yes, Company Name_____ Policy#:_____

## Education:

| | | | | |
|---|---|---|---|---|
| High School: | From | To | Graduated: Yes No | Degree |
| College: | From | To | Graduated: Yes No | Degree |
| Vocational School: | From | To | Graduated: Yes No | Degree |

**Experience:** List all employment, starting with the most recent.

| | |
|---|---|
| **Employer's Name and Address** | |
| Telephone: | Supervisor: |
| Date employed:<br>From: To: | Salary: |
| Position: | Reason for leaving: |
| Responsibilities: | |
| **Employer's Name and Address** | |
| Telephone: | Supervisor: |
| Date employed:<br>From: To: | Salary: |
| Position: | Reason for leaving: |
| Responsibilities: | |
| **Employer's Name and Address** | |
| Telephone: | Supervisor: |
| Date employed:<br>From: To: | Salary: |
| Position: | Reason for leaving: |
| Responsibilities: | |

**Specialized Skills**

□ Microsoft Word □ Mobile Texting □ Emailing □ Adobe □ Other, please list:_____

**References:** List people familiar with your work. (Exclude close friends and relatives)

| | |
|---|---|
| 1. | Telephone: |
| 2. | Telephone: |
| 3. | Telephone: |

I certify that this information is correct and acknowledge that this is accuracy is subject to verification by this agency. I understand that furnishing incorrect or misleading information will render this application void and will be just cause for termination.

Signature of Applicant:_____ Date:_____

Confidential

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# *Skills & Preferences Inventory*

Certification (check one)
___RN ___LPN ___LVN ___CNA Name_____ License #_____

The following information will help us place you where your skills, knowledge of nursing, and preferences will be best suited.

| **Skills** | **Circle One** | | | **Circle One** |
|---|---|---|---|---|
| Can you do vital signs? | Yes No | | Can you do neurological assessments? | Yes No |
| Can you do chart nurses' notes? | Yes No | | Can you give intramuscular medication? | Yes No |
| Can you do catheter care? | Yes No | | Can you give IV medications? | Yes No |
| Can you insert catheters? | Yes No | | Can you assess patients for admission? | Yes No |
| Can you start IV's? | Yes No | | Can you discharge patients? | Yes No |
| Can you suction patients? | Yes No | | Have you had CPR? If so when? | Yes No |
| Can you set up oxygen for patients? | Yes No | | Do you have intensive care experience? | Yes No |

In which of following areas have you had experience? (Check one)

☐ Med-surg ☐ OB/GYN ☐ Oncology ☐ Geriatric ☐ Emergency Room

Have you had any special training in nursing? If so, what? _____

_____

| **Preferences** | **Circle One** | | **Circle One** |
|---|---|---|---|
| Are you a licensed driver? | Yes No | Will you work shifts at a hospital? | Yes No |
| Will you travel 30 minutes one way? | Yes No | Will you work shifts at a nursing home? | Yes No |
| Will you work every other weekend? | Yes No | Will you work private duty cases? | Yes No |

Please rate your physical condition. (Check one)
☐ Excellent ☐ Good ☐ Fair

Circle the times you are available:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Day: | 8 - 5 | S | M | T | W | T | F | S |
| Evening: | 5 - 7 | S | M | T | W | T | F | S |
| Night: | 7 - 10 | S | M | T | W | T | F | S |

Do you have any handicaps? If so, please describe: _____

How many hours per week do wish to work? _____

# TOTAL CARE NURSING SERVICES

## CERTIFICATION

## ALL HEALTH CARE DELIVERY EMPLOYEES HIRES AFTER JANUARY 1, 1985
## CHILD ABUSE REPORTING

California law requires that employees hired as medical practitioners or non-medical practitioners after January 1, 1985 acknowledge that they understand the reporting requirements of Section 11166 of the California Penal Code.

*"Any person who is employed as a child care custodian, medical practitioner, non-medical practitioner, or employee of a child protective agency who has knowledge of or observes a child who has been abused or reasonably suspects has been the victim of child abuse 'is required to report' the known or suspected instance of child protective agency immediately or as soon as possible by telephone and to prepare and send a written report thereof within 36 hours if receiving the information concerning the incident."* [Section 11166 of the Penal Code]

Your department chief or supervisor should be notified whenever you believe you may required to report suspected child abuse.

I acknowledge that I have read and understand the provision of Section 11166 quoted above and will comply with its provisions.

Signature _____ Date _____

Print Name / Title _____

Facility / Department _____

# TOTAL CARE NURSING SERVICES

## DEPENDENT ADULT AND ELDERLY ABUSE REPORTING

California Law requires that employees hired as Medical Practitioners or Non-Medical Practitioners after January 1, 1985 acknowledge that they understand the requirements of Section 15630 of the California Penal Code.

*"Any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who in the scope of his or her employment, either has observed an incident that reasonably appears to be physical abuse, as observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred, or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse,* ***shall report the known or suspected instance of physical abuse*** *either to the long-term care ombudsman coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a long-term care facility, or to either the county adult protective services agency or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report thereof within 36 hours."* ***[Section 15630(a) of the Penal Code]***

Care "Custodians" means an administrator or an employee, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff of any of the following public or private facilities when the facilities provide care of elders or dependent adults.

1. Twenty-four hours health facilities, as defined in sections1250.2, and 1250.3 Of the Health and Safety Code.
2. Clinics.
3. Home Health Agencies.
4. Adult Day Health Care Centers.
5. Secondary Schools which serve 18-22 year old dependent adults and post secondary educational institutions which serve dependent adults or elders.
6. Sheltered Workshops.
7. Camps.
8. Community Care Facilities as defined by section1502 of the Health and Safety Code.
9. Respite Care Facilities.
10. Foster Homes.
11. Regional Centers for persons with developmental disabilities.
12. State Department of Social Services and State Department of health services Licensing Divisions.
13. County Welfare Departments.
14. Offices of Patient's Right Advocates.
15. Office of Long Term Care Ombudsman.
16. Offices of Public conservators and public guardians.
17. Any other protective or public assistance agency which provides health services to elders or dependent adults.

I acknowledge that I have read and understand the provision of Section 11166 quoted above and will comply with its provisions.

Signature _____ Date _____

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# EMPLOYEE HISTORY AND PHYSICAL

Name: _____ Date of Birth: _____ Sex: M__ F__ Date: _____

Address: _____

Job Classification: _____

History (Explain all Yes answers below)

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| __ | __ | Neurological | __ | __ | Vision | __ | __ | Ears/Hearing |
| __ | __ | Seizures | __ | __ | Heart | __ | __ | High Blood Pressure |
| __ | __ | Vascular | __ | __ | Respiratory | __ | __ | Asthma |
| __ | __ | Anemia | __ | __ | Skin Disorders | __ | __ | Hay Fever |
| __ | __ | Back Problems | __ | __ | Gout | __ | __ | Arthritis |
| __ | __ | T.B. | __ | __ | Jaundice/Liver Disorders | __ | __ | G.I. Disorders |
| __ | __ | Kidney/G.U. Disorders | __ | __ | Headaches (Severe - Frequent) | __ | __ | Thyroid Disorders |
| __ | __ | Diabetes | | | Other: _____ | | | |

Explain _____

_____

_____

ROUTINE MEDICATIONS

Taken:

Allergies:

Physical:

Vital Signs: Temp: Pulse: Resp: B/P:

| | No Problems | Other (Explain) |
|---|---|---|
| Heart: | | |
| Cardiac: | | |
| Resp: | | |
| Neuro: | | |
| G.I.: | | |
| G.U.: | | |
| Integumentary: | | |
| Endocrine: | | |
| Psycho/Social: | | |

Test PPD Date: _____ Dose: _____ Result: _____ Read By: _____

Chest X-Ray: Date: Result:

( If PPD is positive, it should be followed by a 35.36 cm x 43.18 chest X-Ray unless contraindicated)

I have examined the applicant and found him/her to be physically and mentally qualified to perform the duties to be assigned and the employee has no health condition that would create a hazard for patients.

Physician's Name: _____ M.D. Date: _____

Address: _____

# HEALTH QUESTIONNAIRE FOR POSITIVE TUBERCULOSIS SKIN TEST REACTIONS

Employee's Name: _____ Date: _____

Work Area: _____ DOB: _____

Date of Positive TB Test: _____

Treated with Tuberculosis Medication? ❑ Yes ❑ No

Duration of Treatment: _____

Medication(s) Used: _____

Have you ever received a BCG (Tuberculosis Vaccination)? ❑ Yes ❑ No

Have you been exposed to an isolated case of TB this year? ❑ Yes ❑ No

Do you have any of the following?

Chronic cough ❑ Yes ❑ No

With sputum ❑ Yes ❑ No

Color of sputum: _____

Persistent night sweats ❑ Yes ❑ No

Involuntary weight loss ❑ Yes ❑ No

Chronic fatigue ❑ Yes ❑ No

Any serious illness ❑ Yes ❑ No

If you answered "Yes" to any of the above, please explain: _____

_____

_____

Are you under medical treatment for any condition at this time? ❑ Yes ❑ No

If you answered "Yes", please explain: _____

_____

_____

Employee's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

TOTAL CARE NURSING SERVICES
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## REFERENCE EVALUATION

Attention: _____Title:_____
Facility: _____Phone #_____
Address: _____
City: _____State:_____Zip Code_____

## AFFIDAVIT

This is to certify that I authorize and release named individuals or organizations to provide wage and employment histories as requested by *Total Care Nursing Services* and hereby fully release said individuals or organizations, as well as *Total Care Nursing Services,* from all liability in issuing or using this information to evaluate my application.

_____ _____
PRINT FULL NAME CLASSIFICATION

_____ _____
SIGNATURE DATE

## PERFORMANCE

Factor Rating:
**(E) Excellent (G) Good (F) Fair (P) Poor (U) Unsatisfactory**

Section1

____ Nursing Knowledge
____ Applied Nursing Skill Proficiency
____ Qualify of Charting
____ Position Knowledge
____ Initiative
____ Adaptability
____ Patient Relations
____ Emergency Responsiveness
____ Cooperation
____ Ability to Organize
____ Consistent Work Quality
____ Professional Appearance
____ Reliability
____ Interpersonal Relationship
____ Attendance

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# BUSINESS ASSOCIATE CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

The purpose of this agreement is to comply with the Standards for Privacy of Individual Identifiable Health Information ("Privacy Rule") published in December 28, 2000 by the Secretary of the U.S. Department of Health and Human Services to amend 45CFR Parts 160 and 164 of Health Insurance Portability and Accountability Act of 1996 (HIPPA), which is effective April 4, 2003. Under the HIPPA Privacy Rule, as it is commonly known, health plans, health clearing house, and certain health care providers (covered entities) must secure and maintain the confidentiality of protected health information (PHI) and limit the sharing of such information.

Total Care Nursing Services (TCNS), a home health agency, is a "covered entity" and therefore must implement policies and procedures governing the access, use, and disclosure of protected health information. TCNS' information systems contain confidential records pertaining to business operations, patients, business associates, health care professionals, and employees. Because this information is vital to the operation of the agency in providing quality care and services to the patients, it must be protected. As such, in accordance with current HIPPA regulations and TCNS policies governing the access, use and disclosure of protected health or agency information, Business Associates have the responsibility to protect such data. Therefore, the Business Associate agrees:

1. To use and/or disclose protected health information, business and financial and employee information in compliance with TCNS' policies and HIPAA regulations and ONLY for the purpose of fulfilling the service requirements of the Business Associate's attached contract with TCNS.
2. To prohibit the use or disclosure of protected health information in any way that would violate current privacy standards.
3. To use reasonable safeguards to prevent the use or disclosure of protected health information stored or maintained by the Business Associate whether in written or electronic form.
4. To report any misuse or disclosure of protected health information to TCNS within twenty-four (24) hours of discovering such misuse or disclosure.
5. To require subcontractors or agents to which provides protected health information to agree to the same restrictions and standards of the Business Associate as set forth in this agreement and the Business Associate's attached contract with TCNS.
6. Not to release, disclose, remove, or copy any protected information, the contents of any patient or agency record or report except to fulfill the provisions of the Business Associate's contract with TCNS.
7. Upon expiration of this Agreement, to return to TCNS or destroy all protected health and agency information received from TCNS during the term of this agreement, whether written or electronic format to retain no copies or back-up tapes disk of such information.
8. That TCNS retains the right to terminate this Agreement or any related agreement/contract without notice if the Business Associate fails to comply with the terms of this Agreement.

I further understand that the duties of this document will continue after the termination, expiration, and cancellation of this agreement to include termination of my service agreement/contract.

By signing this document I acknowledge that (1) a copy of TCNS' HIPPA policies and procedures was made available to me; (2) I have reviewed TCNS' HIPPA policies and procedures and/or participated in an in-service training regarding said policies and procedures; (3) will protect the confidentiality and security of protected information in accordance with current HIPPA regulations and TCNS' policies; (4) I will comply conditions set forth above.

Date: _____ Signature of Business Associate: _____

Business Associate's Printed Name: _____

Date: _____ Signature of HIPPA Compliance Officer: _____

A copy of this completed document must be prevented to the contractor and a copy must be filed with the Business Associate's service agreement contract