ABSOLUTE HomeCare Services, INC.

A new standard of care. A better quality of life

Name: _____

Title: _____ **Date:** _____

PLEASE PROVIDE COPIES OF THE FOLLOWING WITH YOUR COMPLETED APPLICATION:

___ Current Driver's License

___ Social Security Card

___ Professional License/ Certification

___ CPR Card

___ Hepatitis B Vaccination Proof

(Unless Declined)

___ Tuberculosis Vaccination Proof

*** For U.S. Citizen Applicants**

___ U.S. Passport/Passport Card

___ U. S. Naturalization Certificate

**** For Non-U.S. Citizen Applicants**

___ Work Authorization Card

___ Permanent Resident Card

***** PLEASE PUT YOUR TITLE AFTER YOUR NAME AND SIGNATURE ON ALL FORMS**

Note: *The following application does not guarantee employment. Please follow all directions and complete the entire application for consideration of employment. Attach ALL of the requested documents.* ***Please make sure you have passed the competency exam and have scheduled an appointment for your interview.***

ABSOLUTE HOMECARE SERVICES, INC.

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. To be considered for employment, please complete this application in its entirety. If a particular question is not applicable to you, **please indicate**.

(PLEASE PRINT)

Last Name: _____ M.I.: _____ First Name: _____

Social Security #: _____ D.O.B. _____

Present Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone#: (_____) _____ Cell Phone #: (_____) _____ Email: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ M.I.: _____ First Name: _____

Present Home Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: (_____) _____

Position you are applying for: □ **COMPANION** □ **C.N.A.** □ **HHA** □ **LPN** □ **RN**

How many hours can you work weekly? _____ Can you work nights? □Yes □No

Can you travel if a job required it? □Yes □No What areas are you willing to travel? _____

Employment Desired? □**Full-Time only** □**Part-Time only** □**Full-Time or Part-Time**

When are you available to start work? _____

Have you ever been convicted of a crime? □Yes □No

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and types of rehabilitation.

_____

_____

What is your means of transportation? _____

Do you have a Driver's License? □Yes □No

Driver's License Number: _____ State of Issue: _____ Exp. Date:_____

Are you legally eligible for employment in the United States? □ Yes □ No

Note: Proof of employment eligibility and identity will be required upon employment. You must complete an I-9 Form required by the INS within 3 business days of the date your employment begins.

SCHEDULE AVAILABILITY- *please place times you are available to work. Example: (9AM-5PM)*

Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night

Have you ever been employed by ABSOLUTE HomeCare Services, Inc.? □ Yes □ No

If yes, when, where and what position(s)? _____

Do you have relatives currently employed by ABSOLUTE HomeCare Services, Inc.? □ Yes □ No

If yes, identify employee by name and relationship _____

PERSONAL REFERENCE(S):

Name:_____

Relationship:_____

Address:_____

Tel. No:_____

Name:_____

Relationship:_____

Address:_____

Tel. No:_____

EDUCATION/TRAINING BACKGROUND (List all educational and training attended)				
School	**Name of Institution/Address**	**Course of Study**	**Dates Attended**	**Diploma**
High School				
College/University				
Trade/Business School				

SKILLS & QUALIFICATIONS

Describe any other job-related skills, qualifications and or/certifications acquired from employment or other experiences that qualify you for the position applied for (e.g. nursing, social work, office and/or companionship skills):

_____

_____

_____

_____

WORK EXPERIENCE

Please list your work experience in the health care field over the past ***five to seven years within the USA*** *beginning with your most recent job held. Attach additional sheets if necessary.*

Name of a **present** Employer	**Supervisor's Name**	**Position & Duties**	**Start Date** **End Date**
Address:	**Phone:** **Fax:**	**Pay**	**Your Job Title**
Reason for leaving:			

Name of a **previous** Employer	**Supervisor's Name**	**Position & Duties**	**Start Date** **End Date**
Address:	**Phone:** **Fax:**	**Pay**	**Your Job Title**
Reason for leaving:			

Name of a **previous** Employer	**Supervisor's Name**	**Position & Duties**	**Start Date** **End Date**
Address:	**Phone:** **Fax:**	**Pay**	**Your Job Title**
Reason for leaving:			

Can we contact your previous employer(s): □Yes □No

I certify that the information I have given is true and correct to the best of my knowledge. I am also aware that any false information could lead to my termination and possible prosecution.

Signature of Applicant _____ **Date**_____

ABSOLUTE HOMECARE SERVICES, INC.
8605 B ENGLESIDE OFFICE PARK. ALEXANDRIA. VA 22309
TEL: (703) 347-6755 FAX: (703) 347-6086

REFERENCE FORM via ☐Telephone ☐FAX ☐MAIL
(PLEASE PRINT)

Name of Applicant: _____ Social Security: _____

To: _____

The undersigned has applied for employment with Absolute Homecare Services, Inc. (ABSOLUTE) and authorizes you provide information concerning past performance under the provisions of the Privacy Act of 1974. All information is kept confidential. Thank you for your cooperation.

Company Name: _____

Address: _____

Tel. No: _____ Fax No: _____

STOP **DO NOT FILL THIS SECTION** → **PREVIOUS EMPLOYER ONLY** ← **DO NOT FILL THIS SECTION** STOP

Employment Dates: From: _____ To: _____ Position: _____

Reason for leaving: _____

Would you rehire? [ ] Yes [ ] No [ ] N/A

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendance				
Quality of Work				
Job Knowledge				
Cooperation				
Reliability				
Appearance				
Motivation				
Overall Rating				

Comments: _____

_____ _____ _____

Signature (print and sign) **Title** **Date**

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize you to issue any information that you may have regarding my services and character and do hereby unconditionally release your organization from all liability for any damage whatsoever which might result furnishing the same.

_____ _____

Applicant Signature (print and sign) **Date**

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Employment Dates: From: _____ To: _____ Position:_____

Reason for leaving: _____

Would you rehire? [ ] Yes [ ] No [ ] N/A

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendance				
Quality of Work				
Job Knowledge				
Cooperation				
Reliability				
Appearance				
Motivation				
Overall Rating				

Comments: _____

_____ _____ _____

Signature (print and sign) **Title** **Date**

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I hereby authorize you to issue any information that you may have regarding my services and character and do hereby unconditionally release your organization from all liability for any damage whatsoever which might result furnishing the same.

_____ _____

Applicant Signature (print and sign) **Date**

Sworn Statement or Affirmation

State law (§§ 32.1-126.01 and 32.1-162.9:1 Employment for compensation of persons convicted of certain offenses prohibited; criminal records check required; suspension or revocation of license.) requires that each nursing facility, home care or home health organization, and hospice obtain a criminal record background check on new hires within 30 days of employment. The law also requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia Department of State Police.

For Home Care Organizations, Home Health Agencies, and Hospice Programs

§ 32.1-162.9:1. Employment for compensation of persons convicted of certain offenses prohibited; criminal records check required; suspension or revocation of license. - A. A licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a, b, or c of § 32.1-162.8 or any licensed hospice as defined in § 32.1-162.1 shall not hire for compensated employment, persons who have been convicted of murder or manslaughter as set out in Article 1 (§ 18.2-30 et seq.) of Chapter 4 of Title 18.2, malicious wounding by a mob as set out in § 18.2-41, abduction as set out in subsection A of § 18.2-47, abduction for immoral purposes as set out in § 18.2-48, assaults and bodily wounding as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2, robbery as set out in § 18.2-58, carjacking as set out in § 18.2-58.1, threats of death or bodily injury as set out in § 18.2-60, felony stalking as set out in § 18.2-60.3, sexual assault as set out in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2, arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2, drive by shooting as set out in § 18.2-286.1, use of a machine gun in a crime of violence as set out in § 18.2-289, aggressive use of a machine gun as set out in § 18.2-290, use of a sawed-off shotgun in a crime of violence as set out in subsection A of § 18.2-300, pandering as set out in § 18.2-355, crimes against nature involving children as set out in § 18.2-361, incest as set out in § 18.2-366, taking indecent liberties with children as set out in § 18.2-370 or § 18.2-370.1, abuse and neglect of children as set out in § 18.2-371.1, failure to secure medical attention for an injured child as set out in § 18.2-314, obscenity offenses as set out in § 18.2-374.1, possession of child pornography as set out in § 18.2-374.1:1, electronic facilitation of pornography as set out in § 18.2-374.3, abuse and neglect of incapacitated adults as set out in § 18.2-369, employing or permitting a minor to assist in an act constituting an offense under Article 5 (§ 18.2-372 et seq.) of Chapter 8 of Title 18.2 as set out in § 18.2-379, delivery of drugs to prisoners as set out in § 18.2-474.1, escape from jail as set out in § 18.2-477, felonies by prisoners as set out in § 53.1-203, or an equivalent offense in another state.

However, a home care organization or hospice may hire an applicant convicted of one misdemeanor specified in this section not involving abuse or neglect, if five years have elapsed since the conviction.

By execution of this document, I acknowledge that I have been informed by Absolute Homecare Services, Inc and agree that the agency may conduct a State of Virginia background check using the Central Criminal Records Exchange from the Virginia Department of State Police to determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I have informed this agency of all names (i.e. maiden, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the criminal history check. I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.

Last name **First** **Middle** **Maiden**

Have you ever been convicted of or are you the subject of pending charges of any crime within the Commonwealth of Virginia or equivalent offense outside the Commonwealth?

□ YES (Convicted in Virginia) □ YES (Pending in Virginia) □ NO

If Yes or pending, specify crime(s), and location:

_____

_____

Signature **Print Name** **Date**

ABSOLUTE HomeCare Services, INC.

A new standard of care. A better quality of life

CONFIDENTIALITY POLICY

It is the policy of Absolute Homecare Services, Inc. that all information concerning our patients is kept in a confidential manner at all times.

Any case discussion, consultation, examination, or treatment of a patient is confidential and to be done discreetly. Such information is not open to an individual who is not involved directly in the care of the patient, unless the patient or the patient's representative has given such authorization.

The personal and medical records of a patient are confidential and may not be released without the consent of the patient or patient's representative to any individual who is not associated with ABSOLUTE or if associated with ABSOLUTE but does not have a demonstrated need for the information.

The exceptions to this are:

- If the law requires the records to be release; or
- If necessary to transfer a patient to another agency.

Signature _____ **Date** _____

ABSOLUTE HOMECARE SERVICES, INC.
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EMPLOYEE INFORMATION SHEET

HEPATITIS B AND HEPATITIS B VACCINE

Hepatitis B, a viral infection of the liver, is caused by the Hepatitis B virus (HBV). In the United States, some 300,000 person are newly infected with HBV each year. Occupational work related acquisition of HBV occurs through needle stick, mucous membrane or non-intact skin exposure to blood and other body fluids containing HBV. The risk of contracting HBV from a single contaminated needle stick ranges from 6% to 30%. Each year approximately 12,000 healthcare workers (HCW) contract work-related Hepatitis B. three hundred of these will ultimately die from Hepatitis B related complications.

Healthcare workers are 20 times more likely to contract BV infection that the general public. There is a 15% to 30% prevalence of Hepatitis B markers in physicians and HCWs indicating priori exposure to the virus. Since 1970, 20 reported cases of HBV infection from HCWs to patients have been reported.

Although HBV is an unpredictable disease that may incapacitate a person for weeks or months and lead to complications, most people develop antibody to the virus and recover completely. However 5% to 10% of infected persons become chronic carriers of HBV and never develop antibodies.

One in 200 persons in the United States is a chronic HBV carrier. It is estimated that 1% to 2% of all hospital admissions are Hepatitis B antigen positive. A carrier is infectious to others and has an increased risk of developing long-term complications, such as chronic active hepatitis, cirrhosis of the liver and primary carcinoma of the liver. Carriers have a risk 273 times greater than that of the general population of contracting liver cancer.

A vaccine is available for the prevention of Hepatitis B infection. It is a non-infectious genetically engineered recombinant DNA vaccine. No substances of human origin are used in its manufacture. The vaccine is administered in the deltoid area in a series of 3 doses over a 6-month period. The second dose is given one month after the first and third dose 5 months after the second or 6 months after the first dose. Protective antibody titers are achieved in 95% of those vaccinated.

The incidence of side effects, both local and general, has been minimal among recipients of the vaccine. Broad use of the vaccine could have adverse reactions not observed during clinical trials. The most common adverse reaction is local soreness at the injection site. Less common reactions include erythema, swelling and warmth or indurations of the injection site which is generally well tolerated and usually subsides within 48 hours. Low grade fever (101) occurs occasionally; fever over 102 is uncommon. Systematic complaints, including fatigue, malaise, nausea, and vomiting, headache, muscle and joint pain are infrequent. Rash has rarely been reported. There has been no cause and effect relationship established between the vaccine and neurological disorders.

This vaccine is contraindicated in persons allergic to yeast. HBV vaccine would not be expected to be harmful to a developing fetus; however, its safety for the fetus has not yet been demonstrated. Accordingly, HBV vaccine is not generally recommended for pregnant women or nursing mothers.

If you have a medical condition, allergies, are pregnant or breastfeeding, please consult your physician for direction prior to receiving the vaccine.

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- I have been informed of the potential exposure to hepatitis B due to my job responsibilities.
- I have read all the information given to me regarding hepatitis B Vaccine – Hepatitis B Vaccine Employee Information Sheet and Blood borne Pathogen.
- I have had an opportunity to ask questions regarding the hepatitis B vaccine. All questions have been answered to my satisfaction.
- I understand the benefits and risks of the Hepatitis B Vaccine.
- No guarantee or assurance of protection against hepatitis B can/has been made.
- I understand that the vaccine must be administered in three separate doses. The second and third dosages will be given at 1 and 6 months after the first.
- I understand that it is my responsibility to complete the hepatitis B vaccine series and hepatitis B boosters (if applicable) on the dates scheduled by Absolute Homecare Services, Inc.
- I confirm that I am not pregnant or nursing. I have been advised that taking the vaccine may be dangerous to myself and the fetus/infant in the event of pregnancy or nursing. I have been warned that I should not take the vaccine under those circumstances, or if I expect to become pregnant within the next year. I have been told that I must notify the agency immediately if I become pregnant, so that the vaccination series can be immediately suspended. The vaccination series will be resumed after delivery/nursing, based on the time schedule as recommended by the physician.
- I will inform the nurse before the vaccination of any drugs/medications, prescription or nonprescription, which include those taken by mouth, topical, aerosol, injection, intravenous, instillation of drops, or suppository.
- I will inform the nurse if I have any allergies.
- I am not allergic to yeast.
- I have been advised that the vaccine can cause complications with certain medications and diseases.
- I will take the responsibility to contact the agency if I experience any adverse effect from the hepatitis B vaccine.

Please Check One:

____ I have already **received** the Hepatitis B vaccine series
____ I voluntarily **consent** to receive the Hepatitis B vaccine as described above. I release the agency and its staff from any liability arising from my decision to take the vaccine.
____ I **refuse** the Hepatitis B vaccine, and 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. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine. I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Name: (Print) _____

Signature: _____

Complete only if you ARE to receive the vaccine:

____ I am not presently taking any drugs/medications am not ill, nor under the care of physician

____ I am presently taking the following drugs/medications: _____ and/or
am under a physician's care for the following: _____

____ I am allergic to the following: _____

I have read or have had explained to me the information on this form about the Hepatitis B vaccine. I believe I understand the benefits and risks of Hepatitis B vaccine and request that it be given to me.

_____ _____

Signature of person to receive vaccine **Date**

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DISCLOSURE OF PHYSICAL LIMITATIONS

Employee's Name: _____

I certify that I have no physical limitations which would prevent me from safely performing any tasks normally expected from an individual employed as a caregiver (HHA, CNA, LPN, and RN). In the event that such a condition should arise, I will notify Absolute Homecare Services, Inc. within 24 hours of my becoming aware of this condition and/or prior to performing any of these functions, whichever comes first. In the event that I do not advise Absolute Homecare Services, Inc. of a change in my condition, Absolute Homecare Services, Inc. shall be held blameless for any additional injuries, which might occur.

Signature: _____ Date: _____

Supervisor or Witness: _____ Date: _____

****

Female Employees Only:

In the event of pregnancy, I will advise Absolute Homecare Services, Inc. within 24 hours of my becoming aware of this matter, or before performing additional services for Absolute Homecare Services, Inc. This will allow Absolute Homecare Services, Inc. to evaluate the physical requirements of my assignments to insure that potentially dangerous physical activity may be monitored, mutually. I understand that this is not for the purpose of limiting my work but simply to make sure that I am not, unknowingly placed in a position of risk.

In the event that Absolute Homecare Services, Inc. is not notified, I shall hold Absolute Homecare Services, Inc. blameless for any injury or loss related to this matter.

Signature: _____ Date: _____

Supervisor or Witness: _____ Date: _____

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AUTHORIZATION AND RELEASE FORM

I understand that this application does not mean or constitute a job offer or promise of employment. I certify that all of the information provided on this application is true and complete. I agree that any false or inaccurate statements or answers made during the application process will justify a denial of employment or dismissal. I authorize Absolute Homecare Services, Inc. to verify the information provided on this application and obtain any other information concerning my qualifications and background. I authorize all prior employees, schools and listed references to provide Absolute Homecare Services, Inc. with any and all information concerning my prior employment, education and skills as well as any other relevant information they may have concerning my qualifications. I release all such persons or entities from all liability or damages that may result from furnishing such information to Absolute Homecare Services, Inc. I also release Absolute Homecare Services, Inc. from all liability or damages that may result from reliance upon any such information furnished. I understand that Absolute Homecare Services, Inc. requires all applicants to undergo a pre-employment background check unless prohibited by law, as a part of its application process. I understand that failure to consent to such background check will result in denial of employment. I further understand and agree that if such background check indicates the presence of a barrier crime conviction on my record, I will be denied employment or, if already hired, I will be dismissed. If employed by Absolute Homecare Services, Inc. I agree to abide by its workplace policies and procedures. I understand and agree that, if employed, my employment will be at-will, and that my employment might be terminated, with or without cause, at any time, at the option of Absolute Homecare Services, Inc. or myself. I further understand that no one has the authority to enter into an employment contract with me on behalf of Absolute Homecare Services, Inc. I understand that this application will be considered active for only a period of **one hundred eighty (180) days** after the date listed below, and that I must reapply after such time has expired in order to be considered for other positions as they become available.

_____ _____

Applicant's Signature *Date*

ABSOLUTE HOMECARE SERVICES, INC.

8605 B ENGLESIDE OFFICE PARK. ALEXANDRIA. VA 22309
TEL: (703) 347-6755 FAX: (703) 347-6086

Contractor Agreement

This contract agreement is entered into between Absolute Homecare Services, Inc. (ABSOLUTE) and _____ herein called IC i.e. independent contractor. (ENTER YOUR NAME)

ABSOLUTE HomeCare is an approved temporary staffing agency providing service to whosoever needs it

1. ABSOLUTE HomeCare is a placement agency only and does not take responsibility for actions and duty performance.
2. ABSOLUTE HomeCare is not responsible for paying IC taxes, insurance premiums, licensure fees and other fees or monies related to their field of work including but not limited to federal state and local taxes, social security deductions and professional and organizational dues unless IC is working underneath MEDICAID approval. IC is then considered an employee of ABSOLUTE HomeCare. In this case, ABSOLUTE HomeCare is responsible for paying employee federal and state taxes, and any other fees or monies related to their field of work.
3. ABSOLUTE HomeCare will furnish IC with a completed form 1099-MISC at the end of each calendar year.
4. ABSOLUTE HomeCare will not provide any health plan, pension plan or any fringe benefits to IC nor shall it obtain Worker's compensation for IC.
5. ABSOLUTE HomeCare will keep contact with IC about availability work/assignments and IC is under no obligation to accept such assignments.
6. ABSOLUTE HomeCare has absolute and sole discretion of assignments and has the right to terminate any assignment as set forth herein at any time and for no set reason.
7. ABSOLUTE HomeCare does not owe IC any explanation as to reason for termination of assignments.
8. That IC will provide a complete and clear written account of days and hours of services provided to each of the clients serviced in form of an end of week requisition which will be called a **"time sheet"** supplied by ABSOLUTE HomeCare and payments will be made on the set ABSOLUTE HomeCare payday. IC will receive payment in accordance with the agreed rate of pay and field of work and competence shown by IC.
9. That IC, while placed and working for any particular client through ABSOLUTE HomeCare will only work for the client engaged in an exclusive agreement with ABSOLUTE. This requiring that IC not work for client in any capacity except given a written approval by ABSOLUTE to do so. If IC takes up offer with client, ABSOLUTE is entitled to 15% of yearly wage that IC is being offered as a placement of finder's fee.
10. That failure of IC to carry out assignment already agreed to will be considered a breach of contract resulting in the payment to ABSOLUTE of liquid damages in the total amount of the assignment either by direct payment to ABSOLUTE or by withholdings from future payments.
11. That IC shall give a **30 day** notice to terminate this agreement and within that period deal with each other in good faith.
12. That ABSOLUTE or IC may choose to terminate this agreement with reasonable cause upon giving written notice of termination of cause such as a Violation of agreement, danger to exposing either party to liability, personal injury or property damage or any act deemed as unprofessional by IC or ABSOLUTE.
13. That any concealing, taking or removal of property/item which does not belong to IC in an assigned home or facility will be deemed as theft and result in dismissal and immediate prosecution.
14. That IC agrees to no confrontation or heated arguments will be allowed in any facility o home or with any family member or staff member. All reports and concerns should be directed to the Office for necessary action.
15. That ABSOLUTE will not tolerate any documented or confirmed reports of sexual harassment with any male/female staff or client in any home or facility and will lead to immediate termination of IC.
16. That IC will adhere to dress codes at all time while on an assignment.
17. That ABSOLUTE will not permit IC working under the influence of drugs or alcohol and reserves the right to request a drug screen at any time.
18. That ABSOLUTE reserves the right to file legal action against IC for falsification of documents and Times Sheets such as will be deemed as fraud.
19. That contract policies are subject to change and if they do IC will be notified through a written letter.
20. That this agreement shall be governed by and construed under the laws of the Commonwealth of Virginia, Maryland, and Washington DC.
21. That ABSOLUTE and IC have read and fully understand the provisions contained in this agreement.

INDEPENDENT CONTRACTOR **ABSOLUTE HOMECARE SERVICES**

_____ _____

Signature *Date* *Signature* *Date*

ABSOLUTE HomeCare Services, INC.

A new standard of care. A better quality of life

SKILLS CHECKLIST

Name_____ Date ___/___/_____

Title_____

Place a **check mark** in the column that best describes your expertise with each of these tasks as a nurse aide

The scale is as follows:

A. **Never Performed – less than 6 months of knowledge/experience**

B. **Intermittent Experience – 6 months to less than a year**

C. **Continued Experience – over 1 year of knowledge/experience**

	A.	**B.**	**C.**
AMBULATION – Has knowledge of and can provide care and assist patients with the following tasks:			
1. Crutches	___	___	___
2. Walker	___	___	___
3. Cane	___	___	___
4. Gait belt	___	___	___
5. Side rails	___	___	___
PERSONAL CARE			
1. Bath:			
a. bed	___	___	___
b. tub	___	___	___
c. shower	___	___	___
2. Skin Care:			
a. Back rub	___	___	___

b. Decubitus prevention/care ___ ___ ___

3. Dress:

a. Assist as needed ___ ___ ___

b. Use of assistive devices ___ ___ ___

4. Hair Care ___ ___ ___

5. Nail Care (fingers & toes)

a. Clean/file/trim with clippers ___ ___ ___

6. Oral Hygiene:

a. Mouth care ___ ___ ___

b. Brush teeth ___ ___ ___

c. Denture care ___ ___ ___

7. Shaving: Safety razor/electric razor ___ ___ ___

8. Maintains clean, safe & healthy environment

a. Linen change of occupied bed ___ ___ ___

b. Linen change of unoccupied bed ___ ___ ___

NUTRITION/ HYDRATION

1. Feeding techniques ___ ___ ___

2. Assist with eating ___ ___ ___

3. Abdominal thrusts (Heimlich) ___ ___ ___

4. Measure & record intake ___ ___ ___

5. Encourage fluids ___ ___ ___

BASIC INFECTION CONTROL PROCEDURES

1. Hand washing ___ ___ ___

2. Universal precautions ___ ___ ___

3. Use of warm & cool applications ___ ___ ___

ASSISTING of CARE OF PATIENT WITH BOWEL & BLADDER ELIMATION

1. Bed pan/urinal ___ ___ ___

2. Bedside commode ___ ___ ___
3. Care of incontinent patient ___ ___ ___
4. Stoma care ___ ___ ___
5. Bowel / bladder training ___ ___ ___
6. Measure & record output ___ ___ ___

URINARY CATHETER CARE

1. Perineal hygiene ___ ___ ___
2. External catheter ___ ___ ___
3. Foley catheter ___ ___ ___
4. Supra pubic catheter ___ ___ ___

TRANSFER TECHNIQUES

1. Use of transfer gait belt ___ ___ ___
2. Weight bearing ___ ___ ___
3. Non-weight bearing ___ ___ ___
4. Mechanical lift ___ ___ ___
5. Wheelchair ___ ___ ___

TURNING/POSTING PATIENT

1. Supine ___ ___ ___
2. Side – lying ___ ___ ___
3. In chair ___ ___ ___
4. In bed ___ ___ ___
5. Use of lift sheet ___ ___ ___

RANGE OF MOTION EXERCISES

1. Active ___ ___ ___
2. Passive ___ ___ ___
3. Combination ___ ___ ___

TAKE & RECORD VITAL SIGNS

1. Temperature
    a. Oral ___ ___ ___
    b. Rectal ___ ___ ___
    c. Ear canal ___ ___ ___
2. Pulse
    a. Apical ___ ___ ___
    b. Radial ___ ___ ___
    c. Pedal ___ ___ ___
    d. Femoral ___ ___ ___
3. Respirations ___ ___ ___
4. Blood Pressure ___ ___ ___
5. Height ___ ___ ___
6. Weight
    a. Standing ___ ___ ___
    b. Bed scale ___ ___ ___
    c. Chair scale ___ ___ ___

SAFETY DEVICES

1. Vest restraint ___ ___ ___
2. (Soft) wrist/ankle restraint ___ ___ ___
3. Padded side rails ___ ___ ___
4. Side rails ___ ___ ___

MENTAL HEALTH & SOCIAL SERVICE NEEDS

1. Demonstrates principles of behavior management ___ ___ ___
2. Provides emotional support to patient ___ ___ ___
3. Encourages family support ___ ___ ___
4. Encourages patients to make personal choices ___ ___ ___

5. Respects patient's rights, dignity, privacy & confidentiality ___ ___ ___
6. Encourages self-care as ability allows ___ ___ ___
7. Knowledge of adult, child and elder abuse reporting statutes ___ ___ ___
8. Knowledge of domestic violence and violent injury reporting statutes ___ ___ ___

COMMUNICATION

1. Verbal ___ ___ ___
2. Non-verbal with cognitively impaired patients ___ ___ ___
3. Positions call light appropriately ___ ___ ___

CARE OF PROSTHETIC DEVICES

1. Limbs ___ ___ ___
2. Eye glasses ___ ___ ___
3. Hearing Aids ___ ___ ___

SAFETY/EMERGENCIES

1. Recognize & reports safety hazards ___ ___ ___
2. Recognizes & reports emergencies and responds appropriately ___ ___ ___
3. Handles o_2 safely ___ ___ ___
4. Observes, reports & documents changes in body functions, behavior ___ ___ ___

SPECIMEN COLLECTION

1. Urine ___ ___ ___
2. Stool ___ ___ ___
3. Sputum ___ ___ ___
4. Blood ___ ___ ___

UNDERSTANDS AND CAN PERFORM

1. Enemas
    a. Fleets ___ ___ ___

b. Tap water ___ ___ ___

c. Soap suds ___ ___ ___

2. Binders & Bandages

a. ACE bandages ___ ___ ___

b. Support stockings ___ ___ ___

3. Care of the deceased ___ ___ ___

ASSIST THE CARE OF PATIENT WITH:

1. Diabetes ___ ___ ___
2. Cancer ___ ___ ___
3. Heart Cancer ___ ___ ___
4. O^2 therapy ___ ___ ___
5. Respiratory disease ___ ___ ___
6. Terminal ___ ___ ___
7. Infectious disease ___ ___ ___

The information I have given is true and accurate to the best of my knowledge

_____ _____

C.N.A. Signature **Date**

_____

Name (Please Print)

MANAGEMENT AND STAFF

TITLE: **Certified Nurse Assistant (CNA)**

Home Health Aide (HHA)

Personal Care Aide (PCA)

REPORTS TO: Director of Nursing, Administrator

CARE DESCRIPTION: Provides non-medical personal care to clients

SCHEDULE: Any day of the week

HOURS: Dependent on level of care and care plans for clients

SALARY: As per rate of pay scale

BASIC FUNCTIONS

The CNA /HHA/PCA is a key person responsible for delivering direct care to and providing a therapeutic environment for the clients and to maintain their personal comfort.

QUALIFICATIONS

- Active certification as a CNA, PCA, or HHA
- Minimum of six (6) months work experience
- Ability to read, write, and follow a written Plan of Care
- Excellent interpersonal skills
- Reliable transportation

RESPONSIBILITIES

- Continuously provide quality care to all clients.
- Treat all clients with dignity and respect.
- Know, follow and maintain resident rights
- To understand, use and follow nursing principles and practices
- To assist clients in regaining loss abilities and to maximize their strengths

- To assist in creating an atmosphere of independence
- To know and follow clients care plan goals and approaches
- Requires an ability to have a positive attitude towards the client and the responsibilities of the job
- Must attend at least twelve (12) in-service training sessions to fulfill the annual requirement according to the VDH and Medicaid standards.
- Must know and follow existing lines of communication and authority
- Maintain confidentiality of all clients and organizational information
- Follow all safety, security, infection control, universal precautions, and hazardous material policies and procedures.
- Performs all tasks to ensure resident and personal safety
- Must have the ability to perform duties of a certified nursing assistant giving direct client care as staffing dictates
- Requires ability to work harmoniously with the entire team
- Accurately observe, recognize changes and report to nursing supervisor and/or office manager
- Use appropriate work place behavior and adhere to dress code at all times
- Demonstrate respectful relationships with supervisors, managers, and co-workers
- Cooperate with co-workers to ensure maximum client care

I have read the above job description and fully understand the conditions outlined above. If I am employed by Absolute HomeCare Services, Inc. as a Caregiver (CNA/HHA/PCA), I will perform these duties to the best of my knowledge and abilities.

_____ _____

Signature **Date**