DOVE SUPPORT SERVICES, LLC.
JOB APPLICATION FORM

This agency bases hiring decisions on the ability, skills, education, experience, and background of applicants, and does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, sexual orientation, national origin, age, disability, or any other characteristic protected by law.

Equal Opportunity Employer/Provider

Date of Application: (mm/dd/yy) _____/_____/_____

Position(s) Applied for:

_____

Name: _____, _____,

_____

(Last) (First)

(Middle Initial)

Address: _____

(Street)

_____, _____,

_____

(City) (State) (Zip)

Telephone Number (____) _____ Best time to reach ___ A.M. ___ P.M___

E-mail:_____

Date of Birth (mm/dd/yy) _____SSN #:

_____

Are you of legal age to work? □ Yes □ No

Are you a U.S. Citizen? □ Yes □ No If no are you authorized to work in the U.S. □ Yes □ No

If yes, provide Alien Number:

_____

Are you available to work Full-time □ Part-time □ Casual

EDUCATION:

High School

Institution Attended: _____ City: _____ State: _____

Years Attended: (Month/Year) _____/_____

Did you graduate: □ Yes □ No

Diploma:

_____

_____

College

Institution Attended: _____City: _____State: _____

Years Attended: (Month/Year) _____/ _____

Did you graduate: □ Yes □ No

Degree at Completion:

_____

Technical /vocational

Institution Attended: _____ City: _____ State: _____

Years Attended: (Month/Year) _____/ _____

Did you graduate: □ Yes □ No

Course of Study:

_____

Other classes/Training:

_____

_____

_____

_____

Complete this section if you served in the U.S. Armed Forces:

U.S. Military Service: _____

Rank: _____

Present Membership in National Guard or Reserves: _____

Were you honorably discharged? □Yes □ No

Describe your duties and any special training:

_____

_____

_____

_____

_____

CERTIFICATIONS/LICENSURE:

Current certificates or licenses:
Type: _____Organization or State Issued _____ Date Issued__/__/____ Expiration date: __/__/____
Type: _____Organization or State Issued _____ Date Issued__/__/____ Expiration date: __/__/____
Type: _____Organization or State Issued _____ Date Issued__/__/____ Expiration date: __/__/____
(All professional licenses will be verified at the time of employment)

EMPLOYMENT:

List current employer first:
1. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities:
_____
May we contact your present employers? □Yes □ No. If no, please explain why:
_____
References verified by:
_____

2. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities:
_____
May we contact your previous employer? □Yes □ No. If no, please explain why:
_____
References verified by:
_____

3. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities:

_____

May we contact your previous employers? □Yes □ No. If no, please explain why:

_____

References verified by:

_____

4. _____Date of employment:

_____ to _____

(Employers Name) (Beginning)

(Ending)

City: _____ State: _____ Phone #: (___) _____ Supervisor:

_____

Job Title: _____ Starting Salary $: _____ Ending Salary $:

_____

Responsibilities:

_____

May we contact your previous employers? □Yes □ No. If no, please explain

why:_____

References verified by:

_____

REFERRENCES:

1. Name: _____Relationship:

_____Title:_____

Company: _____Phone Number: (_____)

_____

2. Name: _____Relationship:

_____Title:_____ Company:

_____Phone Number: (_____)

_____

3. Name: _____Relationship:

_____Title:_____ Company:

_____Phone Number: (_____)

_____

HEALTH:

Date of your last examination by physician:

_____

Do you have any physical/health limitations that might affect your ability to perform the expected duties you are hired for?

□ Yes □ No

If yes, please attach a written explanation:

Person to notify in case of emergency:

1. Name: _____ Phone Number: (_____)

_____

2. Name: _____ Phone Number: (_____)

_____

Have you ever been dismissed from employment for drug use/addiction or ever been treated for drug use/addiction? □ Yes □ No

If yes, attach a written explanation:

Have you ever been convicted of a crime other than a routine traffic citation? □ Yes □ No

If yes, attach a written explanation:

How did you hear about our company? □ Direct Mailer □ Newspaper Ad □ Referral by another employee

I was referred by:

_____

Please attach copies of licensure, any specialty certification or continuing education within the past 2 years, malpractice policy and resume.

This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, national origin, age, physical or mental limitation unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

By my signing below, I authorize the agency to conduct an investigation of all the facts set forth in the application and hereby release the agency, education institutions, former employers, law enforcement authorities, and all references from any liability in connection with such investigation(s). Additionally, I understand that any falsification, willful omission, or material misrepresentation of the information on this application will constitute good cause for the agency to discontinue the processing of this application or terminate my employment.

I understand that I may be required to undergo a pre-employment drug screening and/or physical examination, and any offer of employment is contingent on those results. I agree to provide documentation of my eligibility to work in the U.S. I understand that nothing in the application is intended to offer employment or create an employment contract.

_____ _____

(Applicant's Signature) (Date)

ADDENDUM TO EMPLOYMENT APPLICATION

The Ohio law requires that home health care companies ascertain from applicants for employment that have not been convicted, plead guilty of the offenses listed below. Your signature below indicates that you have not committed nor plead guilty to:

Aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, failing to provide for a functionally impaired person, aggravated menacing, patient abuse and neglect, kidnapping, abduction, criminal child enticement, rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, importuning, voyeurism, public indecency, compelling prostitution, promoting prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually oriented materials involving a minor, illegal use of a minor in nudity-oriented material or performance, aggravated robbery, robbery, aggravated burglary, burglary, unlawful abortion, endangering children, contributing to unruliness or delinquency of a child, domestic violence, carrying a concealed weapon, having weapons while under disability, improperly discharging a firearm at or into a habitation or school, corrupting others with drugs, drug trafficking, illegal administration or distribution of anabolic steroids, placing harmful objects in food or confection, child stealing, possession of drugs, felonious sexual penetration.

I, _____ have read the contents of this

addendum to my application for employment with DOVE SUPPORT SERVICES, LLC.. I also understand that I am required by law to notify DOVE SUPPORT SERVICES, LLC. within 14 (fourteen) days if I receive formal charges, convictions or make a guilty plea to any one of the disqualifying offenses listed above.

_____ _____

(Applicant Signature) (Date)

HEPATITIS B VACCINATION DISCLOSURE

I, _____ (name) am a contracted employee for DOVE SUPPORT SERVICES, LLC. as a _____ (occupation). I understand that due to my occupational exposure to blood and other potentially infectious material, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection.

I decline the Hepatitis B Vaccination at this time. □
I am currently vaccinated with Hepatitis B. □
I will be taking a Hepatitis B Vaccination; will submit results when available. □

I understand that by declining this vaccine, I will continue to be at risk of becoming infected with Hepatitis B and that Hepatitis B is a serious illness.

My signature signifies my agreement to all of the above stipulations.

_____ _____ _____

Signature Print Name Date

CONFIDENTIALITY AGREEMENT

In compliance with government (federal, state, local) rules, regulations and guidelines, as well as professional standards of the health care industry, the nature of services DOVE SUPPORT SERVICES, LLC. providers requires that all client information be handled in a private and confidential manner by all staff and employees.

In compliance with HIPPA regulations, information about our agency, employees or clients will only be released to authorized individuals with prior written client consent. Exceptions to this policy will be explained during our New Employee Orientation. All staff, managers and employees are hereby advised that all agency reports, memoranda, notes, invoices and any other documents will remain a part of the agency's confidential records.

As a condition of employment, the undersigned agrees to abide by the terms of this confidentiality agreement.

_____ _____

Applicant Signature Print Name Date

_____ Date
DOVE HS Associate

CODE OF ETHICS FOR HOME HEATLH AIDES/ HOMEMAKERS/ PERSONAL CARE ATTENDANTS

All Dove HEALTH SERVICES, LLC. Aides/Homemakers/Personal Care Attendants (employees, contractors, associates) are required to observe the following code of ethics.

Employees will deliver services in a manner that is professional, respectful and legal.

The employee shall **NOT:**

- Consume the client's food and or drink or use the client's vehicle. The employee shall not eat food brought into the client's home without the client's consent.
- Bring children, pets, friends, relatives or anyone else to the client's home.
- Take the client toe the employee's home or take the client away from home unless authorized.
- Consume alcohol, medicine, drugs or other chemical substances not in accordance with the legal, valid, prescribed use and/or in any way that impairs the employee's ability to deliver services to the client.
- Discuss religion or politics with the client or anyone else in the client's home.
- Discuss their personal issues with the client or anyone else in the client's home. The employee shall not breach client's privacy or confidentiality of the client's records or divulge client information.
- Accept, obtain or attempt to obtain money or anything of value, including gifts or tips from the client or anyone else in the client's home.
- Engage in, with the client or anyone else in the client's home, sexual conduct or conduct that may be reasonably interpreted as sexual in nature, regardless or whether or not the contact is consensual.
- Watch TV, play computer games or play video games while on duty.
- Make or receive personal phone calls while on duty.
- Forge client's signature and/or falsify documentation or leave client's home before the end of the shift for a purpose not related to the provision of services without notifying the agency supervisor, the client (or client's emergency contact) and/or the client's case manager.
- Engage in non-care related socialization with anyone other than the client.
- Provide care to individuals in the client's home other than the client.
- Smoke in the client's home and/or property without the client's consent
- Sleep while on duty.
- Engage in behavior that causes, or may cause physical, verbal, mental, or emotional distress or abuse to the client.
- Engage in behavior that may reasonably be interpreted as inappropriate involvement in the client's personal relationships.
- Be designated to make decisions for the client in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney or legal guardian.

- Sell or purchase anything from the client's products or personal items. (The only exception to this occurs when the client is a family member and the employee is not on duty during the time of the transaction.)
- Engage in behavior that constitutes a conflict of interest or takes advantage or manipulates the client's services in an unintended advantage for personal gain that has detrimental results for the client, the client's family or caregivers, or another provider.

_____ _____

Employee Signature Date