MAZENO HEALTHCARE SERVICES

EMPLOYMENT / JOB APPLICATION

hr@mazenohealthcareservices.com

PERSONAL INFORMATION

FULL NAME: _____ **DATE:** _____
First Middle Last

ADDRESS: _____
Street Address Apt/Suite

_____
City State Zip Code

DATE OF BIRTH:_____**SOCIAL SECURITY NUMBER (SSN):** _____-_____-_____

E-MAIL: _____ **PHONE:** _____

DATE AVAILABLE: _____ **PLEASE CHECK ONE** ☐ MALE ☐ FEMALE

POSITION APPLIED FOR: _____

EMPLOYMENT DESIRED: ☐ FULL-TIME ☐ PART-TIME ☐ PRN ☐ WEEKENDS ☐ DAY ☐ OVERNIGHT

EMPLOYMENT ELIGIBILITY

ARE YOU LEGALLY ELIGIBLE TO WORK IN THE U.S? ☐ YES ☐ NO

HAVE YOU EVER WORKED FOR THIS EMPLOYER? ☐ YES ☐ NO

***IF YES, WRITE THE START AND END DATES:** _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ☐ YES ☐ NO

***IF YES, PLEASE EXPLAIN:** _____

EDUCATION

HIGH SCHOOL: _____ CITY / STATE: _____

FROM: _____ TO: _____

GRADUATE? ☐ YES ☐ NO DIPLOMA: _____

COLLEGE: _____ CITY / STATE: _____

FROM: _____ TO: _____

GRADUATE? ☐ YES ☐ NO DEGREE: _____

OTHER: _____ CITY / STATE: _____

FROM: _____ TO: _____

GRADUATE? ☐ YES ☐ NO DEGREE/CERTIFICATION: _____

OTHER: _____ CITY / STATE: _____

FROM: _____ TO: _____

GRADUATE? ☐ YES ☐ NO DEGREE/CERTIFICATION: _____

PREVIOUS EMPLOYMENT

EMPLOYER 1: _____
Company / Individual

E-MAIL: _____ PHONE: _____

ADDRESS**:** _____
Street Address Apt/Suite

_____
City State Zip Code

STARTING PAY: $_____ ☐ HOUR ☐ SALARY ENDING PAY: $_____ ☐ HOUR ☐ SALARY

JOB TITLE: _____ RESPONSIBILITIES: _____

FROM: _____ TO: _____

REASON FOR LEAVING: _____

EMPLOYER 2: _____
Company / Individual

E-MAIL: _____ PHONE: _____

ADDRESS**:** _____
Street Address Apt/Suite

_____
City State Zip Code

STARTING PAY: $_____ ☐ HOUR ☐ SALARY ENDING PAY: $_____ ☐ HOUR ☐ SALARY

JOB TITLE: _____ RESPONSIBILITIES: _____

FROM: _____ TO: _____

REASON FOR LEAVING: _____

EMPLOYER 3: _____
Company / Individual

E-MAIL: _____ PHONE: _____

ADDRESS**:** _____
Street Address Apt/Suite

_____
City State Zip Code

STARTING PAY: $_____ ☐ HOUR ☐ SALARY ENDING PAY: $_____ ☐ HOUR ☐ SALARY

JOB TITLE: _____ RESPONSIBILITIES: _____

FROM: _____ TO: _____

REASON FOR LEAVING: _____

REFERENCES
(PROFESSIONAL ONLY)

FULL NAME: _____ RELATIONSHIP: _____
First Last

COMPANY: _____ TITLE: _____

E-MAIL: _____ PHONE: _____

FULL NAME: _____ RELATIONSHIP: _____
First Last

COMPANY: _____ TITLE: _____

E-MAIL: _____ PHONE: _____

FULL NAME: _____ RELATIONSHIP: _____
First Last

COMPANY: _____ TITLE: _____

E-MAIL: _____ PHONE: _____

EMMERGENCY CONTACT

FULL NAME: _____ RELATIONSHIP: _____

E-MAIL: _____ PHONE: _____

ADDRESS**:** _____

FULL NAME: _____ RELATIONSHIP: _____

E-MAIL: _____ PHONE: _____

ADDRESS**:** _____

MILITARY SERVICE

ARE YOU A VETERAN? ☐ YES ☐ NO

BRANCH**:** _____ RANK AT DISCHARGE: _____

FROM: _____ TO: _____

TYPE OF DISCHARGE: _____

IF NOT HONORABLE, PLEASE EXPLAIN: _____

DRIVING INFORMATION

1. Driver's License Number: _____ State: _____

2. How long have you had a U.S driver's license? _____

3. Do you have a valid driver's license from the state you currently live in? ☐ YES ☐ NO

4. During the past 5 years:

   A. Have you received a traffic ticket for speeding 20 miles over the speed limit? ☐ YES ☐ NO

   B. Have you been involved in a vehicle accident? ☐ YES ☐ NO

   C. In the past 5 years have you received any tickets for traffic violations? ☐ YES ☐ NO

If yes, convicted of _____

Date: _____ Jurisdiction: _____

5. Has your driver's license ever been suspended? ☐ YES ☐ NO

If yes, dates of suspension(s): _____

Reason(s): _____

Jurisdiction(s): _____

BACKGROUND CHECK CONSENT

IF ASKED, ARE YOU WILLING TO CONSENT TO A BACKGROUND CHECK? ☐ YES ☐ NO

DISCLAIMER

Applicant understands that this is an Equal Opportunity Employer and committed to excellence through diversity. In order to ensure this application is acceptable, please print or type with the application being fully completed in order for it to be considered.

Please complete each section EVEN IF you decide to attach a resume.

I, the Applicant, certify that my answers are true and honest to the best of my knowledge. If this application leads to my eventual employment, I understand that any false or misleading information in my application or interview may result in my employment being terminated.

SIGNATURE _____ DATE _____

PRINT NAME _____

AFFIRMATION & AUTHORIZATION

I hereby affirm that the information provided on the application and accompanying resume, if any, is true and complete to the best of my knowledge. I also agree that my falsification or omission of required information may disqualify me from further consideration for employment and may be considered justification for dismissal from employment if discovered at a later date.

I authorize a thorough investigation of my past educational and employment activities, agree to cooperate in such investigation, and release from all liability or responsibility all persons and concerns requesting or supplying information. I understand and agree that Mazeno Healthcare Services, LLC may contact any or all past employers pursuant to this investigation.

It is the policy of Mazeno Healthcare Services, LLC not to discriminate in hiring and employment, in accordance with the requirements of all applicable State and Federal laws, on the basis of race creed, religion, national origin, sex, citizenship status, age or the presence of a qualified mental, physical or visual handicap. I hereby agree to submit to any lawful drug, integrity and skill testing that may be required as a condition of my employment or continued employment and understand that unless otherwise prohibited by law, refusal to submit to such testing during the course of my employment may result in dismissal.

I understand that this application is valid for 90 days only. I also understand that if I am employed, I agree to accept the employment conditions of the company. In consideration of employment, I agree to conform to the policies and procedures of Mazeno Healthcare Services, LLC and understand that the company may change these from time to time without notice; and that employment may be terminated at any time with or without cause or any notice at the option of either the company or me. I understand that this application is not intended to be a contract for employment now or in the future. I understand that no company manual or document is intended to change this, and no manager or representative of Mazeno Healthcare Services, LLC other than the executive Director has any authority to enter into any agreement for employment.

Print Name: _____Date: _____

Signature: _____

PRE-EMPLOYMENT INQUIRY AUTHORIZATION

I _____ hereby authorize and agree that Mazeno Healthcare Services, LLC will conduct the appropriate inquiries to determine my eligibility for my employment on behalf of the company. I fully understand that these inquiries may include, but are not limited to, criminal record checks, driving records, credit reports and interviews.

I agree to indemnify and hold Mazeno Healthcare Services, LLC and its agents harmless against any and all liability, cost and expenses, including attorney's fees, occasioned by claims or suits for loss or damage arising out of the reasonable and lawful acts.

This authorization is valid for a period of 30 days.

Address: _____

Address of Former Residences: (If lived at present residence less than seven years):

1. _____

2. _____

3. _____

Driver's License Number: _____ State: _____

Former Driver's License Number: _____ State: _____

Date of Birth: _____ SS#: _____

Name: _____ Date: _____

Signature: _____

EMPLOYEE REFERENCE CHECK

Date:_____

Mazeno Healthcare Services, LLC, has my authorization to check my references.

PRINT EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

Company Contacted: _____

Mr. / Mrs.: _____ is seeking employment with our company. It is our policy to ask for references prior to employment. Please complete this form for our records ***and sign below***. We would greatly appreciate your assistance.

PLEASE VERIFY EMPLOYMENT DATES:

From: _____ To: _____

ELIGIBLE FOR REHIRE? ☐ YES ☐ NO

COMMENTS:

_____

_____

_____

INFORMATION WAS RECEIVED BY: ☐ Phone ☐ Fax ☐ Mail

Name of company _____

*** (IF FAXED) Company Contact Signature** _____

_____ _____

Signature of Agency Representative & Title ***Date***

EMPLOYEE REFERENCE CHECK

Date:_____

Mazeno Healthcare Services, LLC, has my authorization to check my references.

PRINT EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

Company Contacted: _____

Mr. / Mrs.: _____ is seeking employment with our company. It is our policy to ask for references prior to employment. Please complete this form for our records ***and sign below***. We would greatly appreciate your assistance.

PLEASE VERIFY EMPLOYMENT DATES:

From: _____ To: _____

ELIGIBLE FOR REHIRE? ☐ YES ☐ NO

COMMENTS:

_____

_____

_____

INFORMATION WAS RECEIVED BY: ☐ Phone ☐ Fax ☐ Mail

Name of company _____

*** (IF FAXED) Company Contact Signature** _____

MARTHER ENO/Program Admin _____ _____

Signature of Agency Representative & Title ***Date***

SWORN STATEMENT OF AFFIRMATION/BACKGROUND CHECK CONSENT

To The Applicant: _____ D.O.B _____

Section s32.1-162.9:1 of the code of Virginia requires that any applicant for employment with a licensed home care organization provide the Commissioner's representative with a sworn statement or affirmation disclosing (1) whether the applicant has a criminal conviction or is the subject of any pending criminal charges within or outside The Commonwealth of Virginia, and (2) whether the applicant has been the subject of a found complaint of child abuse or neglect within or outside the Commonwealth of Virginia.

Any person making a materially false statement on this from shall be guilty of a Class I misdemeanor.

Further dissemination of the information provided on this form is prohibited other than to the Commissioner's representative or a federal or state authority of court as many be required to comply with an express requirement of law for such further dissemination.

1. _____ _____ _____
Last Name First Name Middle Name Social Security Numer

_____ _____ _____ _____
Street/PO Box City State Zip Code

2. Have you ever been convicted of a crime within or outside Virginia (but excluding offenses committed before your eighteenth birthday that were finally adjudicated in a juvenile court or under a youth offender law)?

☐ YES ☐ NO

If yes, list all and explain.

_____

3. Are you the subject of any pending criminal charges within or outside Virginia? ☐ YES ☐ NO

If yes, explain.

_____

4. Have you ever been the subject of a founded complaint of child abuse or neglect within or outside Virginia? ☐ YES ☐ NO

If yes, explain.

_____

5. I hereby affirm that the information provided on this form is true and complete. I understand that the information is subject verification.

Applicant's Signature:_____ Date: _____

CELL PHONE USE

Employee Name: _____

Mazeno Healthcare Services, LLC **does not** permit employees on company time to talk on their cellular phones while driving a vehicle. This is very dangerous and should be avoided any time. It is mandatory that I must pull over and stop my vehicle each time I conduct agency business per cellular phone.

The agency is not responsible for any moving violations, accidents or other incident that may occur while I am using my cellular phone and driving.

I have read and understand the above information of the agency regulation regarding cellular phone use, and I will comply.

Employee's Signature:_____ Date: _____

Agency Representative:_____**MARTHER ENO/Program Admin**_____ Date: _____

HBV VACCINE/WAIVER FORM

Last Name	First Name	Middle Name	Social Security Numer

I understand that due to my occupation exposure to blood or other potential infectious materials I may be at risk acquiring Hepatitis B Virus (HBV) Infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. 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.

I have been advised of my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.

_____ I choose to waive my rights to receive the HBV Vaccine

_____ I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3-part series.

Series # 1 Date_____ Series # 2 Date_____ Series # 3 Date_____

Employee's Signature:_____ Date: _____

Agency Representative:_____ Date: _____

ANNUAL TUBERCULOSIS QUESTIONNAIRE

Employee Name: _____

For personnel who have a known positive PPD and previously negative chest x-ray, you are requested to complete this questionnaire with either a yes or no.

Have you noticed any of the following?

1. Unexplained fevers	☐ YES	☐ NO
2. Night Sweats	☐ YES	☐ NO
3. Unintentional weight loss	☐ YES	☐ NO
4. Cough	☐ YES	☐ NO
5. Hoarseness	☐ YES	☐ NO
6. Bloody Sputum	☐ YES	☐ NO
7. Have you completed INH therapy?	☐ YES	☐ NO
8. Have you ever had a BCG vaccine?	☐ YES	☐ NO
9. Have you had an x-ray while employed here?	☐ YES	☐ NO

Employee's Signature:_____ Date: _____

Follow-up Needed ☐ YES ☐ NO

Comments: _____

_____

Agency Representative:_____ Date: _____

CONFIDENTIALITY OF INFORMATION AGREEMENT

Employee Name: _____

Confidentiality of Information

• All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.

• All information that is gathered, maintained, or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.

• Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

What We Can Do to Maintain Confidentiality of Information

• In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.

• Access to information will be limited to a need-to-know basis to perform the scope of one's duties and responsibilities.

• Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.

• Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for following this Confidentiality Policy Agreement & The Guidelines, Both Written and Verbal.

Employee's Signature:_____ Date: _____

PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Applicant's Rights: Your fingerprints will be used to check the criminal history records of the FBI and the Central Criminal Records Exchange (CCRE) of the Virginia State Police. You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of state or federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks. If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.) You may obtain a copy of your Virginia Criminal History by submitting form SP-167, available at https://vsp.virginia.gov/services/criminal-background/ to the CCRE. You may challenge the accuracy or completeness of a Virginia criminal history record through the CCRE Expungement/Record Challenge Section, which can be reached at (804) 674-6723 for further information about this process.

Credentials needed before Hiring:

- State ID or Driver's License
- PPD or Chest X-Ray.
- Covid-19 Vaccination Card
- CPR Card
- First Aid Card
- Green Card/USA Passport/USA Birth Certificate/Work Permit
- Social Security Card
- Professional Certificate
- Professional License
- Resume

Send Form and credentials to *hr@mazenohealthcareservices.com*

Upon Hiring:

- Employment Verification
- Driving Record from the DMV (Current)
- Professional License Lookup
- Professional Certificate Verification
- Tax Forms Completed (W-4, W-9, VA-4)
- Background Check
- Interview Employee
- Give Orientation (In-services on Hire)
- Give Employee Handbook to Employee
- Give Employee Pay Schedule & Documentation Memorandum