



OLIVER HOME HEALTHCARE AGENCY, LLC
APPLICATION FOR EMPLOYMENT

Note: Applicants will be tested for illegal drugs.

Date of Application
Date of Hire:

PLEASE PRINT LEGABLY ALL INFORMATION REQUESTED EXCEPT SIGNATURE AND COMPLETE ALL QUESTIONS OR STATE "N/A" IF NOT APPLICABLE.



PERSONAL INFORMATION:

Name: Last First Middle

Present Address: Address City State Zip

Social Security Number: Cell Number: Home Number:

If under 18 please list age: How did you hear about OHHC?

Are you applying for position of Attendant Provider? YES NO If you checked NO, What position are you applying for? How many hours a week can you work?

Days and Hours available to work (circle all days that apply and document hours):

No Preference: Sunday: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday:

Can you work nights? What date are you available to start working?



EDUCATION: Check all that apply.

High School Diploma GED College Business/Trade School

HAVE YOU EVER BEEN CONVICTED OF A CRIME? (We do perform Background Checks) 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) and type(s) of rehabilitation.



APPLICATION CONTINUED

**WORK EXPERIENCE:** *(You may skip this section if you have attached a resume)*

Please list your work experience for the past 3 years beginning with your most recent job held. If you were self-employed, give firm name. Attach additional sheets if necessary.

Name of Employer: \_\_\_\_\_

Employment Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Position Held: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Duties: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_

Reason for Leaving: *(please be specific)*

\_\_\_\_\_  
\_\_\_\_\_



Name of Employer: \_\_\_\_\_

Employment Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Position Held: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Duties: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_

Reason for Leaving: *(please be specific)*

\_\_\_\_\_  
\_\_\_\_\_



Name of Employer: \_\_\_\_\_

Employment Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Position Held: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Duties: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_



**Reason for Leaving:** *(please be specific)*

---

---

**APPLICATION FORM WAIVER:** *(Please read carefully and sign below)*

*In exchange for the consideration of my job application by OLIVER HOME HEALTHCARE AGENCY LLC, (herein after called "the Agency"), I agree that:*

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship either in the position applied for or any other position, and regardless of the contents of employee handbooks personal manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Agency practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of the Agency, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the owner or administrator of the Agency. Both the undersigned and the Agency may end the employment relationship at any time without specified notice or reason. If employed, I understand that the Agency may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for4 is cause for dismissal at any time without any previous notice. I hereby give the Agency permission to contact schools, previous employers (unless otherwise indicated), references etc... And I hereby release the Agency from any liability as a result of such contact.

I further understand that my employment with the Agency shall be probationary for a period of sixty (60) days and further that at any time during the probationary period or thereafter my employment relation with the Agency is terminable at will for any reason by either party.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



This Agency is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this Agency depends solely on your qualifications.

**REFERENCE VERIFICATION FORMS:** (We *must have two* references – One reference can be of Personal nature)

Check one:  Professional  Personal

I, \_\_\_\_\_ Date: \_\_\_\_\_ give my permission to release any/all information concerning my work relationship to **Oliver Home Healthcare Agency**.

I was employed with \_\_\_\_\_ (Company/Agency)

From \_\_\_\_\_ to \_\_\_\_\_ and my position was \_\_\_\_\_. My duties included \_\_\_\_\_

My reason for leaving is: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_



**APPLICANT Please Do not write below this line - for Office use only**

Reference Given By: \_\_\_\_\_ Title: \_\_\_\_\_

- |                         |                                    |  |                                  |                                       |
|-------------------------|------------------------------------|--|----------------------------------|---------------------------------------|
| Quality of work:        | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Communication Skills    | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Interpersonal Skills    | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Professional Competency | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Dependability           | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |

Reason for Termination? \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_ Eligible for rehire?  YES  NO



Comments: \_\_\_\_\_

\_\_\_\_\_

Reference Taken By: \_\_\_\_\_

Date: \_\_\_\_\_

**REFERENCE VERIFICATION FORMS:** (We *must have two* references – One reference can be of Personal nature)

Check one:  Professional  Personal

I, \_\_\_\_\_ Date: \_\_\_\_\_ give my permission to release any/all information concerning my work relationship to **Oliver Home Healthcare Agency**.

I was employed with \_\_\_\_\_ (Company/Agency),  
From \_\_\_\_\_ To \_\_\_\_\_, and my position was \_\_\_\_\_. My duties included but were not limited to \_\_\_\_\_

My reason for leaving is/was: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_



**APPLICANT Please Do not write below this line - for Office use only**

Reference Given By: \_\_\_\_\_

Title: \_\_\_\_\_

- |                         |                                    |  |                                  |                                       |
|-------------------------|------------------------------------|--|----------------------------------|---------------------------------------|
| Quality of work:        | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Communication Skills    | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Interpersonal Skills    | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Professional Competency | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |
| Dependability           | <input type="checkbox"/> Excellent | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Unacceptable |

Reason for Termination? \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_ Eligible for rehire?  YES  NO



Comments: \_\_\_\_\_

Reference Taken By: \_\_\_\_\_

Date: \_\_\_\_\_

### CRIMINAL HISTORY CHECK: NOTIFICATION AND STATEMENT OF EMPLOYABILITY

I acknowledge that I have been informed by the Agency that a criminal history and Employee Misconduct or Nurse Aide Registry check will be performed on my name. I have informed this Agency of all names (for example, maiden name, aliases) that I have used in the past. I understand that if I have been employed on an emergency basis that my employment is temporary pending the results of the criminal history check. I also understand that if I have been listed in either registry or convicted of the following offenses, that I cannot be employed by this Agency.

**A. I have not ever been convicted of the following crimes:**

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20, Penal Code (kidnapping and unlawful restraint);
- An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);
- An offense under Section 21.11, Penal Code (indecent with a child);
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual or disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.08, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- An offense under Section 21.15, Penal Code (improper photography or visual recording);
- An offense under Section 22.05, Penal Code (deadly conduct);
- An offense under Section 22.021, Penal Code (aggravated sexual assault);
- An offense under Section 22.07, Penal Code (terroristic threat);
- An offense under Section 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering);
- An offense under Section 35A.02, Penal Code (Medicaid fraud);
- An offense under Section 42.08, Penal Code (cruelty to animals); or
- A conviction under the laws of another State, Federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed in this section and,
- An offense that the Agency determines to be a contra-indication to employment with the consumers the Agency serves.

**B. I have not been convicted of the following crimes within five years of this date:**

- An offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony.
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft), that is punishable as a felony;
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or as a felony,



- An offense under Section 32.46, Penal Code (securing execution of a document by deception), that is punishable as a Class A misdemeanor or a felony,
- An offense under Section 21.12, Penal Code (false identification as a police officer); or
- An offense under Section 42.010 (a), (7), (8) or (9), Penal Code (disorderly conduct).

I understand that all information obtained by this Agency regarding my criminal history will remain confidential. I certify that the information on this form contains no willful misrepresentation and that the information is true and complete to the best of my knowledge.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## DISCLOSURE OF DRUG TESTING

### POLICY

The Agency will provide a written statement describing the Agency’s policy for drug testing of employees who have direct contact with Clients to each person applying for services from the Agency and any person requesting the information.

The Agency recognizes its responsibility to protect its’ employees and Clients from the dangers posed by the use of illegal drugs, misuse of controlled substances and the effects of alcohol use in the office or in the home setting. Employees who illegally use drugs, misuse drugs or use alcohol on the job create a serious risk to the safety, security and health of themselves, other employees and Clients.

- In compliance with state and federal law, the Agency forbids any illegal or improper use of drugs and/or alcohol by its employees while on duty. (On duty includes rest periods, meal breaks and on-call hours).
- The Agency forbids selling, dispensing, distributing, possessing or manufacturing drugs, drug paraphernalia, alcohol or controlled substances during work hours or during any work-related activities.
- Any employee who is found to have violated this policy will be disciplined or terminated.
- An exception to this policy covers any employee who, under the direction of a physician, is taking prescribed medication while at work, while using agency equipment, while conducting agency business or while on breaks. In this circumstance, it is the responsibility of the employee to report the use of the prescribed medication that might affect job performance before job performance is actually impaired.

### PROCEDURE – At will testing:

The Agency does test for drugs or alcohol as a condition for employment. Also, the Agency may at will request an employee to submit to a drug and or alcohol test if the employee is suspected of being under the influence of such. The Agency will not tolerate such use or possession of. The Agency reserves the right to require a drug screen and/or alcohol use. Alcohol or drug use may be evidenced by odor of Alcohol or drugs on the employee’s breath or by inappropriate behavior or performance on the job. Testing may also be done after a work-related accident.

### PRESCRIPTION MEDICATIONS

If the employee is on a prescription medication, it is the employee’s duty to report the use of prescribed medication that might affect job performance before job performance is actually impaired. Reporting or excuses “After the fact” are not sufficient to limit or modify disciplinary or remedial action taken. For the purpose of this policy, individuals who report to work or perform work while



impaired or under the influence of a prescribed medication, the usage of which has not been reported previously, will be treated as having reported to work impaired or under the influence of a drug, and thus in violation of the policy.

**EMPLOYEE ASSISTANCE**

Employees in need of assistance in dealing with alcohol or drug related problems are encouraged to seek professional help prior to the necessity for application of this policy and corresponding procedure. Any employee who violates the above prohibitions will be subject to termination of employment or other relationship with the Agency or, at the Agency’s sole discretion, be required to satisfactorily participate in a drug and/or alcohol abuse assistance or rehabilitation program.

**METHOD BY WHICH DRUG TESTING IS CONDUCTED**

The method for drug testing will be either by urine, blood or breathalyzer data.

**EMPLOYEE INFORMATION FORM**

**Employee Name:** \_\_\_\_\_  
Last First Maiden

**Contact Number:** Home: ( ) \_\_\_\_\_  
Cell: ( ) \_\_\_\_\_  
Other: ( ) \_\_\_\_\_

**Email Address:** \_\_\_\_\_ @ \_\_\_\_\_ .com  
please print legibly

**Physical Address:** \_\_\_\_\_  
Street Address City State/Zip

**Emergency Contacts:** (Please submit at least 2)

**Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_



Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

OLIVER HOME HEALTHCARE AGENCY, LLC