Health Care Plus

Private Home Care Services

110 Harmony Crossing, Suite 1 - Eatonton, GA 31024
(706) 923-1977 office - (706)923-1978 fax

Application Procedures

Complete All Forms

- Application
- Background Questionnaire
- Motor Vehicle Record Request

❖ In order to complete the application process, please provide a $20 money order, which will cover the cost of the background check and the motor vehicle record.

❖ Please fill-out and return all forms including the money order **(sign & date).**

Please check that the following items are included before submitting your application:

- ☐ CNA Card/Certification (If applicable but not required)
- ☐ Drivers License
- ☐ Social Security Card
- ☐ CPR Card
- ☐ First Aid Card
- ☐ TB Test Results
- ☐ Proof Of Vehicle Insurance

Please submit a copy of the items listed within 30 days of orientation to prevent termination.

If you fax your application, the original copy will be requested during orientation.

(Background checks will be processed before orientation is conducted)

Application For Employment

Health Care Plus, LLC
Private Home Care Services
110 Harmony Crossing, Suite #1
Eatonton, GA 31024
(706) 923-1977

An Equal Opportunity Employer

Confidential

Please Print in Dark Ink

Date_____

Position Applying for: RN LPN CNA PCA
Other_____

Last Name	**First Name**	**Middle Initial**	**Social Security #**	**Date of Birth**

Present Address	**City**	**State**	**Zip Code**

Day Telephone #	**Night Telephone #**	**Cell Phone #**	**Licensure/Certification (circle one)**
			Number/State_____ Expiration Date_____ Number/Sate_____ Expiration Date_____

Date Available for Employment:	**County/s You Prefer to Work**	**(circle all that apply):**	**Check shift you are willing to work:**
Do you have current: - **CPR?** Yes No Exp: Date_____ - **1st Aid** Yes No Exp: Date_____	Greene Jasper Baldwin Morgan	Putnam Hancock Taliaferro Jones	_____7 a.m. – 3 p.m. _____11 p.m. – 7 a.m. _____ 7 a.m. – 7p.m. _____3 p.m. – 11 p.m. _____ 7 p.m. – 7 a.m. **Willing to work:** _____ Weekends _____ Holidays _____ Weekdays Only _____ Weekends Only
	I have transportation:	Yes No	**Days available for work assignments: (circle all that apply)**
	Are you on other Registries?	Yes No	Monday Tuesday Wednesday Thursday Friday

Education

School	Name Location	Major Course of Study	Dates Attended	Date Graduated
Primary School		Grade Completed –		
High School				
Vocational/ Technical				
College				
Graduate				
Other				

Professional Training:

General Information:

Are you presently employed? _____ Yes _____ No If yes, may we call you at work to offer you work? _____ Yes _____ No

Would you take last-minute called in shifts? ___ Yes___ No Have you ever been convicted of control substance abuse, sexual, or abuse violation? ____Yes _____ No

If Yes please explain: _____

Employment History: Please list your job history starting with your current position, going back 5 years.

Company			Street Address	City	State	Zip Code
From Mo/Yr	To Mo/Yr	Telephone #	Duties			
Position			Shift Worked		Supervisor's Name & Telephone #	
Starting Salary			Leaving Salary		Reason for Leaving	
Company			Street Address	City	State	Zip Code
From Mo/Yr	To Mo/Yr	Telephone #	Duties			
Position			Shift Worked		Supervisor's Name & Telephone #	
Starting Salary			Leaving Salary		Reason for Leaving	
Company			Street Address	City	State	Zip Code
From Mo/Yr	To Mo/Yr	Telephone #	Duties			
Position			Shift Worked		Supervisor's Name & Telephone #	
Starting Salary			Leaving Salary		Reason for Leaving	
Company			Street Address	City	State	Zip Code
From Mo/Yr	To Mo/Yr	Telephone #	Duties			
Position			Shift Worked		Supervisor's Name & Telephone #	
Starting Salary			Leaving Salary		Reason for Leaving	

May we contact your employers listed above? _________Yes _______No If No, indicate which we should not call and why________________________

____

Medical History: Have you ever had any problems, physical disabilities, or injuries involving any of the following:

Yes	No	Date	Condition	Yes	No	Date	Condition
			Emotional Problems				Liver Disease
			Epilepsy				Hernia
			Respiratory Problems				Stomach Ulcer
			Arthritis				Dysmennorrhea
			Sickle Cell Trait/Anemia				Hypertension
			Back Injury/Problems				Heart Disease
			Phlebitis				Cancer
			Rheumatic Fever				Tuberculosis
			Kidney/Bladder Problems				Diabetes
			Eye Disease/Glaucoma				Skin Disease
			Herpes				AIDS
			Allergies				Headaches

Current Physical Condition/Status

Condition	Yes	No	Explain
Currently Pregnant (months)			
Under Physician's Care?			
Current On Medication?			For what conditions?
Ever Received Treatment For Alcohol or Drugs?			
Surgery Last two (2) years?			
Do You Smoke?			Amount per week
Days Lost from Work or School Due to Sickness Last Year?			

Have You Ever Had Any Restrictions On Your Nursing License or Certification (if applicable)
_____Yes _____ No
Explain if Yes:

_____

_____

Have You Ever Had Any Counseling or Disciplinary Action Taken By Past or Current Employees As A Result of Drinking, Drugs, or Any Other Addiction While On The Job? _____Yes _____NO
Explain if Yes:

_____

_____

Do You Have Current Malpractice Insurance? _____Yes _____No Company Name_____

Policy #_____ Expiration Date_____

PLEASE READ CAREFULLY AND SIGN:

I certify that the information above is true and complete to the best of my knowledge. I authorize investigation of the above information concerning my past medical history and release all parties from liability for any damage that may result from furnishing same to you.

_____ _____
Signature of Applicant Date

Before you can begin working for Health Care Plus, LLC your file must be complete with the following documentation:

Document	**Required For Personal Care Assistant (PCA)**	**Required For Certified Nursing Assistant (CNA)**	**Required For Licensed Practical (LPN) or Registered Nurses (RN)**	**Date Submitted**
Drivers License	To Drive Client's Vehicle	To Drive Client's Vehicle		
Auto Insurance Card	X	X	X	
CPR Card	X	X	X	
1st Aid Card	X	X	X	
Hepatitis B	Encouraged	Encouraged	Encouraged	
Current Nursing License			X	
Certification Certificates (CNA, CPR Instr., ACLS etc.)	X	X	X	
Tine Test/PPD	X	X	X	
Physical Examination	X	X	X	

References – Please give three (3) references (References should not be related to the Applicant):

Reference Name	Address (Street, City, State, Zip Code)	Telephone #

Do Not Write Below This Line

Georgia Department of Driver Services
Customer Service, Licensing and Records Division
P.O. Box 80447
Conyers, Georgia 30013

REQUEST FOR MOTOR VEHICLE REPORT (MVR)

☐ I am requesting my own Georgia MVR. (Complete Sections 1, 3, and 4)

☐ I am requesting a Georgia MVR of another individual. (Complete Sections 1, 2, 3, and 4)

PLEASE PRINT LEGIBLY

SECTION 1 – DRIVER INFORMATION (must exactly match driving record)			
Full Name (First, Middle, Last)			
Driver Date of Birth (MM/DD/YY)		Driver's License Number	

SECTION 2 – THIRD PARTY REQUESTOR INFORMATION	
Full Name (First, Middle, Last)	
Firm Name (if applicable)	
Address	
FOR DEPARTMENTAL USE ONLY	

SECTION 3 – TERM OF REQUEST

Please choose one of the following options:
☐ Three (3) year Georgia MVR ($6.00 fee) ☐ Seven (7) year Georgia MVR ($8.00 fee)

If you are requesting a Georgia MVR by mail, please include a business sized self-addressed stamped envelope along with this request and the required payment amount. By mail, we accept personal checks, cashier's checks, money orders, and company checks.

SECTION 4 – AUTHORIZATION TO RELEASE RECORD OF DRIVER

Under penalty of law, I hereby (please check one)
☐ request release of my driving record; OR
☐ consent to release of my driving record to the person and/or entity named in Section 2, in accordance with O.C.G.A. §40-5-2.

Signature of Driver		Date (MM-DD-YY)	

Georgia College & State University
Background Investigation Questionnaire

Confidential

I understand that this form will be kept separately from my employment application and that the information regarding my date of birth, place of birth and listed physical characteristics will not be available to the hiring supervisor. I further understand that any employment decision will be made based on my qualifications, employment record and police record as related to the requirements of the position for which I am being considered.

NAME _____
Last First Middle

Other names used: (Maiden name, names by former marriages, former names changed legally or otherwise: Aliases, nicknames, etc. Specify which and show dated used) _____

_____

_____

DRIVERS LICENSE # _____ SOCIAL SECURITY # _____

ADDRESS _____ PHONE _____
Number Street

_____
City State Zip

DOB _____ PLACE OF BIRTH _____ SEX _____ RACE _____

HEIGHT _____ WEIGHT _____ EYE COLOR _____ HAIR COLOR _____

Have you ever been arrested by Federal, State or other law enforcement authorities for any violation of any federal law, state law, county or municipal law, regulation or ordinance? (Do not include anything that happened before your 17th birthday.
Do not include minor traffic violations for which a fine of $ 35.00 or less was imposed. All other arrests must be included even if they were pardoned) YES ☐ NO ☐

List all arrests to include date, location and agency involved _____

_____

_____

_____

I hereby authorize Health Care Plus to receive any criminal history record information pertaining to me, which may be in the files of any local, state or federal agency. I hereby release the Board of Regents of the University System of Georgia, Georgia College & State University and their employees and agents from any and all liability arising from this authorization for the subsequent review of the information disclosed pursuant to this authorization.

_____ _____
FULL NAME PRINTED LEGAL SIGNATURE