



**NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.
APPLICATION FOR EMPLOYMENT**

DATE OF APPLICATION: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ COUNTY: _____

STATE: _____ ZIP CODE: _____ HOME PHONE: _____

BUSINESS PHONE: _____ EMAIL ADDRESS: _____

HAVE YOU EVER BEEN CONVICTED OF AN OFFENSE AGAINST THE LAW OTHER THAN A MINOR TRAFFIC VIOLATION?

____ YES ____ NO

CHECK THE TYPES OF WORK YOU WILL ACCEPT: _____ FULL TIME _____ PART TIME

____ TEMPORARY FULL TIME _____ TEMPORARY PART TIME _____ WORK INVOLVING TRAVEL

ARE YOU AVAILABLE FOR WORK NOW? _____ YES _____ NO

WHEN WOULD YOU BE AVAILABLE FOR WORK? _____

WHAT POSITION ARE YOU APPLYING FOR? _____

PLEASE INDICATE YOUR REFERRAL SOURCE. _____

EDUCATION: HIGHEST LEVEL COMPLETED: _____

SCHOOLS	NAME AND LOCATION	MAJOR:	GRAD?	DEGREE RECEIVED
HIGH SCHOOL				
COLLEGE/UNIVERSITY				
GRADUATE SCHOOL				
OTHER EDUCATION				

SPECIAL TRAINING PROGRAMS AND SEMINARS YOU HAVE COMPLETED IN THE LAST FIVE YEARS:

CURRENT PROFESSIONAL STATUS: (List fields of work for which you are required to register.)

REGISTRATION: _____ STATE: _____ NUMBER: _____

REGISTRATION: _____ STATE: _____ NUMBER: _____

LICENSES AND CERTIFICATION: (List each with dates and sources of issuance.) :

OTHER SKILLS: _____

WORK EXPERIENCE: (start with present position and work back)

MAY WE CONTACT YOUR PRESENT AND PAST EMPLOYER(S)? _____ YES _____ NO

CURRENT OR PREVIOUS EMPLOYER: _____

SUPERVISOR'S NAME: _____ TELEPHONE NUMBER _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE EMPLOYED: _____ DATED SEPARATED: _____

REASON FOR LEAVING: _____ ENDING SALARY: _____

List major duties in order of importance:

PREVIOUS EMPLOYER: _____

SUPERVISOR'S NAME: _____ TELEPHONE NUMBER _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE EMPLOYED: _____ DATED SEPARATED: _____

REASON FOR LEAVING: _____ ENDING SALARY: _____

List major duties in order of importance:

PREVIOUS EMPLOYER: _____

SUPERVISOR'S NAME: _____ TELEPHONE NUMBER _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE EMPLOYED: _____ DATED SEPARATED: _____

REASON FOR LEAVING: _____ ENDING SALARY: _____

List major duties in order of importance:

This agency requires Criminal Background Checks on all unlicensed direct care providers (i.e. CNAs). Signature of this application gives consent to the same. Signature also certifies that true, accurate and complete information, to the best of my knowledge has been given. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registrations and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigation of all statements made in this application and understand that false information or documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action or dismissal if I am employed, and/or criminal action. I further understand that dismissal upon employment shall be mandatory if fraudulent disclosures are given to meet position qualifications. (Authority: G.S. 126-30, G.S. 14-122.1.)

SIGNATURE: _____ DATE: _____

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.

CONFIDENTIALITY FORM

I understand as an employee of the Alliance and as a patient care provider, I must use discretion when discussing any patient information. Patients and any patient information is discussed on a need to know basis, to only those health care providers involved in that particular case. I will not acknowledge or reveal the names of the clients/patients seen by me to anyone other than those directly involved in the case, reviewers, in response to legal summons or as directed by agency management. As a Staffing Pool employee, I will read, sign, and adhere to the Confidentiality Policy of the agency(s) with which I am working.

I further understand that all medical record information must be safe guarded, that I may copy designated parts of the chart to aid me in caring for patients, however, it is my responsibility to ensure that these materials are safe guarded as well. I understand that I am not to leave any patient materials unprotected and that once a patient has been discharged or is no longer in my care, I am responsible for the safe destruction of that patient's information in my position.

I understand that failure to comply with this policy could result in termination of my employment and legal action.

I have read this policy and understand its content.

Employee Signature

Date

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.

HEPATITIS B VACCINATION WAIVER FORM

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring HBV (Hepatitis B Virus) infection.

I have read the Hepatitis B Information Sheet and have had an opportunity to ask questions and understand the risks and benefits of the HBV vaccine.

I have been given the opportunity to be vaccinated at no charge to myself.

Having been so informed,

_____ I request the HBV vaccine.

_____ I decline to take the HBV vaccine at this time.

_____ I have already had the HBV vaccine.

I understand that due to my occupational exposure to blood or other potentially infectious material I may be at risk of acquiring hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to me. However, I decline hepatitis B vaccine 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.

Employee's signature

Date

[PLEASE COMPLETE & RETURN TO US]

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.

EMPLOYEE IMMUNIZATION RECORD

The Alliance follows the CDC Immunization Guidelines for all of our employees.

Please complete the form or submit copies of your immunization records from your health care provider.

Employee: _____ Date: _____
County _____ Position: _____

Hepatitis B Series: Yes _____ Dates: _____
No _____ Declination Form Signed? Yes _____ No _____

Tetanus:

1. One dose of Tdap vaccine at least 5 years after last Tetanus booster
Date Received: _____ Date Due: _____
2. Tetanus (Td) booster every 10 years
Last Dose: _____ Date Due: _____

MMR / MR: (Measles, Mumps, Rubella)

One of the following is required:

1. Titer indicating immunity
Date: _____
2. Birth during or after 1957 and documentation of 2 doses of vaccine
Dates: _____
3. Birth prior to 1957 and 1 dose of vaccine
Date: _____

[For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957 or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) physician-diagnosed measles or mumps disease.]

Varicella:

One of the following required:

1. Titer indicating immunity
Date: _____
2. Documentation of 2 doses of vaccine
Dates _____

It is recommended that all HCP be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart.

TB Skin test:

1. Two-step test if no skin test in the past year.
Date of test #1: _____ Date of test #2: _____
2. Please provide documentation of test in the past year, only one required.
[If documentation in the past year, only one test is required.]
Date of last skin test: _____ Date of test #2 _____

If you do not have these immunizations, you will need to get them unless your worksite follows different guidelines or due to a documented medical condition.

WORK HISTORY AUTHORIZATION TO RELEASE FORM

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.
7424 Chapel Hill Rd., Suite 201
Raleigh, NC 27607
(919) 233-7334

The above agency has permission from my signature below to request and receive information regarding my previous employment with your agency. (Photocopies of this authorization are valid.)

Signature

Date

SS#

NORTH CAROLINA ALLIANCE of PUBLIC HEALTH AGENCIES, INC.

Complete only if the position you are applying for requires on-the job driving.

DRIVER HISTORY FORM

Name (Print): _____

Home Address: _____

City: _____ State: _____ Zip: _____

1. Do you have a valid Driver's License? Yes _____ No _____

2. In what State are you a Licensed Driver? _____

3. If you have held a license in any other state during the past 5 years, please provide the following information:

Dates		State
From _____	to _____	_____
From _____	to _____	_____
From _____	to _____	_____

4. Have you been convicted of driving while impaired or under the influence of alcohol and/or drugs within the past three years? Yes () No () If Yes, give explanation(s) and date(s):

5. Have you refused to submit to a Blood Alcohol Content (BAC) test within the past three years? Yes () No () If Yes, give explanation(s) and date(s):

6. Have you been convicted of reckless driving, or leaving the scene of an accident, or committing a felony involving a vehicle within the past three years? Yes () No () If Yes, give explanation(s) and date(s):

7. Have you had your operator's license suspended, revoked or administratively restricted within the past three years? Yes () No () If Yes, give explanation(s) and date(s):

8. Have you been convicted or found at fault for any non-fatal accident involving a motor vehicle during the past three years? Yes () No () If Yes, list the date(s):

9. Have you been convicted or found at fault for any fatal accidents involving a motor vehicle during the past three years? Yes () No () If Yes, list the date(s):

10. Have you been convicted of any other moving vehicle violations during the past three years? Yes () No () If Yes, list type(s) and date(s):

I certify that the answers provided to the questions on this form are true to the best of my knowledge.

I authorize NCAPHA or its designated representative(s) to obtain information regarding my driving record in any state at any time while I am employed by (or seeking employment with) the company.

I understand that any misstatement of the facts on this form may be grounds for termination of employment.

In the event that my MVR indicates that I am a "High Risk Driver" as defined in the glossary of the Fleet Safety Program, I understand that I may be subject to dismissal.

Driver's signature

Date

Driver's License Number

Expiration Date

State

Important Note: Attach photocopy of both sides of driver's license

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.

FLEET SAFETY CHECK SHEET

Complete only if the position you are applying for requires on-the job driving.

_____ Current N C Drivers License
Expiration Date _____

_____ Documentation of Current Insurance
Expiration Date _____

_____ Vehicle Safety Inspection
Expiration Date _____

_____ The employee has been informed that they are required to notify the supervisor/Alliance if they have any illness, injury, physical condition or use medication that may impair or affect their ability to safely drive a "Motor Vehicle," or if their license is revoked, or they have had administrative restrictions imposed.

_____ Agrees to comply with requirement that all drivers must wear seat belts.

I certify that I have had the Fleet Safety Policy reviewed with me and will follow all state, federal, and local laws involving the use of my vehicle. I further acknowledge that any actions taken by me in the use of my vehicle which are considered unsafe/dangerous may result in termination of my employment.

Signature of employee

Date



A better way to better people.

APPLICANT'S *Disclosure & Consent* RELEASE OF INFORMATION

PLEASE COMPLETE & RETURN TO US.

APPLICANT INFORMATION (Please Print)

Applicant Name: (First Middle Last)	Current Address: (street address)
Other Name(s) Used: (like Maiden)	City: State: Zip:
Social Security Number:	Former Address: (1)
Sex: Race:	City: State: Zip:
Driver's License No.: State of Issue:	Former Address: (2)
Month, Day and Year of Birth: Place of Birth: (City, State, Country)	City: State: Zip:

Applicant Instructions: Please read this disclosure and consent form carefully before signing. You will be provided with a copy of this form at any time upon request.

DISCLOSURE AND CONSENT CONCERNING CONSUMER REPORTS FOR EMPLOYMENT APPLICANTS AND EMPLOYMENT PURPOSES.

You should read carefully. This consent and release has been provided to you for this employer to request a consumer report or investigate consumer reports in connection with your application for employment, resume or during the course of your employment, if any.

The Applicant acknowledges that this company may now, or at any time while employed, verify information within the application, resume or contract for employment. The verifications and/or checks may include but not limited to: driving record, workers compensation records, credit bureau files, employment references, personal references, any educational and licensing institution and to receive any criminal record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in North Carolina or any other State. A photocopy or telephonic facsimile (Fax) of this Disclosure and Consent authorization for Release of Information shall be valid as the original. The results of this verification process will be used to determine employment eligibility. All results will be kept CONFIDENTIAL. The information obtained will not be provided to any parties other than to designated Company Personnel.

According to the Fair Credit Reporting Act, if any adverse decision is made with regard to application for employment, based entirely or in part on the information contained in a consumer report or investigative consumer report prepared by a consumer reporting agency, you are entitled to receive a copy of this report upon written request, and a disclosure of the nature and scope of the investigative report.

Your signature below indicates that you have carefully read and understand that a consumer report or investigative consumer report regarding you may be requested and reviewed for employment purposes, including any future decisions concerning your employment, promotion, or retention as an employee. Additionally, your signature below reflects your understanding that such consent will remain in effect indefinitely until you revoke it in writing.



CONSENT STATEMENT

I have carefully read and understand this disclosure and consent form and by my signature consent to the release of consumer or investigative consumer reports, as defined above in conjunction with my application for employment. I further understand this consent will apply during the course of my employment, should I obtain such employment, and that such consent will remain effect until revoked in a written document signed by me. In the event that I wish to refuse or revoke my consent at any time, I understand that I may do so. I further understand that any and all information contained in my job application, or otherwise disclosed to this company by me may be utilized for the purpose of obtaining the consumer reports or investigative consumer reports requested by the Employer and confirm that all such information is true and correct.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as a cause for possible dismissal.

I authorize Hirease, Inc. and any of its Agents/designated Company Personnel, to disclose orally and in writing the results of this verification process and/or interview to authorized representatives. I do hereby agree to forever release and discharge This company , our agent, Hirease, Inc. and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint arising from the retrieving and reporting of information. **CALIFORNIA CONSUMER REPORTING ACT DISCLOSURE FOR EMPLOYMENT IN CALIFORNIA ONLY:** By checking this box, I request to receive a copy of the report from the credit reporting agency at no charge at the same time the report is provided to the prospective employer.

FOR CA, MN, OK: PLEASE PROVIDE ME WITH A COPY OF MY BACKGROUND INVESTIGATION REPORT. _____ YES _____NO

IF YOU RESIDE IN CT, PLEASE LIST YOUR CONTACT INFORMATON FOR REPORT NOTIFICATION:

EMAIL: _____

Applicant Signature

Date

Applicant Name Typed or Printed