LARLIN

6900 Main St., Suite 6 Downers Grove, Il 60516
Tel. No. (630) 852-4007; Fax No. (630) 852-1220

Please check which company you are applying for:

- ☐ **Health Care, Inc.**
- ☐ **HomeCare Services**
- ☐ **Private HomeCare, Inc.**

JOB APPLICATION

Today's Date:

Applying for:

- ☐ Registered Nurse (RN)
- ☐ Licensed Practical Nurse (LPN)
- ☐ Physical Therapist (PT)
- ☐ Occupational Therapist (OT)
- ☐ Medical Social Worker (MSW)
- ☐ Speech Therapist (ST)
- ☐ Home Health Aide (CNA)
- ☐ Homemaker
- ☐ Others (please specify: _____)

Availability:

- ☐ Full Time
- ☐ Part Time:
- ☐ available days: _____
- ☐ available time: _____
- ☐ Others: Specify _____

How Did You Learn About Us? Please check.

☐ Advertisement ☐ Friend (Name of your friend:_____) ☐ Walk-In

☐ Internet search ☐ Relative (Name of relative: _____) ☐ Other

LAST NAME	**FIRST NAME**	**MIDDLE NAME**

ADDRESS NUMBER	**STREET**	**CITY**	**STATE**	**ZIP**

(PREVIOUS ADDRESS IF CURRENT RESIDENCE UNDER ONE YEAR)

TELEPHONE NUMBER (S) **Cellphone:.** **House Phone**:	**E-mail address:**
SOCIAL SECURITY NUMBER	**DRIVER'S LICENSE NUMBER** (Include State)

Have you ever been given a job placement with this company before? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No

Are you either a U.S. citizen or an alien authorized to work in the United States? ☐ Yes ☐ No
Proof of citizenship or immigration status will be required (encircle if US citizen or alien with permit to work)

Have you been convicted of a felony within the last 7 years? ☐ Yes ☐ No
Conviction will not necessarily disqualify an applicant from employment

Do you have a valid Illinois driver's license? or, ☐ Yes ☐ No

Do you have a valid out of state driver's license? ☐ Yes ☐ No

Do you drive your own car? ☐ Yes ☐ No

Do we have your permission to take a picture of you? ☐ Yes ☐ No

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

Education:

	Name and Address of School	(Specify degree earned)	Years(From-To)
High School			
College			
Graduate			
Others			

Are you computer literate? ☐ Yes ☐ No

If yes, using scale of 1-10, 10 being the best, please describe your computer proficiency. ☐

List all computer training:

List any/all programs you are proficient with:

If your education was in a different country, state what country and any other additional information.

Describe other specialized training or any other extra-curricular activities involving your field of expertise.

Indicate any foreign language/s you can speak, read and/or write

	Fluent	Good	Fair
Speak			
Read			
Write			

Additional Information:

Previous experience working with: (check all that apply)

- ☐ Alzheimer's/Dementia
- ☐ Cooking for Client
- ☐ Foley Catheter
- ☐ Incontinence
- ☐ Sponge baths (bed)
- ☐ Bedridden
- ☐ Diabetic
- ☐ Hospice
- ☐ Patient Lifting – how many pounds:_____
- ☐ Stroke
- ☐ Wheelchair Assistance

Do you have any physical limitations that preclude you from performing any work for which you are being considered? (check one) ☐ Yes ☐ No

If yes, what can be done to accommodate your limitations? Please describe: _____

In case of Emergency Notify _____

Name Relationship Telephone

_____

Address

LIST OF PREFERRED AREA OF ASSIGNMENT

	NAME OF CITY OR VILLAGE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Personal References:

PROVIDE NAMES, ADDRESSES AND PHONE NUMBERS OF PERSONS NOT RELATED TO YOU, WHOM YOU'VE KNOWN FOR **AT LEAST ONE YEAR** THAT CAN SPEAK OF YOUR CHARACTER.

1) _____(_____)_____
(Name) (Area Code) (Telephone)

_____
(Address)

2) _____(_____)_____
(Name) (Area Code) (Telephone)

_____
(Address)

3) _____(_____)_____
(Name) (Area Code) (Telephone)

_____
(Address)

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST 5 YEARS

Current Address: Street:	Apt:	City	State:	Zip:
Previous Address: Street:	Apt:	City	State:	Zip:
Previous Address: Street:	Apt:	City	State:	Zip:
Previous Address: Street:	Apt:	City	State:	Zip:

Employment Experience

Start with your last job. Include any Healthcare assignment and Non-Healthcare jobs.

This section is very important, make sure you give us enough information so we can thoroughly check your past job experience.

EMPLOYER 1:	Dates Employed		Work Performed
	From	To	
ADDRESS			
	Hourly Rate/Salary		
(Telephone)	Start	Final	
(IF EMPLOYER IS NOT ABLE TO VERIFY YOU MUST GIVE OTHER CONTACT) Contact Name: Relationship: Telephone:			Reason for leaving

EMPLOYER 2:	Dates Employed		Work Performed
	From	To	
ADDRESS			
	Hourly Rate/Salary		
(Telephone)	Start	Final	
(IF EMPLOYER IS NOT ABLE TO VERIFY YOU MUST GIVE OTHER CONTACT) Contact Name: Relationship: Telephone:			Reason for leaving

EMPLOYER 3:	Dates Employed		Work Performed
	From	To	
ADDRESS			
	Hourly Rate/Salary		
(Telephone)	Start	Final	
(IF EMPLOYER IS NOT ABLE TO VERIFY YOU MUST GIVE OTHER CONTACT) Contact Name: Relationship: Telephone:			Reason for leaving

EMPLOYER 4:	Dates Employed		Work Performed
	From	To	
ADDRESS			
	Hourly Rate/Salary		
(Telephone)	Start	Final	
(IF EMPLOYER IS NOT ABLE TO VERIFY YOU MUST GIVE OTHER CONTACT) Contact Name: Relationship: Telephone:			Reason for leaving

ALL INFORMATION, DATES AND SIGNATURES MUST BE COMPLETED TO PROCESS.

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EMPLOYEE HEALTH RECORD

This section must be completed and signed before employment.

Name:	Date of Birth:	S.S. #"
Address:	City	State and Zip:

Please indicate with an (✓) if you have any of the following:

- ☐ Severe Headaches
- ☐ Vision Impairment
- ☐ Hearing Difficulties
- ☐ Speech Impairments
- ☐ Fainting/ Dizzy Spells
- ☐ Asthma/ Allergy
- ☐ Frequent Colds
- ☐ TB/ other Communicable Diseases
- ☐ Chronic Coughing
- ☐ Chest Pain
- ☐ Heart Problems
- ☐ Varicose Veins
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Back Problems
- ☐ Arthritis/bone Problems
- ☐ Stomach Ulcers
- ☐ Bowel Problems/ Hernia
- ☐ Menstrual Difficulties
- ☐ Venereal Disease
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Skin Disease
- ☐ Alcoholism/ Drug Addiction
- ☐ Nervous breakdown

If you check any of the above, please explain:

Medical History: (Past Five Years)

A.	Are you under the care of a physician?	☐ Yes	☐ No
B.	Are you currently taking any medications?	☐ Yes	☐ No
C.	Have you had an operation/been hospitalized?	☐ Yes	☐ No
D.	Have you had any serious accidents?	☐ Yes	☐ No
E.	Have you had a positive reading on any test for tuberculosis?	☐ Yes	☐ No

If you answered yes to any of the above, please explain:

If required in your position, would you be wiling to have screening test for drugs/alcohol done on your blood/urine as a condition of your employment? ☐ Yes ☐ No
If no, please explain:

I hereby give permission to release the results of any test and/or information regarding my health status to LarLin company(ies). I understand that I must have an annual PPD/chest x-ray to retain active employment with LarLin company(ies).

Employee Signature Date

Please have your medical exams performed by your preferred Physician

Must be completed by Health Examiner/Physician.

		Date Tested	Results
A.	Physical Exam (Pre-employment)		
B.	PPD/Mantoux Test (if positive) Chest X-ray Required		
C.	Hepatitis		

Physical Exam	Normal	Abnormal	Comments
Skin			
Eyes			
Respiratory			
CV			
GI			
Urinary			
Nervous			
Musculoskeletal			

Height: _____ Weight: _____ Vital Signs: BP:_____ P: _____ R:_____ T: _____

I certify that the above person is free from symptoms indicating the presence of infectious diseases and does not have any condition, which would interfere with the performance of his/her duties.

Physician Signature: Date:

Printed Name of Physician:

BACKGROUND CHECK PERMISSION

FOR PROSPECTIVE EMPLOYEE

In connection with my application for employment with LARLIN company(ies). I hereby agree as follows:

1. GENERAL CONSENT TO BACKGROUND INVESTIGATION

As a condition of Company's consideration of my employment application, I give permission to Company to investigate my personal and employment history. I understand that this background investigation will include, but not be limited to, verification of all information on my employment application.

2. Consent To Contact Past Employers

I specifically give permission to Company to contact all of my prior employers for references. I further give permission to all current or previous employers and/or managers or supervisors to discuss my relevant personal and employment history with Company, consent to the release of such information orally or in writing, and hereby release them from all liability and agree not to sue them for defamation or other claims based upon any statements they make to any representative of Company. I further waive all rights I may have under law to receive a copy of any written statement provided by any of my former employers to Company. I further agree to indemnify all past employers for any liability they may incur because of their reliance upon this Agreement.

3. Consent To Contact Government Agencies

I further give permission to the Company to receive a copy of any information obtained in the file of any federal, state, or local court, or governmental agency concerning or relating to me. I further consent to the release of such information and waive any right under law concerning notification of the request for a release of such information. In the event a law does not provide for prospective employers to have access to information, I hereby delegate Company as my agent for the receipt of information. I understand that the scope of this investigation will be limited as required by applicable law.

4. Cooperation With Investigation

I agree to fully cooperate in Company's background investigation, and to sign any waivers or releases that may be necessary or desirable to obtain access to relevant information.

Law enforcement agencies and other entities for positive identification purposes require the following information when checking public records. It is confidential and will not be used for any other purposes. I hereby release LarLin company(ies) and all persons, agencies, and entities providing information or reports about me from any and all liability arising out of the request for or release any of the above-mentioned information or reports.

Signed:	Date:
Print name:	Position Applied for:
S.S. #:	Date of Birth:
Driver's License #:	D.L. State:

Other names you have used or are also known as:

_____

CONSENT AND RELEASE FOR HEPATITIS VACCINATION

Background:
The Occupational Safety and Health Administration of the U.S. Department of Labor (OSHA) issued regulations regarding occupational exposure to Hepatitis B Virus (HBV), Human Immunodeficiency Virus (HIV), and other blood borne pathogens. Under these regulations, employers in the health care industry are required to implement measures to prevent HBV and (HIV) exposure to employees. FJBV vaccine is one such measure. It provides active immunity against Hepatitis only and not against HIV infection. The vaccine must be taken in three doses at initial, one, and six-month intervals for hull immunization effect.

Who Should Consider Receiving HBV Vaccine?
In accordance with OSHA's regulations, LarLin company(ies) is offering the HBV vaccine free of charge to all employees who may reasonably anticipate occupational exposure to blood or other potentially infectious materials. I have been informed of the modes of transmission of blood borne pathogens including the Hepatitis B Virus. I have been instructed on LarLin company(ies) exposure control plan and understand the procedure to follow if exposure incident occurs. I have also been instructed on and understand the efficacy, safety, method of administration, benefits and possible adverse reactions of the Hepatitis B vaccine.

To Accept Vaccine:
I understand the potential benefits and side effects/adverse reactions HBV vaccine. I choose to receive the vaccine. I consent to receive the Hepatitis B vaccine. I release Medical Staffing, Inc. and its employees from all liability in connection with the administration of the vaccine. I understand that the vaccine is given in three doses: initial, in one month, and in six months. I understand that the HBV vaccine is being special ordered for me. I also understand that it is my responsibility to contact Medical Staffing, Inc. to arrange an appointment for each of the three doses throughout the six-month period.

Date Initial Vaccine Received: _____ Administered By: _____

Date Second Dose Received: _____ Administered By: _____
(1 month after initial)

Date Third Dose Received: _____ Administered By: _____
(6 months after initial)

Consent/Release for HBV Vaccination - B

_____ _____
Signature Date

_____ _____
Witness Print Name:

I wish to decline this vaccine: _____ Date: _____

Complete the following questions prior to administration of vaccine.

1.	Are you allergic to bread or bread products which contain yeast?	Yes ☐	No ☐
2.	Have you ever developed a rash, itching or other symptoms after any injection?	Yes ☐	No ☐
3.	Do you currently have a cold/fever or other active infection?	Yes ☐	No ☐
4.	Do you have a history of any heart problem, breathing difficulties, or lung problems?	Yes ☐	No ☐
5.	Are you currently pregnant or planning to have children in the near future?	Yes ☐	No ☐
6.	Are you currently breast feeding and/or giving your breast milk to your child?	Yes ☐	No ☐

_____ _____
Signature Of Applicant **Date**

_____ _____
Physician Signature **Telephone**

_____
Printed Name of Physician: **Date**

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INFLUENZA VACCINE DECLINATION FORM

(Please initial all that applies)

1. _____☐ I have read the "Influenza Vaccine Information Sheet, date _____. I had an opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks to influenza vaccine.
   _____☐ I intend to be vaccinated.

Print Name: _____ Department:_____

2. _____☐ I have already had an influenza vaccination this year.

   Location where vaccinated _____ Date _____

3. I acknowledge that I am aware of the following facts:
   - Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
   - Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
   - Up to 30% of people with influenza have no symptoms, allowing transmission to others.
   - Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
   - I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent the disease.
   - I have declined to receive the influenza vaccine for the _____ season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all health care employees to prevent infection from and transmission of influenza and its complications, including death, to patients/residents/clients, my co-workers, my family and my community.

4. I decline the offer of vaccination for the following reasons:
   _____☐ My philosophical or religious beliefs prohibit vaccination.
   _____☐ I have a medical contraindication to receiving the vaccine.
   _____☐ Other reason _____
   _____☐ I do not wish to say why I decline.

5. Knowing the facts set forth above, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

Print Name: _____ Department: _____

Signature: _____ Date _____

Applicant's Statement

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if given a job placement; falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references included in this application to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you.

I authorize LARLIN company(ies) and/or their designated representative, including an outside investigation company, to conduct a background and character investigation as a matter of procedure, which could, but is not limited to prior employment, consumer credit report, education verification, criminal background check and personal references. I understand that misrepresentation or omission of facts/requested information is cause for dismissal. Further, I release from liability all persons, companies and corporations supplying information as a result of this investigation. I further release and indemnify the agencies named above and the investigation company, against any liability that might result from conducting these investigations.

I understand and agree that, if given a job placement the duration is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time without prior notice.

Applicant's Signature _____ Date:_____

Company Representative Signature: _____

FOR PERSONNEL DEPARTMENT USE ONLY

NOTES

_____

_____

_____

CONFIDENTIALITY OF COMPANY INFORMATION

In the course of my employment, I understand I am likely to become familiar with confidential information at a LarLin company(ies) and/or its customers, such as, but not limited to names of customers, customers' medical conditions and health care information, price lists, and other information relating to the business and operations of LarLin company(ies) which is reasonably or customarily considered to be confidential, proprietary or otherwise sensitive. As such, this information is required to be maintained for the continued success of the corporation and its business as well as to preserve the confidentiality of medical information under applicable law.

The undersigned agrees:

a. Not to divulge, to anyone, either during or after the termination of my employment, any such information acquired during employment with Larlin company(ies)
b. To only disclose information to a current LarLin company employee who has a need to know that information.

I understand that the unauthorized release of such information and any breach of this confidentiality policy may constitute grounds for my termination, civil remedies, and/or criminal prosecution.

Read and approved:

Signed: **Date:**

Printed Name: