

Uniform Employment Application for Nurse Aide Staff

This application form is required by Title 63 O.S. § 1-1950.4 of state law and by the Oklahoma State Board of Health Rules OAC 310-2-15-3. This uniform application shall be used as the *only* application for employment of nurse aides in nursing and specialized nursing facilities, residential care homes, assisted living centers, continuum of care facilities, hospice programs, adult day care centers and home care agencies.

This employer does not discriminate in its hiring decisions or in any other employment decision on the basis of race, color, sex, religion, citizenship, national origin, veteran status, age or upon a physical or mental disability which is unrelated to the applicant's/employee's ability to perform the essential functions of the position.

ATTENTION NURSE AIDES: RETURN YOUR COMPLETED APPLICATION TO EMPLOYER.

Date of Application: _____

Date Available to Start Work: _____

1. Personal Information

Name: _____ Social Security Number: _____
(Last) (First) (Middle)

List any other name(s) you have previously worked under, such as maiden name: _____

Present Address: _____
(Street) (City) (State) (Zip)

Permanent Address (if different than present address): _____
(Street) (City) (State) (Zip)

Telephone Number: _____ Date of Birth: _____ Sex: M F Race: _____

Emergency Contact Person: _____
(Name) (Address) (Phone Number)

2. Employment Desired

Position applied for: _____ Salary required: _____

Hours available to work: _____ Days _____ Evenings _____ Nights _____ Weekends

Will you accept employment of: _____ Full Time? _____ Part Time? _____ Occasional Part Time?

3. U.S. Military Record

Branch: _____ Date Entered: _____ Date Discharged: _____ Type of Discharge: _____

4. Prior Work History (List your last four (4) jobs beginning with your most recent or current employer.)

Employer's Name: _____ Telephone Number: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

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Employer's Name: _____ Telephone Number: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Employer's Name: _____ Telephone Number: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Employer's Name: _____ Telephone Number: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

List name(s) of all other employers for the last five (5) years:

May we contact your present employer? Yes No Not applicable

Have you ever been terminated or asked to resign from any position? Yes No

If yes, provide reason. _____

5. Educational Background (List all educational schools attended with degrees, diplomas or certificates received.)

Name of Institution (High School, Technical School, College)	Type of Studies	Dates Attended & Diplomas, etc.

If your school or employment records are under another name(s), indicate that name(s): _____

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6. Certification

If you hold a current certification as a nurse aide (CNA), check the appropriate certification(s) below:

- Long Term Care (LTC) Home Health Aide (HHA) Adult Day Care (ADC)
 Residential Care Aide (RCA) Developmental Disability Aide (DDA) Certified Medication Aide (CMA)
 Certified Medication Aide-Gastrostomy (CMA-G) Certified Medication Aide-Glucose Monitoring (CMA-GM)
 Certified Medication Aide-Respiratory (CMA-R) Certified Medication Aide-Insulin Administration (CMA-IA)

List all technical special skills or education honors, certificates, licenses, memberships or Medication Administration Technician (MAT) certification not previously listed: _____

If you are a CMA, have you obtained your 8 hours of continuing education for the current 12-month certification period before your certification expires? Yes No

If yes, where and when did you obtain. _____

7. References (List name, address and telephone number of three (3) references who are not relatives or former employers.)

8. Background Information

If you answer YES to any of the questions below, explain in the space after the question. The explanation for a YES answer should include, but not be limited to:

1. State and/or jurisdiction.
2. Nature of complaint/offense.
3. Disposition of complaint and/or offense (e.g., "dismissed insufficient evidence", "deferred sentence").
4. Date of disposition.
5. Attach copy of any correspondence received by you, the applicant, regarding the complaint/offense.

a. Yes No Have you ever: 1) been arrested; 2) been charged; 3) pled guilty or no contest; 4) been convicted; 5) received a deferred sentence; and/or 6) been sentenced, for any criminal offense in any state or US jurisdiction?

b. Yes No Have you ever been found in violation of any state, US jurisdiction, or federal law regulating the practice of a health care profession?

c. Yes No Are any disciplinary actions or allegations, pending or substantiated, against you or your CNA certification or health care professional license in any state or U.S. jurisdiction?

d. Yes No Have you had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured or placed on probation by a state or US jurisdiction, federal or foreign authority or have you ever surrendered such credential to avoid, or in connection with, action by such authority?

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9. Applicant's Certification and Agreement

Please Read Carefully - If you answer 'No' to any of the questions below, explain in the space after the question.

a. Yes No I understand the employer has the right to proceed with any criminal background check.

b. Yes No I understand as a part of the job selection process, I may be required to take a drug-screening test at the time of employment and if requested in accordance with the state and federal law at anytime during my employment. A test result that has been confirmed as positive will eliminate me from employment. If I refuse to sign this form and submit to drug testing, the employer will reject my application.

c. Yes No I understand I may be required to have a physical examination and I hereby consent to take a physical examination and any future physical examinations as required by the employer.

d. Yes No I understand if I am hired I will be required to produce proof that I have a legal right to work in the U.S.A. in accordance with the IRCA of 1986.

e. Yes No I understand this form is not an employment contract.

10. Previous CNA Training - Complete this section only if you will require training.

Please complete the following if you have had CNA training in the past for any of these categories: LTC, HH, ADC, RC, or DBDC

Category	Program Name	Start Date	End Date
Category	Program Name	Start Date	End Date
Category	Program Name	Start Date	End Date

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11. Important Information for the Job Applicant

It is unlawful for any person to provide false information regarding a criminal conviction on this uniform employment application for nurse aides. Providing false information regarding a criminal conviction is a misdemeanor under Title 63 of the Oklahoma Statutes, Section 1-1950.4a. Providing false information about a criminal conviction on this application is punishable by a fine not to exceed Five Hundred Dollars (\$500.00), by imprisonment in the county jail for a term of not more than one (1) year, or by both such fine and imprisonment.

*** NOTICE ***

I UNDERSTAND PROVIDING FALSE OR MISLEADING INFORMATION TO A TRAINING PROGRAM, A FACILITY, OR THE DEPARTMENT IS GROUNDS FOR DENIAL, SUSPENSION, WITHDRAWAL, AND/OR NONRENEWAL OF CERTIFICATION. I ALSO UNDERSTAND PROVIDING FALSE INFORMATION OR OMISSION OF FACTS MAY DISQUALIFY ME FROM EMPLOYMENT AND MAY CAUSE TERMINATION IF DISCOVERED AT A LATER DATE.

INITIAL HERE _____

I certify I have read and completed this application and that the information I have provided on this application is true and complete.

Signature of Applicant

Date of Signature

12. Criminal Arrest Check List

Employment at this employer shall not be considered if the below signed individual has been convicted of one of the following crimes as stated by Oklahoma Statute, Section 1-1950.1 (F) (1) Title 63 (A through P of the list in this section):

- | | |
|--|---|
| <ul style="list-style-type: none"> A. Assault, battery, or assault and battery with a dangerous weapon, B. Aggravated assault and battery, C. Murder or attempted murder, D. Manslaughter, except involuntary manslaughter, E. Rape, incest or sodomy, F. Indecent exposure and Indecent exhibition, G. Pandering, H. Child abuse, | <ul style="list-style-type: none"> I. Abuse, neglect or financial exploitation of any person entrusted to the care or possession of such person, J. Burglary in the first or second degree, K. Robbery in the first or second degree, L. Robbery or attempted robbery with a dangerous weapon, or imitation firearm, M. Arson in the first or second degree, N. Unlawful possession or distribution, or intent to distribute unlawfully, Schedule I through V drugs as defined by the Uniform Controlled Dangerous Substance Act, O. Grand larceny, or P. Petit larceny or shoplifting within the past seven (7) years. |
|--|---|

It is further understood that if I am hired, it will be as a temporary employee until the employer receives my criminal background check. If I have no criminal record in accordance with state law, I may be considered for employment, subject to training requirements and other requirements of the job for which I am applying with this employer.

I hereby certify I have no previous convictions as listed in the Oklahoma Statute § 1-1950.1 (F) (1) Title 63 (A through P of the list in this section). My signature below authorizes the employer to run a check with the Nurse Aide Registry of the Oklahoma State Department of Health for notations of abuse, neglect or misappropriation of resident's property. I hereby give the Oklahoma State Bureau of Investigation authority to proceed with criminal record history checks as required by law.

Signature of Applicant

Date of Signature



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Employment Application Supplement

Applicant name (print)	Date
Provider agency	

As I apply for a job as a community services worker, I understand:

- prior to employing me, the community services provider is required by Oklahoma law to conduct a search of:
 - criminal history records with Oklahoma State Bureau of Investigation (OSBI); and
 - Oklahoma Department of Human Services (OKDHS) Community Services Registry (Registry);
- the community services provider is prohibited by Oklahoma law from hiring, contracting with, or using as a volunteer, any person;
 - who has been convicted, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony, except under circumstances described in OAC 340:100-3-39; and
 - whose name appears on the Registry;
- my employment may be terminated if my name appears on the Registry, even though my name may not have been on the Registry at the time of my application or hiring;
- I must report to the community services provider all of my current and previous employers who provide services to adults who are vulnerable; and
- giving false information regarding my current and previous employers may result in termination of my employment.

Applicant signature Date

Routing: Original – community services worker personnel record
 Copy – community services worker



Oxford HealthCare, Long Term Care Division
WAGE STATUS: Non-Exempt

LONG TERM CARE NURSE AIDE JOB DESCRIPTION

POSITION SUMMARY

This position is accountable for providing designated personal care services to the consumer in order to maintain their physical and emotional well-being and performing household activities to maintain a safe and clean environment.

POSITION REQUIREMENTS

Eighteen (18) years of age or older. Ability to follow directions and perform duties with minimal supervision. Ability to communicate and deal effectively and courteously with consumers, families, and co-workers. Must exhibit an empathetic attitude toward the sick, handicapped and elderly.

NATURE AND SCOPE

- Reports to Staffing Coordinator
- Communicates changes in the status of the consumer and/or family
- Provides personal care services and maintains household routines as directed by the Supervisor and Service Plan
- Participates in supportive activities to ensure maximum consumer independence in the home setting

ESSENTIAL FUNCTIONS

Provide Homemaker/Chore Services to maintain a safe and clean environment. These services include:

- Meal planning/preparation
- Making/changing linens on beds
- Tidying/dusting the home
- Sweeping/vacuuming/mopping floors (not on hands and knees)
- Cleaning kitchen counter and appliances
- Cleaning bathroom
- Laundering clothing and linens
- Washing dishes, pots and pans
- Shopping for essential items

PERSONAL CARE

Provide Personal Care (as directed by the Supervisor and Service Plan). These services include:

- Assistance with bathing and dressing
- Bed making—occupied and unoccupied
- Brushing, combing and shampooing hair
- Assistance with oral care
- Fingernail and toenail care (cannot trim or cut)
- Shaving
- Assistance with ambulation and transferring when consumer is able to assist
- Universal Precautions

ADVANCED CARE

Provide Advanced Supportive/Restorative Assistance (if aide is AS/R certified) which may include:

- Ostomy care
- Bowel program
- Catheter care
- Gastrostomy
- Dressings
- Lift
- Range of motion
- Universal Precautions

OTHER FUNCTIONS

Performs other related duties as directed by Supervisor.

RESPONSIBILITIES AND DUTIES

- Follow a written Service Plan (every hour of delivery must match the hours authorized).
- Observe and record the consumer's care.
- Report pertinent observations and significant changes in consumer's condition to the appropriate person
- Accurately and punctually complete necessary records and reports
- Use Universal Precautions appropriately when providing supportive/restorative assistance and homemaking tasks
- Attend required In-Service twice each year

REQUIRED SKILLS

VERBAL PROCESSING

- Read/Comprehend written instructions
- Communicate in written format
- Follow verbal instructions
- Interpersonal
- Organizational
- Computer
- Mathematical

POTENTIAL EXPOSURES (including but not limited to)

- Dust/fumes/gas
- Potential electrical shock
- High pitched noises
- Needle sticks
- Caustic/toxic/chemicals/detergents
- Extreme weather and/or temperature conditions
- Requirement to Use Universal Precautions
- Moving mechanical parts
- Communicable diseases
- Blood/body fluids
- Cigarette Smoke/Client Family Members/Pets

PHYSICAL REQUIREMENTS

- Position performed without physical assistance from another caregiver.
- Ability to lift, carry, push, and/or pull up to 50 pounds frequently.
- Ability to push or pull in excess of 100 pounds.
- Adequate vision and manual dexterity so that performance of tasks will not pose a threat to the health and safety of client and others.
- Adapt to varying home conditions including, but not limited to temperatures in excess of 80 degrees F. and below 55 degrees F. as well as high or low humidity.
- Prolonged periods of sitting and exerting up to 10# force occasionally.
- Exerts up to 20# force occasionally or frequently, and/or up to 10# constantly.
- Exerts up to 50# force occasionally or frequently, and/or up to 20# constantly.
- Exerts up to 100# force occasionally/frequently, and/or more than 20# constantly.

The requirements and activity percentages for this position are based on the following:

- 1 = not at all (0%) 2 = occasionally (1-33%)
 3 = frequently (34-66%) 4 = continually (67-100%)

4	Balancing	3	Bending	2	Climbing
4	Crouching	3	Kneeling	2	Lift Above Shoulders/Head
2	Lift from Floor	3	Lift from Waist	3	Pull with Force
2	Reach Above Head	3	Squatting	3	Twisting at Waist
4	Stand	4	Walk	2	Sit
4	Repetitive Motions	4	Good Manual Dexterity	4	Good Eye/Hand Coordination
4	Hear Normal Speaking Voice	4	Have Clarity of Vision	1	Heavy Data Entry

I have read and understand the Nurse Aide job description and Physical Requirements and can perform the essential functions with or without reasonable accommodation.

Signature of Applicant

Date



**AUTHORIZATION AND
AGREEMENT FORM**

3040 N. Hemlock Circle
Broken Arrow, OK 74012
918-258-1111
1-800-316-2222
Fax: 918-258-1114

REFERENCE AUTHORIZATION

I authorize Oxford HealthCare and/or its agents, including consumer reporting bureaus, to verify my employment experience. I also authorize any reference source to provide Oxford HealthCare with any and all information covering my background and hereby release any said sources from any liability for any damage whatsoever for issuing this information. A copy of this document shall have the same force and effect as the original.

_____ LAST NAME	_____ FIRST NAME	_____ MIDDLE NAME
_____ SOC. SEC. NO./IDENTIFICATION	_____ POSITION APPLIED FOR	
_____ FORMER NAMES		
_____ Signature of Applicant	_____ Date	

RELEASE OF INFORMATION

I agree that if the company or its employees are subject to review or investigation for accreditation or law enforcement purposes or to remain a participant in federal health care programs, I will cooperate in such investigations, which may include the release of information related to my employment with the company.

_____ Signature of Applicant	_____ Date
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AT WILL EMPLOYMENT

I understand and agree that any employment offered to me will not be for any definite period of time and is subject to termination with or without cause by myself or the company at any time. I further understand and agree that my employment will be "at will," that no statements have been made to the contrary and that this policy cannot be changed except in writing, signed by an authorized officer of the company.

_____ Signature of Applicant	_____ Date
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Name: _____

AVAILABILITY

TYPE OF WORK DESIRED:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Hospital Staff Relief | <input type="checkbox"/> Nurse Aide | <input type="checkbox"/> Elderly Care |
| <input type="checkbox"/> Hospital Private Duty | <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Nursing Home Staff Relief | <input type="checkbox"/> Companion | <input type="checkbox"/> Live-In |
| <input type="checkbox"/> Nursing Home Private Duty- | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Home Care | <input type="checkbox"/> Housekeeper | _____ |

GEOGRAPHIC AREAS WILLING TO WORK

CAN WORK (Specify hours each week)

	Sat.	Sun.	Mon.	Tue.	Wed.	Thu.	Fri.
From							
To							

TOTAL HOURS YOU WISH TO WORK PER WEEK

How soon are you available for work?

EXPERIENCE CHECKLIST

Check those areas shown below in which you are currently competent and willing to do.

PATIENT TYPES AND CONDITIONS

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcoholism/Drugs | <input type="checkbox"/> Confusion | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Convulsive Disorders | <input type="checkbox"/> Infant/Child Care | <input type="checkbox"/> Retardation |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Para/Quadriplegic | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Geriatrics (Elderly) | <input type="checkbox"/> Parkinson's Disease | |

TASKS AND ACTIVITIES

AMBULATION, ASSISTING PATIENT WITH:

- Walking (Support)
- Cane
- Crutches
- Walker

COLLECTION OF SPECIMENS:

- Sputum
- Stool
- Urine

PATIENT TRANSFERS:

- Bed to Chair
- Chair to Bed
- Hydraulic Lift (Ex. Hoyer)
- Transfer Belt, Use of
- Perineal Care
- Positioning
- Rectal Tube, Insertion & Removal
- Shampoo- Bed
- Shaving-Electric Razor
- Shaving-Safety Razor
- Sitz Bath
- Special Diets
 - Diabetic
 - Lo-Sodium
 - Soft
- Urine Testing for Sugar & Acetone

APPLICATION OF:

- Hot or Cold Compress
- Hot Water Bottle
- Ice Bag
- Ice Collar

DRESSING CHANGE, Non Sterile

- Dressing Change, Non Sterile
- Elimination-Bed Pan
- Elimination-Commode
- Enemas-Fleets
- Enemas-Soap Suds
- Enemas-Tap Water
- Feeding Patient
- Intake and Output

BATHS:

- Bed Tub
- Sponge
- Bed Making-Occupied
- Bed Making-Unoccupied

ORAL HYGIENE:

- Dentures
- Special Mouth Care

CATHETER

- Apply-Remove External Catheter
- Change Drainage Tubing and Bag
- Measure Urine and Empty Bag

OSTOMIES:

- Bag Change
- Irrigation

VITAL SIGNS:

- B/P Pulse
- Respiration Temperature
- Other _____

In some situations some of the following duties are required while doing private home care. Please check and you are willing to do

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Clean Bathroom | <input type="checkbox"/> Dusting | <input type="checkbox"/> Meal Planning | <input type="checkbox"/> Vacuuming |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Drive as Needed | <input type="checkbox"/> Mop Kitchen/Bathroom | |
| <input type="checkbox"/> Dishes | <input type="checkbox"/> Light Ironing | <input type="checkbox"/> Personal Laundry | |