Anchor Healthcare Services

Application for Employment & Request for Background Information

APPLICANT INFORMATION							
Last Name		First		M.I.		DOB	
Street Address						Apartment/ Unit	
City		State		ZIP			
Home Phone		Cell Phone					
Social Security Number		Date available to work				Desired Salary	
Position Applied for: ☐ LPN ☐ RN ☐ Other_____						Professional License Number	
Are you a citizen of the United States?	YES ☐	NO ☐	If not, are you authorized to work in the U.S.?			YES ☐	NO ☐
Have you ever worked for this company?	YES ☐	NO ☐	Email address				

EDUCATION								
High School					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	
College					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	
Other					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	

REFERENCES – THREE REFERENCES REQUIRED			
Two must be from previous or current employers, one must be a Character Reference			
Full Name		Relationship	
Company or Affiliation		Phone Number	( )
Address			
Full Name		Relationship	
Company or Affiliation		Phone Number	( )
Address			
Full Name		Relationship	
Company or Affiliation		Phone Number	( )
Address			
Emergence Contact:			

PREVIOUS EMPLOYMENT – LIST CURRENT EMPLOYER FIRST						
Company Name				Phone	( )	
Address				Supervisor		
Job Title		Starting Salary		$	Ending Salary	$
Responsibilities						
From	To	Reason for Leaving				
May we contact your previous supervisor for a reference?		YES ☐	NO ☐			

Company Name				Phone	( )	
Address				Supervisor		
Job Title		Starting Salary		$	Ending Salary	$
Responsibilities						
From	To	Reason for Leaving				
May we contact your previous supervisor for a reference?		YES ☐	NO ☐			

Company Name				Phone	( )	
Address				Supervisor		
Job Title		Starting Salary		$	Ending Salary	$
Responsibilities						
From	To	Reason for Leaving				
May we contact your previous supervisor for a reference?		YES ☐	NO ☐			

EEOC POLICY STATEMENT

- This institution does not discriminate in hiring or in any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.
- I understand that my employment is at will and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form.
- If employed, I will be required to complete an Employment Verification Form (1-9), and will show satisfactory evidence of identity and eligibility for employment.
- In connection with this request, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employers to release information they may have about me and release them from any liability and responsibility from doing so; further I authorize the procurement of a Criminal Records Report or other investigative report and understand that such reports may contain information as to my background, mode of living, character and personal reputation.

DISCLAIMER AND SIGNATURE

- I certify that my answers are true and complete to the best of my knowledge.
- If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release from employment.

Applicant's Signature		Date	

Anchor Healthcare Services

Character Reference

Name of applicant for employment:_____

has applied for employment with our company, Anchor Healthcare Services. Please provide a reference as to their character, including the following information:

Reference's Name: _____
Address_____
Phone Number:_____

How long have you known the applicant? _____yrs _____months

In what capacity have you known the applicant? □ Friend □ Relative □ Co-worker

Please assess the applicant's character and attest that you fell that the applicant is a fit and proper person to work in the Homecare Nursing field. Please include any traits you feel are relevant in your character reference.

	Poor	*Fair*	*Good*	*Exceptional*
Diligent				
Responsible				
Honest				
Punctual				
Detail oriented				
Considerate				
Enthusiastic				
Works well with others				
Good communicator				
Wants to learn and grow				

Any additional comments: _____
_____

Verified By: _____ Date: _____

Thank you for your assistance!

Anchor Healthcare Services

Employee Reference

I hereby authorize the release of information regarding my current/past employment with _____ to Anchor Healthcare Services. I am/was employed from _____ to _____.

Mail request to:

Company: _____
Address: _____
_____
Telephone: _____
Contact name: _____

Employee's Name: _____ SSN: xxx-xx-_____

Employee's Signature: _____ Date: _____

TO BE COMPLETED BY PREVIOUS EMPLOYER

Employee's Job Title: _____

Employed from: _____ to _____

	Excellent	Good	Average	Unsatisfactory
Clinical Competency	[ ]	[ ]	[ ]	[ ]
Punctuality	[ ]	[ ]	[ ]	[ ]
Attendance	[ ]	[ ]	[ ]	[ ]
Attitude	[ ]	[ ]	[ ]	[ ]
Appearance	[ ]	[ ]	[ ]	[ ]
Dependability	[ ]	[ ]	[ ]	[ ]
Leadership Skills	[ ]	[ ]	[ ]	[ ]
Honesty	[ ]	[ ]	[ ]	[ ]
Cooperation	[ ]	[ ]	[ ]	[ ]
Knowledge	[ ]	[ ]	[ ]	[ ]
Quality of Work	[ ]	[ ]	[ ]	[ ]
Quantity of Work	[ ]	[ ]	[ ]	[ ]

*Verified experience with*_____

- *Pediatric experience (minimum 1 yr experience within the last 2 yrs) ☐Yes ☐No*
- *Adult experience ☐Yes ☐No*

Reason for Leaving: _____

Eligible for rehire? ☐*Yes* ☐*No* Proper notice given? ☐*Yes* ☐*No*

Do you consider this person a safe practitioner? ☐*Yes* ☐*No*

Comments: _____

_____

_____

Completed/Verified By: _____

Title:_____

Date: _____

Thank you for your assistance!

Anchor Healthcare Services

Employee Reference

I hereby authorize the release of information regarding my current/past employment with _____ to Anchor Healthcare Services. I am/was employed from _____ to _____.

Mail request to:

Company: _____
Address: _____
_____
Telephone: _____
Contact name: _____

Employee's Name: _____ SSN: xxx-xx-_____

Employee's Signature: _____ Date: _____

TO BE COMPLETED BY PREVIOUS EMPLOYER

Employee's Job Title: _____

Employed from: _____ to _____

	Excellent	Good	Average	Unsatisfactory
Clinical Competency	[ ]	[ ]	[ ]	[ ]
Punctuality	[ ]	[ ]	[ ]	[ ]
Attendance	[ ]	[ ]	[ ]	[ ]
Attitude	[ ]	[ ]	[ ]	[ ]
Appearance	[ ]	[ ]	[ ]	[ ]
Dependability	[ ]	[ ]	[ ]	[ ]
Leadership Skills	[ ]	[ ]	[ ]	[ ]
Honesty	[ ]	[ ]	[ ]	[ ]
Cooperation	[ ]	[ ]	[ ]	[ ]
Knowledge	[ ]	[ ]	[ ]	[ ]
Quality of Work	[ ]	[ ]	[ ]	[ ]
Quantity of Work	[ ]	[ ]	[ ]	[ ]

*Verified experience with*_____

- *Pediatric experience (minimum 1 yr experience within the last 2 yrs) ☐Yes ☐No*
- *Adult experience ☐Yes ☐No*

Reason for Leaving: _____

Eligible for rehire? ☐*Yes* ☐*No* Proper notice given? ☐*Yes* ☐*No*

Do you consider this person a safe practitioner? ☐*Yes* ☐*No*

Comments: _____

_____

_____

Completed/Verified By: _____

Title:_____

Date: _____

Thank you for your assistance!

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

MARYLAND
FORM
MW507

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions you will claim on your tax return. However, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based on itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. Last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND,

b. This year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Certification of nonresidence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Residents of Pennsylvania who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more, should complete line 5 to exempt themselves from the state portion of the withholding tax. These employees are still liable for withholding tax at the rate in effect for the Maryland county in which they are employed, unless they qualify for an exemption on either line 6 or line 7. Pennsylvania residents of York and Adams counties may claim an exemption from the local withholding tax by completing line 6. Pennsylvania residents living in other local jurisdictions which do not impose an earnings or income tax on Maryland residents may claim an exemption by completing line 7. Employees qualifying for exemption under 6 or 7, should also write "EXEMPT" on line 4.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 8; enter "EXEMPT" in the box to the right on Line 8; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. You have any reason to believe this certificate is incorrect;
2. The employee claims more than 10 exemptions;
3. The employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. The employee claims an exemption from withholding on the basis of nonresidence; or
5. The employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee must file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507 Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security Number
Street Address, City, State, ZIP	County of residence (Nonresidents enter Maryland county (or Baltimore City) where you are employed.)

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2. . . . . 1. _____
2. Additional withholding per pay period under agreement with employer. . . . . 2. _____
3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld and
   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirements). If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here . . . . . 3. _____
4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here. . . . . 4. _____
5. I claim exemption from Maryland **state** withholding because I am domiciled in the Commonwealth of Pennsylvania and I do not maintain a place of abode in Maryland as described in the instructions on Form MW507. Enter "EXEMPT" here. . . . . 5. _____
6. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction within York or Adams counties. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 6. _____
7. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction that does not impose an earnings or income tax on Maryland residents. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 7. _____
8. I certify that I am a legal resident of the state of _____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Enter "EXEMPT" here. . . . 8. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on whichever line(s) I completed.

Employee's signature	Date
Employer's name and address including ZIP code (For employer use only)	Federal Employer Identification Number

Personal Exemptions Worksheet

Line 1

a. Multiply the number of your personal exemptions by the value of each exemption from the table below. (Generally the value of your exemption will be $3,200; however, if your federal adjusted gross income is expected to be over $100,000, the value of your exemption may be reduced. **Do not claim any personal exemptions you currently claim at another job, or any exemptions being claimed by your spouse.** To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year. **NOTE:** Dependent taxpayers may not claim themselves as an exemption. . . . . a. _____

b. Multiply the number of additional exemptions you are claiming for dependents age 65 or over by the value of each exemption from the table below. . . . . b. _____

c. Enter the estimated amount of your itemized deductions (excluding state and local income taxes) that exceed the amount of your standard deduction, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. Do not claim any additional amounts you currently claim at another job or any amounts being claimed by your spouse. **NOTE:** Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,550 and a maximum of $2,300. c. _____

d. Enter $1,000 for additional exemptions for taxpayer and/or spouse age 65 or over and/or blind.. . . . . d. _____

e. Add total of lines **a** through **d**. . . . . e. _____

f. Divide the amount on line e by $3,200. **Drop any fraction. Do not round up.** This is the **maximum** number of exemptions you may claim for withholding tax purposes. . . . . f. _____

If your federal AGI is		**If you will file your tax return**	
		Single or Married Filing Separately **Your Exemption is**	Joint, Head of Household or Qualifying Widow(er) **Your Exemption is**
$100,000 or less		**$3,200**	**$3,200**
Over	**But not over**		
$100,000	**$125,000**	**$1,600**	**$3,200**
$125,000	**$150,000**	**$800**	**$3,200**
$150,000	**$175,000**	**$0**	**$1,600**
$175,000	**$200,000**	**$0**	**$800**
In excess of $200,000		**$0**	**$0**

FEDERAL PRIVACY ACT INFORMATION

Social Security numbers must be included. The mandatory disclosure of your Social Security number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws administered by the person having statutory right to obtain it.

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:			
Date of birth:	SSN:	Gender: ☐ Male ☐ Female *(Please check)*	
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*			
Place of Birth:		Citizenship:	
Current address:			
City:		State:	ZIP Code: -
Daytime Phone:	Evening Phone:	Driver's License #:	

AGENCY INFORMATION

Agency Authorization #: 1600000625	
ORI # (if required): MD004455Y	Reason fingerprinted?
Position Applied for:	

Request Type: *(Choose one ONLY)*

- ☐ Adult Dependent Care
- ☐ Attorney/Client
- ☒ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: _____

Address: _____

City, State, Zip code: _____

Anchor Healthcare Services

Annual Tuberculosis Health Checklist

Our records indicate that you have had reactive tuberculosis screening (skin test positive). A positive skin reaction means that at some point in your life you have come in contact with the tuberculosis bacteria; it does not mean that you have tuberculosis now.

In the past, a yearly chest X-ray was thought to be sufficient follow-up. However, some individuals may develop an active tuberculosis infection (relapse or reinfection) with a normal chest X-ray.

Consequently, this brief questionnaire is very important. You should answer all of the questions on this page at least once each year. When you are finished, please return this form to Anchor Healthcare Services.

SYMPTOMS	**YES**	**NO**
Productive cough (3 weeks or more)		
Persistent weight loss without dieting		
Persistent low grade fever		
Night sweats		
Loss of appetite		
Swollen glands, usually in the neck		
Recurrent kidney or bladder infection		
Coughing up blood		
Shortness of breath		
Chest pain		

_____ _____

Employee Signature Date

Anchor HealthcareServices

Consent Form for Hepatitis B Vaccination

Hepatitis B is a viral infection caused by Hepatitis B (HBV). Approximately 200,000 persons are infected each year in the United States. A small percentage of these infected persons may become chronic carriers of Hepatitis B virus or develop chronic active Hepatitis and/or cirrhosis. There may also be an association between the HBV carrier state and the occurrence of liver cancer.

Inactivated Hepatitis B vaccine has recently become available. The safety and efficacy of the vaccine has been extensively tested. After a series of three intramuscular doses of Hepatitis B vaccine, given in the deltoid muscle over a six-month period, greater than 90% of healthy adults developed protection against Hepatitis B. Protection against illness was complete for persons who developed antibodies after vaccination but before exposure; however, the duration of protection and subsequent need for booster doses has not been defined. There is no evidence that the vaccine ever caused Hepatitis B, but persons who have been infected with HBV prior to immunization may develop clinical Hepatitis despite vaccination. The vaccine is a noninfectious subunit viral vaccine derived from Hepatitis B surface antigen (HBsAg) produced in yeast cells. The vaccine against Hepatitis B prepared from recombinant yeast cultures is free of association with human blood or blood products.

The most common side effects are soreness and redness at the injection site for about 48 hours. Low-grade fever (less than 101 Fahrenheit) occurs in some patients for 48 hours. Complaints of malaise, fatigue and joint pain are infrequent and usually last for only a few days. A rash has rarely been reported. In a small number of patients, neurologic reactions, including the Guillian-Barre syndrome, have occurred in the period following Hepatitis B vaccination. The rate of occurrence of Guillian-Barre syndrome is not thought to be significantly increased above that observed in normal adults. These reactions are not thought to be related to the Hepatitis B vaccine. Hepatitis B vaccine should not be administered to individuals with hypersensitivity to vaccine components. Hepatitis B vaccine would not be expected to be harmful to a developing fetus; however, its safety for the fetus has not been demonstrated; accordingly, Hepatitis B vaccine should not be given to pregnant women and nursing mothers unless it is strongly indicated. A brochure describing Hepatitis B and the vaccine is available.

I have read the above statement about Hepatitis B and the Hepatitis B vaccine. I believe that I understand the benefits and risks of the Hepatitis B vaccination. I understand that I must have all three doses of the vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune, that the vaccine will prevent me from developing Hepatitis B, or that I will not experience an adverse side effect from the vaccine.

_____ _____

Name Date

I have read the information supplied by the vaccine manufacturer. I understand the risk of an allergic reaction. I understand that I must take all three doses of the vaccine. I request that the vaccine be given to me.

Contraindication: Hypersensitivity to yeast.

_____ _____ _____

Signature Corporation Date

_____ _____

Witness Date

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination 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 the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Signature Date

_____ _____

Witness Date

I acknowledge that I have previously received Hepatitis B injections and/or completed the vaccination series.

_____ _____

Signature Date

I wish to receive the Hepatitis Titre. I agree to make the appointment for this blood test within ten (10) days of having signed this agreement.

_____ _____

Signature Date

I ***do not*** wish to receive the Hepatitis Titre. I understand that this Titre would have been paid by Anchor Healthcare Services

_____ _____

Signature Date

Anchor Healthcare Services

Job Description of the Licensed Practical Nurse

1. **Qualifications:**
   a. Licensed as a Licensed Practical Nurse in the state of Maryland and/or Virginia.
   b. Certified and holds a current CPR certificate.
   c. Free of communicable disease and physically able to perform job.
   d. At least one year experience in providing pediatric and/or adult home care

2. **Duties and Responsibilities:**
   a. Deliver nursing services in accordance with agency policies under the supervision of the nursing supervisor.
   b. Provide quality-nursing care as outlined in the patient's plan treatment and nursing care plan.
   c. Review all physician's orders and medical records and nursing notes pertaining to the patient
   d. Assist the physician or Registered Nurse in performing specialized procedures.
   e. Prepare and maintain equipment and supplies for treatment that require adherence to sterile and antiseptic techniques.
   f. Prepare and maintain all home care equipment for use with patient.
   g. Assist the patient with activities of daily living, including the teaching of self-care techniques.
   h. Report any changes in the patient's medical or mental status to nursing supervisor and patient's caretakers.

3. **Reports to:**
   The CEO and/or Nursing Supervisor.

4. **Salary Scale:**
   $ _____ per hour.

_____ _____
Signature of Applicant Date

_____ _____
Signature of AHCS Authorized Representative Date

Anchor Healthcare Services

Job Description of the Registered Nurse

1. **Qualifications:**
   a. Graduate of an accredited Nursing Program
   b. Licensed as a Registered Nurse in the state of Virginia or Maryland.
   c. Certified and holds a current CPR certificate.
   d. At least one year experience in providing pediatric and/or adult home care.
2. **Duties and Responsibilities:**
   a. Deliver nursing services in accordance with agency policies under the supervision of the nursing supervisor.
   b. Provide quality-nursing care as outlined in the patient's plan of treatment and nursing care plan.
   c. Review all physicians' orders, medical records, nursing notes and communications pertaining to the client.
   d. Maintain a safe and clean environment for the patient. Check all equipment and emergency equipment to ensure proper functions.
   e. Maintain open communication with nursing supervisors and client's caretakers.
   f. Assist the client with activities of daily living, including the teaching of self-care techniques.
   g. Report any changes in the client's medical or mental status to the nursing supervisor and the clients' caretakers.
   h. Maintain appropriate and accurate records of nursing care provided on the client flow sheets, nursing notes and medical records.
   i. Inform nursing supervisor of any telephone orders that are taken.
   j. Coordinate schedule with the staffing coordinator, nursing supervisor, or on-call supervisor.
   k. Contact nursing supervisor in a timely manner of cancellations.
   l. Maintain a stocked emergency bag, as required, for each client in the client's home.
   m. Assist in the orientation of new nursing staff to a client.
3. **Reports to:**

   The CEO and/or Nursing Supervisor.
4. **Salary Scale:**

   $ _____ per hour.

_____ _____

Signature Date

_____ _____

Signature of AHCS Authorized Representative Date

ANCHOR HEALTHCARE SERVICES

Employment Agreement

- I _____, understand that Anchor Healthcare Services is a part-time employer and cannot guarantee any specific number of hours in a given week.
- I recognize that my employment is on an "as needed" basis and that I may be terminated at any time and for any reason.
- I agree to help staff clients on some holidays and specifically agree to work either Christmas Eve/Day or New Years Eve/Day.
- I will not accept any types of gifts from the client/parent/family for service rendered.
- When on assignment, I will keep the Nursing Supervisor informed of any medication changes, new Physician's orders and/or any concerns of the client's well being.
- I understand that I will be counseled for an inappropriate action.
- I have also been advised at the time of my orientation that I ***will*** be terminated if I do any of the following:

1. Any action that would legally be considered detrimental to the agency.
2. Verbal and/or physical abuse of a client.
3. Stealing from the client or agency.
4. Working under the influence of alcohol or drugs.
5. Falsification of any information given to or pertaining to the agency.
6. Functioning in a capacity beyond or completely removed from my job description.
7. Accepting an assignment, then not showing up for work, without a twenty-four hour notice, unless due to inclement weather or any other justifiable emergency. Then the On-call Personnel must be notified immediately of an inability to provide client care at the scheduled time.
8. Being absent from or late for work more than two times in one month without a reasonable excuse -- in the event of illness, a physician's certificate may be requested.
9. Accepting work from a client whose services originated through the agency.
10. Having another person accompany me to work.
11. Refusing to comply with assigned duties and dress code.
12. Leaving an assignment before scheduled time without approval of client/parent or Nursing Supervisor.
13. Transporting a client.
14. Actions or omissions adversely affecting a client's safety, comfort, or well being.
15. Divulging or allowing divulgement of any information regarding the client or family to anyone other than members of the healthcare team, state surveyors, accrediting body representatives or for the purposes of payment to representative(s) of the client's insurance company or funding source
16. Sleeping while on duty.

_____ _____

Signature of Employee Date

Required Inservice Acknowledgement

Educational inservice manuals are available in each client's home for all caregivers to utilize. Please choose **either** one educational offering one hour in length **or** two one-half hour offerings per quarter. Our agency is required to verify that all of our nursing personnel have had at least one hour of educational inservice per quarter in accordance to our state licensure. We will assist you in fulfilling this requirement by offering these inservices. By signing below, you are acknowledging that you will fulfill this requirement.

These inservices are intended for educational purposes only. **You are required to keep a record of the inservices that you have completed.** The inservices do not include demonstrations of technical skills. Please contact the office if you have any concerns or questions.

_____ _____

Employee Signature Date

PAYCHEX

Direct Deposit Enrollment/Change Form*

Company Name and/or Client Number _____

Employee/Worker Name_____ **Employee/Worker Number** _____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer/company.

EMPLOYER/COMPANY: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS - *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number

Checking/Savings Account Number**

Financial Institution ("Bank") Name

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____ .00 ☐ Remainder of Net Pay

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number

Checking/Savings Account Number**

Financial Institution ("Bank") Name

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____ .00 ☐ Remainder of Net Pay

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number

Checking/Savings Account Number**

Financial Institution ("Bank") Name

I wish to change my deposit amount to (check one): ☐ From _____% to____% of Net ☐ From $_____ .00 To $_____.00
☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Company Representative Printed Name: _____

Employer/Company Representative Signature: _____ **Date:** _____

*** All fields are required except Employee/Worker Number.**

**** Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

Name:_____ Date:_____

OSHA Inservice Test

Directions: Circle the ONE correct answer to each question. This test will remain in your personal file.

1. OSHA recommends that all workers who come into contact with blood be vaccinated to prevent HBV infections.
   a) TRUE b) FALSE

2. HIV can cause a flu-like illness with fever, aches and swollen glands.
   a) TRUE b) FALSE

3. OSHA has introduced a standard based on guidelines developed by the CDC that are designed to protect you from blood borne disease.
   a) TRUE b) FALSE

4. An HBV or HIV carriers may have no symptoms but can spread the disease to others.
   a) TRUE b) FALSE

5. Which group faces the greatest risk of getting AIDS?
   a) Healthcare workers b) Married couples c) Drug users who share needles d) Blood donors

6. Blood tests are used to determine if you have been infected with HIV or HBV.
   a) TRUE b) FALSE

7. Blood is the most common source of HIV and HBV in the workplace.
   a) TRUE b) FALSE

8. Universal Precautions should be observed when working with which groups?
   a) Male homosexuals b) Only patients with AIDS c) Drug users d) All patients

9. Blood on instruments or equipment cannot infect you.
   a) TRUE b) FALSE

10. If recapping used needles is necessary, you should always use the one-handed scoop method or a recapping device to prevent needlestick injury.
    a) TRUE b) FALSE

11. Which task requires wearing protective gloves?
    a) Cleaning up blood b) Assisting in minor surgery c) Changing a dressing d) All of the above

12. Masks and protective eyewear are designed to protect you from?
    a) Needlestick injury b) Clothing contamination c) Mucous membrane contact d) All the above

13. Clearly marked, puncture-resistant containers should be available to dispose of used needles or other disposable sharps.
    a) TRUE b) FALSE

14. Which activity can spread HIV or HBV from one person to another outside of work?
    a) Using the toilet b) Giving blood c) Shaking hand d) Having sex

15. You can get HIV or HBV from puncture wounds, broken skin contact, and mucous membrane contact.
    a) TRUE b) FALSE