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.

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION
PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

1. If you wish to claim yourself, write "1" ..... _____
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" ..... _____
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) ..... _____
4. Subtotal Personal Exemptions (add lines 1 through 3) ..... _____
5. Exemptions for age
   (a) If you will be 65 or older on January 1, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" ..... _____
6. Exemptions for blindness
   (a) If you are legally blind, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" ..... _____
7. Subtotal exemptions for age and blindness (add lines 5 through 6) ..... _____
8. Total of Exemptions - add line 4 and line 7 ..... _____

Detach here and give the certificate to your employer. Keep the top portion for your records

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FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name	
Street Address		
City	State	Zip Code

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet ..... _____
   (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet ..... _____
   (c) Total Exemptions - line 8 of the Personal Exemption Worksheet ..... _____
2. Enter the amount of additional withholding requested (see instructions) ..... _____.
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions ..... (check here) ☐
4. I certify that I am not subject to Virginia withholding. I meet the conditions set forth Under the Service member Civil Relief Act, as amended by the Military Spouses Residency Relief Act ..... (check here) ☐

Signature Date

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037. Note: Employers may establish a system to electronically receive Forms VA-4 from employees, provided the system meets Internal Revenue Service requirements as specified in § 31.3402(f)(5)-1(c) of the Treasury Regulations (26 CFR).

2601064 Rev. 08/11

FORM VA-4 INSTRUCTIONS

Use this form to notify your employer whether you are subject to Virginia income tax withholding and how many exemptions you are allowed to claim. You must file this form with your employer when your employment begins. If you do not file this form, your employer must withhold Virginia income tax as if you had no exemptions.

PERSONAL EXEMPTION WORKSHEET

You may not claim more personal exemptions on form VA-4 than you are allowed to claim on your income tax return unless you have received written permission to do so from the Department of Taxation.

Line 1. You may claim an exemption for yourself.

Line 2. You may claim an exemption for your spouse if he or she is not already claimed on his or her own certificate.

Line 3. Enter the number of dependents you are allowed to claim on your income tax return.

NOTE: A spouse is not a dependent.

Line 5. If you will be age 65 or over by January 1, you may claim one exemption on Line 5(a). If you claim an exemption for your spouse on Line 2, and your spouse will also be age 65 or over by January 1, you may claim an additional exemption on Line 5(b).

Line 6. If you are legally blind, you may claim an exemption on Line 6(a). If you claimed an exemption for your spouse on Line 2, and your spouse is legally blind, you may claim an exemption on Line 6(b).

FORM VA-4

Be sure to enter your social security number, name and address in the spaces provided.

Line 1. If you are subject to withholding, enter the number of exemptions from:

(a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet

(b) Subtotal of Exemptions for Age and Blindness - line 7 of the Personal Exemption Worksheet

(c) Total Exemptions - line 8 of the Personal Exemption Worksheet

Line 2. If you wish to have additional tax withheld, and your employer has agreed to do so, enter the amount of additional tax on this line.

Line 3. If you are not subject to Virginia withholding, check the box on this line. You are not subject to withholding if you meet any one of the conditions listed below. Form VA-4 must be filed with your employer for each calendar year for which you claim exemption from Virginia withholding.

(a) You had no liability for Virginia income tax last year and you do not expect to have any liability for this year.

(b) You expect your Virginia adjusted gross income to be less than the amount shown below for your filing status:

	Taxable Years 2005, 2006 and 2007	Taxable Years 2008 and 2009	Taxable Years 2010 and 2011	Taxable Years 2012 and Beyond
Single	$7,000	$11,250	$11,650	$11,950
Married	$14,000	$22,500	$23,300	$23,900
Married, filing a separate return	$7,000	$11,250	$11,650	$11,950

(c) You live in Kentucky or the District of Columbia and commute on a daily basis to your place of employment in Virginia.

(d) You are a domiciliary or legal resident of Maryland, Pennsylvania or West Virginia whose only Virginia source income is from salaries and wages and such salaries and wages are subject to income taxation by your state of domicile.

Line 4. Under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Virginia income tax on your wages if (i) your spouse is a member of the armed forces present in Virginia in compliance with military orders; (ii) you are present in Virginia solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA check the box on Line 4 and attach a copy of your spousal military identification card to Form VA-4.

STATEMENT REQUIRED BY POLICY 32.1-162.9:1
OF THE CODE OF VIRGINIA

I, _____, solemnly swear and affirm:
Print Name

1. I have never been convicted of murder, abduction for immoral purpose as set out in §18.2-18 of the Code of Virginia, assaults and bodily wounding as set out in Article 4 (§182.2-51 et seq.) of Chapter 4 of Title 18.2, robbery as set out in §18.2-58, sexual assault as set out in Article 7 (§18.2-61 et seq.) of Chapter 4 of Title 18.2, arson as set out in Article 1 (§18.2-77 et seq.) of Chapter 5 of Title 18.2, pandering as set out in §18.2-355, crimes against nature involving children as set out in §18.2-361, taking indecent liberties with children as set out in §18.2-370 or §18.2-370.1, abuse and neglect of children as set out in §18.2-371.1, failure to secure medical attention for an injured child as set out in §18.2-314, obscenity offenses as set out in §18.2-374.1 or §18.2-379, or abuse or neglect of an incapacitated adult a set out in §18.2-369.

   I ***Have Not*** been convicted_____ I ***Have*** been convicted_____

2. If I have been convicted of one of the crimes as specified in 1 above, It was only one misdemeanor not involving abuse or neglect, or moral turpitude (that is, crimes that "gravely violate the accepted moral standards of the community"), and that one conviction occurred at least five years ago.

   Yes: _____ No: _____

3. I have not been convicted of any crime whatsoever whether in Virginia or otherwise.

   I ***Have Not*** been convicted_____ I ***Have*** been convicted_____

   If you have, describe charge(s):

   _____

   _____

   _____

   _____

4. There are no pending charges, of any kind, in Virginia or elsewhere.

   There ***Are No*** pending charges_____ There ***Are*** pending charges: _____

   If you have, describe charge(s):

   _____

   _____

   _____

   _____

5. I understand it is a crime to make a materially false statement (including an omission) regarding any criminal convictions or pending charges in my background.

   _____
   Signature

   _____
   Date

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00

INSTRUCTIONS

Purpose

The Virginia Child Abuse and Neglect Central Registry is mandated by the Virginia Child Protective Law and contains the names of individuals identified as an abuser or neglector in founded child abuse and/or neglect investigations conducted in the state of Virginia. The findings are made by Child Protective Services staff in local departments of social services and are maintained by the Virginia Department of Social Services. Legal mandates for the Virginia Department of Social Services to provide a Central Registry and a mechanism for conducting searches of the registry are found in § 63.2-1515 of the Code Virginia.

Read all instructions before completing the form: (Incomplete forms will be returned)

1. Answer all questions completely and accurately by printing clearly in black ink or typing your answers. Failure to complete or print clearly may delay or deny your request. Given the nature of the form and the actions to be taken when received, the **Office of Background Investigations shall not accept forms that have been altered in any fashion.** Forms that contain strike outs, correction tape or white-out will be returned.
2. If a middle name is an initial, indicate "initial only" otherwise, enter a full middle name given at birth.
3. For "other names used" list all previous names; nick names, all previous married names, legal name changes, changes due to adoption, etc. Circle appropriate title description on the form.
4. If the answer to any question is none, write "N/A".
5. Sign the Central Registry Release of Information Form in the presence of an official Notary Public. Each request form must be notarized. Only original signatures will be accepted. No copies of the form will be accepted.
6. A $10.00 fee is charged for each search. Payment must accompany search forms. Only money orders, company/business checks, or cashier checks will be accepted. (If multiple requests are mailed together, payment may be combined on in one money order, company/business check, or cashier's check. (ex. 4 requests at $10.00 each will total $40.00). A $50 fee will be charged for all returned checks.)

   All money orders, company/business checks, or cashier checks should be made payable to: Virginia Department of Social Services.

   Personal checks and cash will not be accepted.
7. For agencies and facilities that require several searches per year, an agency code will be assigned to expedite processing of the search requests.
8. If additional space is needed to complete the form (ie. providing information on addresses, spouses, and children) attach an 8x11 sheet sheet of paper along with your form to be mailed.
9. Search results are not transferable and are not considered official beyond the requesting agency or individual.
10. Mail your completed form and additional sheets (if used) to:

    Virginia Department of Social Services
    Office of Background Investigations - Search Unit
    801 East Main Street, 6th Floor
    Richmond, VA 23219-2901

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00

Purpose of Search, Check one: ☐ Adam Walsh Law ☐ Adoptive Parent ☐ Babysitter/Family Day Care ☐ CASA ☐ Children's Residential Facility ☐ Custody Evaluation ☐ Day Care Center ☐ Foster Parent ☐ Institutional Employee ☐ Other Employment ☐ School Personnel ☐ Volunteer ☒ Other

MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search

Name	Anchor Healthcare Services
Address	PO Box 626
City	Merrifield **State** VA **Zip** 22116
Contact Name	Caryn Bucia **Tel.#** 703-955-2143 **Ext**
Contact E-Mail	Val0808@aol.com

Payment/FIPS Code
(Use only if assigned by OBI-CRU)

U-00019

Mandatory if agency code has been assigned

PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED

Last Name	First Name	Full Middle Name – (given at birth) - **No initials** (if middle name is an initial, indicate "Initial Only")

Maiden Name (last name before marriage)	Sex	Date of Birth **(MM/DD/YYYY)**	Race
	☐ Male ☐ Female		

Driver's License Number or ID #	Social Security Number	Other names used; nicknames, legal names (refer to instruction page)

Current Address (Include Street # and Apt #)	City	State	Zip

Applicant's Prior Addresses

Include Street # and Apt #	City	State	Zip	Start Date **(MM/YY)**	End Date **(MM/YY)**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

Last Name	First Name	Full Middle Name (given at birth)	Maiden Name	Race	Sex	Date of Birth **(MM/DD/YYYY)**
					☐ Male ☐ Female	
					☐ Male ☐ Female	
					☐ Male ☐ Female	

List all of your children. If you have none, write **'N/A'.** Include all adult children, step and foster children not living with you.

Last Name	First Name	Full Middle Name (given at birth)	Relationship	Sex	Date of Birth **(MM/DD/YYYY)**
				☐ Male ☐ Female	
				☐ Male ☐ Female	
				☐ Male ☐ Female	

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00

PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

_____ _____

Signature of person whose name is being searched (Sign in presence of Notary)

Parent or Guardian signature required for minor children under the age of 18

PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL

City/County of _____

Commonwealth/State of _____

Acknowledged before me this _____ day of _____, year_____

_____ _____

Notary Public Signature **Notary Number**

My Commission Expires: _____ Notary Seal

PART IV: CENTRAL REGISTRY FINDINGS – COMPLETED BY CENTRAL REGISTRY STAFF ONLY

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to the Central Registry Unit in order for us to make a determination:

_____
_____
_____
_____
_____

Worker: _____ Date: _____

2. _____ Based on information provided by the Local Department of Social Services, we have determined that _____ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

_____ Dept. of Social Services in reference to referral _____ phone#_____

_____ Dept. of Social Services in reference to referral _____ phone#_____

3. _____ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry of Child Abuse/Neglect.

Signature of worker completing search: _____ Date: _____

OBI Staff Only

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