

**Uniform Employment Application
for Nurse Aide Staff**

Effective November 1, 2012

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

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

ATTENTION NURSE AIDES: RETURN YOUR COMPLETED APPLICATION TO EMPLOYER.

Date of Application: _____ Date Available to Start Work: _____

1. Personal Information

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

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

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

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

Telephone #: _____ Date of Birth: _____ Sex: ___ M ___ F Race: _____
[----- For purposes of Criminal History Records Search -----]

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

2. Employment Desired

Position applied for: _____ Salary required: _____

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

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

3. U.S. Military Record

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

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

Employer's Name: _____ Telephone Number: _____

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

Position Held: _____ Supervisor: _____

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

Reason for Leaving: _____

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Employer's Name: _____ Telephone Number: _____

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

Position Held: _____ Supervisor: _____

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

Reason for Leaving: _____

Employer's Name: _____ Telephone Number: _____

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

Position Held: _____ Supervisor: _____

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

Reason for Leaving: _____

Employer's Name: _____ Telephone Number: _____

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

Position Held: _____ Supervisor: _____

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

Reason for Leaving: _____

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

May we contact your present employer? Yes No Not applicable

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

If yes, provide reason. _____

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

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

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

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

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

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

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

If yes, where and when did you obtain. _____

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

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

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

a. Yes No Have you ever: 1) participated in a first offender program; 2) deferred adjudication or other program or arrangement where adjudication has been withheld; 3) pled guilty or no contest; 4) been convicted; 5) received a deferred sentence; and/or 6) been sentenced for any criminal offense in any state or US jurisdiction regardless of whether this matter has been expunged or otherwise removed?

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

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

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

9. **Applicant's Certification and Agreement**

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

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

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

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

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

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

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

| | | | |
|--|--------------|------------|----------|
| Please complete the following if you have had CNA Training in the past for any of these categories: LTC, HH, ADC, RC, or DDDC. | | | |
| Category | Program Name | Start Date | End Date |
| Category | Program Name | Start Date | End Date |
| Category | Program Name | Start Date | End Date |

11. **Important Information for the Job Applicant**

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

***** NOTICE *****

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

INITIAL HERE _____

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

Signature of Applicant

Date of Signature

12. Criminal Arrest Check List

Effective November 1, 2012, and in accordance with public law, Title 63 of the Oklahoma Statutes, Section 1-1950.1, employment at this employer shall **not be** considered if the below signed individual has been *convicted of, pled guilty or no contest to, or received a deferred sentence for, a felony or misdemeanor offense for any of the following offenses in any state or federal jurisdiction, as stated by Oklahoma Statute, Section 1-1950.1(C)(1) of Title 63:*

- | | |
|--|---|
| <ul style="list-style-type: none"> a. abuse, neglect or financial exploitation of any person entrusted to the care or possession of such person, b. rape, incest or sodomy, c. child abuse, d. murder or attempted murder, | <ul style="list-style-type: none"> e. manslaughter, f. kidnapping, g. aggravated assault and battery, h. assault and battery with a dangerous weapon, or i. arson in the first degree. |
|--|---|

Effective November 1, 2012, and in accordance with public law, Title 63 of the Oklahoma Statutes, Section 1-1950.1, employment at this employer shall **not be** considered for the below signed individual *if less than seven (7) years have elapsed since the completion of sentence¹, and the results of a criminal history check reveal that the subject person has been convicted of, or pled guilty or no contest to, a felony or misdemeanor offense for any of the following offenses, in any state or federal jurisdiction, as stated by Oklahoma Statute, Section 1-1950.1(C)(2) of Title 63:*

- | | |
|--|--|
| <ul style="list-style-type: none"> a. assault, b. battery, c. indecent exposure and indecent exhibition, except where such offense disqualifies the applicant as a registered sex offender, d. pandering, e. burglary in the first or second degree, f. robbery in the first or second degree, | <ul style="list-style-type: none"> g. robbery or attempted robbery with a dangerous weapon, or imitation firearm, h. arson in the second degree, i. unlawful manufacture, distribution, prescription, or dispensing of a Schedule I through V drug as defined by the Uniform Controlled Dangerous Substances Act, j. grand larceny, or k. petit larceny or shoplifting. |
|--|--|

¹ Pursuant to 63 O.S. § 1-1950.1(A)(5), "Completion of the sentence" means the last day of the entire term of the incarceration imposed by the sentence including any term that is deferred, suspended or subject to parole.

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

I hereby certify I have no disqualifications for employment as described above and specified in Title 63 of the Oklahoma Statutes, Section 1-1950.1(C). My signature below authorizes the employer to run a check with the Nurse Aide Registry of the Oklahoma State Department of Health for notations of abuse, neglect or misappropriation of resident's property. I hereby give the Oklahoma State Bureau of Investigation authority to proceed with a criminal history records check as authorized by Title 63 of the Oklahoma Statutes, Section 1-1950.1(B).

Signature of Applicant

Date of Signature



Faith Home Care Services, LLC

Background Check Form

Furnished for the purpose of positive identification: (Print Clearly)

Last: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

A.K.A. (include maiden name): _____

SSN: _____ - _____ - _____ DOB: _____ / _____ / _____

Place of Birth: _____

Driver License #: _____ State: _____

Have you had your fingerprints taken since 2014? Yes No

Address History and Dates (Past 20 Years)
