APPLICATION FOR EMPLOYMENT

APPLICANT INFORMATION							
Social Security Number				Date of Application			
Last Name		First Name			Middle Initial		
Street Address		Apt #		City		State	
Zip Code		Primary Phone Number					
Secondary Phone Number							
Personal Email Address							

EMERGENCY CONTACT INFORMATION			
Emergency Contact Name		Relation	
Primary Phone Number			

DESIRED POSITION

Choose the position for which you would like to apply.

☐ PT	☐ PTA	☐ OT	☐ COTA	☐ RN	☐ LVN	☐ CNA	☐ Chaplain
☐ Clerical	☐ Scheduler/Intake	☐ Billing	☐ Marketer				
☐ Other: _____							

AVAILABILITY/HOURS

Desired employment type	☐ Full-time (30-40 hours) ☐ Part-time/PRN (>30 hours)		
Availability	☐ SUN ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ SAT		
Are you able to take on-call shifts?	☐ Yes ☐ No	Are you able to work holidays?	☐ Yes ☐ No

EDUCATION

Name of High School							
Address		City		State		Zip	
Did you graduate?	Yes ☐ No ☐	Did you receive your GED?	☐ Yes ☐ No				
Name of College/University							
Address		City		State		Zip	
Did you graduate College or Trade School?	☐ Yes ☐ No	If yes, degree received_____					
Name of College/University							
Address		City		State		Zip	
Did you graduate College or Trade School?	☐ Yes ☐ No	If yes, degree received_____					
Name of College/University							
Address		City		State		Zip	
Did you graduate College or Trade School?	☐ Yes ☐ No	If yes, degree received_____					

PREVIOUS FACILTY EXPERIENCE

Please check all facilities you have worked in and list the number of years you have experience working in each type of facility (if any).

☐ Home Health	Yrs._____	☐ Hospital	Yrs._____	☐ Skilled Nursing Facility	Yrs._____
☐ Hospice	Yrs._____	☐ Outpatient Clinic/Rehab	Yrs._____	☐ Medical Office	Yrs._____
☐ Infusion Clinic	Yrs._____	☐ Mental Health	Yrs._____	☐ Other:	Yrs._____

PREVIOUS UNIT EXPERIENCE

Please check all units you have worked in and list the number of years you have experience working in each type of unit (if any).

☐ Burn	Yrs.	☐ ENT	Yrs.	☐ Pediatrics	Yrs.	☐ Detox/Drug Rehab	Yrs.	☐ Other	Yrs.
☐ L&D	Yrs.	☐ Rehab	Yrs.	☐ Telemetry	Yrs.	☐ Post-partum	Yrs.	☐ Other	Yrs.
☐ MICU	Yrs.	☐ Nursery	Yrs.	☐ Psychiatry	Yrs.	☐ Orthopedics	Yrs.	☐ Other	Yrs.
☐ NICU	Yrs.	☐ Dialysis	Yrs.	☐ Open Heart	Yrs.	☐ Mother/Baby	Yrs.	☐ Other	Yrs.
☐ PACU	Yrs.	☐ Geriatric	Yrs.	☐ Stepdown	Yrs.	☐ Recovery Room	Yrs.	☐ Other	Yrs.
☐ SICU	Yrs.	☐ CCU	Yrs.	☐ Oncology	Yrs.	☐ Operating Room	Yrs.	☐ Other	Yrs.
☐ Pedi ICU	Yrs.	☐ Med/Surg	Yrs.	☐ Neurology	Yrs.	☐ Emergency Room	Yrs.	☐ Other	Yrs.

APPLICATION FOR EMPLOYMENT

Licenses (CLINICAL APPLICANTS)		
Do you have a multi-state license or does your state participate with reciprocity of another state(s)?	Yes ☐ No ☐	If yes, please list what state(s):
Has your license ever been suspended, revoked or investigated?	☐ Yes ☐ No	
If yes, please explain: _____ _____ _____		

License Type		License Number		State		Exp. Date	
License Type		License Number		State		Exp. Date	
License Type		License Number		State		Exp. Date	
License Type		License Number		State		Exp. Date	

Certifications
(CLINICAL APPLICANTS)
Check all applicable certifications and list the expiration date.

Certification	Expiration Date	Certification	Expiration Date
☐ ACLS		☐ IV	
☐ BLS		☐ NALS	
☐ CPR		☐ OTHER _____	
☐ PALS		☐ OTHER _____	

WORK EXPERIENCE
Please list your work experience beginning with your most recent/current job. If you have gaps in your employment, please be prepared to explain.
You may attach additional sheet(s) if necessary.

Employer/Company	From (mm/yyyy)	To (mm/yyyy)	Position Title	Job Duties	Reason for leaving	Name of Supervisor and Contact Number
						May we Contact ☒ Yes ☐ No
						May we Contact ☒ Yes ☐ No
						May we Contact ☒ Yes ☐ No

ADDITIONAL INFORMATION

Are you 18 years of age or older?	☐ Yes ☐ No	Are you authorized to work in the U.S.?	☐ Yes ☐ No
How did you find out about this position (if applicable)?			
☐ Indeed ☐ Zip Recruiter ☐ Newspaper ☐ Job Fair/Open House ☐ Craigslist			
☐ Employee Referral Employee Name _____		☐ Recruiter Recruiter Name_____	

ACKNOWLEDGEMENT

Please read the following statement carefully, acknowledge and sign.

In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and serve as the cause for my immediate dismissal from employment.

I give Capitol permission to use any information in this application to enable it and its agents to verify the information contained in this application. I authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by Capitol with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, Capitol may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Capitol Health Management, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

In consideration of my employment and of my being considered for employment by Capitol, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either Capitol or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of Capitol at any time, can constitute a contract of employment. No representative or agent of Capitol has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment, I agree that my continued employment may be contingent on the results. I understand that Capitol is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies Capitol against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I, (Print Name) _____, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENT.

SIGNATURE _____ DATE _____

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Reference #1 (of 2)

Section 1: For APPLICANT Use

Applicant Name: _____ SSN: _____

I voluntarily give Capitol the right to investigate my past and/or present employment and release from all liability or responsibility by all persons, companies, or organizations supplying information.

***Applicant Signature*:** _____ Date: _____

Reference Name: _____

Reference Phone Number: _____

Reference Email Address: _____

How do you know this reference? _____

Section 2: For COMPANY Use ONLY

Employment Dates: _____

Eligible for rehire? (Circle One) YES NO

Position Held: _____

Reason for termination/separation: _____

Please rate this individual on the basis of his/her employment with you:

Quality of Work: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory
Quantity of Work: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory
Ability to Do Work: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory
Attendance: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory

Notes: _____

_____

_____

_____

Reference Information Provided By: _____ Job Title: _____

Verified by: (Circle One) Phone Mail

HR Representative: _____ Job Title: _____

Reference #2 (of 2)

Section 1: For APPLICANT Use

Applicant Name: _____ SSN: _____

I voluntarily give Capitol the right to investigate my past and/or present employment and release from all liability or responsibility by all persons, companies, or organizations supplying information.

***Applicant Signature*:** _____ Date: _____

Reference Name: _____

Reference Phone Number: _____

Reference Email Address: _____

How do you know this reference? _____

Section 2: COMPANY Use ONLY

Employment Dates: _____

Eligible for rehire? (Circle One) YES NO

Position Held: _____

Reason for termination/separation: _____

Please rate this individual on the basis of his/her employment with you:

Quality of Work: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory
Quantity of Work: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory
Ability to Do Work: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory
Attendance: (Please Circle One)	Exceptional	Satisfactory	Unsatisfactory

Notes: _____

_____

_____

_____

Reference Information Provided By: _____ Job Title: _____

Verified by: (Circle One) Phone Mail

HR Representative: _____ Job Title: _____

NOTICE TO APPLICANT OF BACKGROUND CHECK

Capitol performs background checks on all applicants and then on employees **annually** using the following registries:

1. Criminal History
2. Department of Public Safety/Department of Motor Vehicles Driving Record
3. Misconduct (EMR)
4. Office of Inspector General (OIG)
5. National Sex Offender
6. RN-LVN/PT-PTA/OT-COTA/SLP Licensure

I, (Print Name) _____, have been notified that these background checks may provide Capitol with negative information that is listed in these registries and I consent to pre-employment background checks.

I acknowledge that I have been given the opportunity to disclose anything that might be discovered through these background checks and to divulge any information needed to explain the findings.

Signature _____ Date _____

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TEXAS Health and Human Services

Form 1725
September 2015-E

Consumer Directed Services

Criminal Conviction History and Registry Checks

Applicant is a person being considered as a service provider (employee or independent contractor [when required]).

Section I - Applicant Authorization/Acknowledgment (Applicant must complete this section.)

I, (applicant's printed name) _____, give my permission to check for a criminal conviction history, to check the required registries annually, and to check the state and federal lists of individuals and entities excluded from participation in Medicaid (LEIE) monthly as part of my application as a service provider through the Consumer Directed Services (CDS) option. I also understand that a criminal conviction or a registry listing that prohibits a person from employment in a health care setting in the state of Texas may prohibit my employment.

I understand that I must not provide services for payment until the required criminal history and registry checks are conducted, the employer and Financial Management Services Agency (FMSA) review the results and determine that I can be paid for services, and this form is signed by the FMSA.

_____ _____

Signature - Applicant | Date

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must print.)

Individual's Name (Last, First, Middle)	Alias	Maiden Name

Date of Birth (mm/dd/yyyy)	Social Security No.

Section II - Criminal Conviction History Check and Registry Verification Process (Employer must complete this section.)

Individual's Name	Employer Name

Criminal Conviction History Check (Check each box to certify agreement):

☐ I request that my FMSA obtain a **current** Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.

☐ I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.

☐ I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.

☐ I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.

☐ I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.

_____ _____

Signature - Employer | Date

Registry Check

☐ I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.

☐ I understand that the FMSA will screen the applicant initially and monthly using both the state and federal lists of excluded individuals and entities (LEIE).

☐ I also understand that the applicant cannot provide services and cannot be paid with program funds until the criminal history and registry checks are completed and my FMSA has notified me that the applicant meets the qualifications.

_____ _____

Signature - Employer | Date

I request that the FMSA provide the criminal history to me:

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail

_____
Date

Section III - Criminal Conviction History and Registry Check Results

DPS Criminal Conviction Criminal History Check

Date of DPS Check	Time (specify a.m. or p.m.)
Obtained By	Convictions: ☐ **Yes** ☐ **No**
DPS approved dissemination method used to inform employer of results: ☐ Verbally ☐ Encrypted email ☐ Certified mail ☐ Did not request report – sent Form 1725	Date FMSA staff notified employer: _____ FMSA staff:

Date disseminated by FMSA: _____

If yes, does the conviction(s) prohibit service delivery in compliance with Health and Safety Code Chapter 250, §250.006(a), or §250.006(b)? ..... ☐ Yes ☐ No

Within five calendar days after the hiring decision, the FMSA must destroy the criminal history record information obtained from DPS whether or not hired or retained by the employer or designated representative.

Date report was destroyed: _____

Date employer notified FMSA of hiring decision: _____

Registry Checks (Conduct search at https://emr.dads.state.tx.us/DadsEMRWeb/)

Date of Registry Checks	Time (specify a.m. or p.m.)	Obtained By	☐ Employer ☐ FMSA Representative

Employee Misconduct Registry: ☐ No Record ☐ Record (must not be hired or retained)

Nurse Aide Registry: ☐ No Record ☐ Record (must not be hired or retained)

Medicaid Exclusion List: ☐ No Record ☐ Record (must not be hired)

Certification - I acknowledge that the applicant's DPS criminal conviction history and registry record were checked.

The applicant ☐ **is** ☐ **is not** eligible for hire, to be retained for service delivery based on the checks above.

_____
Signature - FMSA Representative

_____
Date FMSA notified the employer or Designated Representative

FMSA and Employer Must Each Keep Original or Copy of This Form

PRE-HIRE PACKET CHECKLIST

Applicant Name _____

Email Address _____

Phone Number _____

Checklist

- ❑ Job Application
- ❑ Two (2) References
- ❑ Notice to Applicant of Background Check Form
- ❑ **Photo of Valid Driver License - Email to hr@capitolhh.com**
- ❑ Form 1725 – **TEXAS ONLY**

*If you are completing the application by hand and you do not have access to a scanner, you can download a scanner application for mobile devices from the App Store (Apple) or the Google Play Store (Android). These applications are typically free and use the camera on your device to turn photos into PDFs. We suggest Genius Scan, but there are other options.