Comfort Home Care, LLC
A Residential Service Agency

7611 S Osborne Rd, Ste. 203
Upper Marlboro, MD 20772
info@comforthomecarellc.com

Office: (240) 510-5788
Fax: (240) 339-1785
www.comforthomecarellc.com

Dear Applicant,

We are currently recruiting Companions/Caregivers, Home Health Aides, Certified Nursing Assistants, Certified Medication Technicians, Licensed Practical Nurses and Registered Nurses.

Thank you for your interest in employment with Comfort Home Care.

All Comfort Home Care applicants, at a minimum, must:

- Have a high school diploma/GED or equivalent
- Present valid CPR and First Aid certificates
- Demonstrate the ability to provide care to clients through previous work experience
- Successfully complete a Maryland state criminal background investigation
- Provide Physician's Statement from a licensed medical provider (Completed by a physician, physician assistant, or nurse practitioner), verifying your physical ability to perform work-related activities as stated in the job description
- Provide proof of Hepatitis B vaccination or signed documentation indicating declination of Hepatitis B vaccination
- Obtain an annual PPD and TB test or provide negative chest X-ray, indicating that the individual does not have a communicable risk to the public
- Successfully pass a drug test
- Provide proof of employment eligibility in the United States

Additionally, to be considered for employment, all applicants must complete and submit the following enclosed documents:

- ❒ Employment Application Form
- ❒ Skills Assessment Form

All qualified individuals with completed application packets will be invited for a personal interview with Comfort Home Care management.

If you have any questions do not hesitate to contact us. We are looking forward to learning more about you.

Thanks,

Management

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COMFORT HOME CARE EMPLOYMENT APPLICATION FORM

PART A: PERSONAL INFORMATION

Title: Mr. /Mrs. / Miss Other	First Name	Last Name	M.I.

Current Home Address: Street	City	State	Zip Code:

Email

Home Telephone	Cell Phone	Date of Birth

Are you a citizen of the United States? Yes No If no, are you eligible to work in the United States? Yes No	Do you have a work permit or a right to work Visa? Yes No

Have you ever been convicted of a misdemeanor or felony? Yes No If yes, please explain the circumstances of the conviction.

What position(s) are you applying for?

Weekly Availability	When are you available to start work?

Do you have a Driver's License? Yes No Please indicate state of issue	What is your means of transportation to work?

Can you lift a weight of seventy pounds? Yes No

PART B: EDUCATION AND TRAINING

Type of School	**Name of School**	**Location** ***(Complete Mailing Address)***	**Dates Attended**	**Major/Degree/Diploma**

PART C: LICENSE - *Note: All nursing employees **MUST** hold an active license from the Maryland Board of Nursing.*

License Type	License #	Status	Issue Date	Expiration Date

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PART D: PRESENT & MOST RECENT EMPLOYER		
Employer name Address City, State Zip Code Phone number	**Employment Date** From To	Starting Salary Ending Salary
Last position held	May we contact this employer? Yes No If no, please indicate reason.	
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.		

PART E: REFERENCES				
*Please list one Employment reference **and** one Character reference we may contact.*				
Type of Reference	**Name**	**Relationship**	**Years of Affiliation**	**Phone #**
Employment Reference				
Character Reference				

PART F: EMERGENCY CONTACT	
Emergency Contact Name	Emergency Contact Phone

PART G: DECLARATION
By signing below, I _____, certify that all information included in the above application is true and valid to the best of my knowledge. I also understand that misrepresentation or falsification of the information provided above will result in my immediate disqualification from the selection process and dismissal from any position appointed to by the Agency.
Signature: Date:

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Hepatitis B Vaccination, Consent, and Declination

I. Acceptance of Hepatitis B Vaccine

I acknowledge that I am at risk of exposure or have been unknowingly exposed to the Hepatitis B virus as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis B Vaccine at no cost to myself. It is my decision to request that I receive the Hepatitis B Vaccine.

_____ _____

Employee Signature Date

II. Declination of Hepatitis B Vaccine

I am refusing the Hepatitis B Vaccine and hold harmless the Agency. 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 Hepatitis B Vaccination.

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 want to be vaccinated with the Hepatitis B Vaccine, I may receive the Hepatitis B Vaccination Series at no charge to me from the Agency.

_____ _____

Employee Signature Date

III. Documentation of Hepatitis B Vaccine Series

If you have received the complete Hepatitis B Vaccine Series, you must attach to this form the documentation, which proves your receipt of the HBV Series and the titer results indicating your immunity. If you are unable to receive the vaccination series for medical reasons please attach supporting documentation.

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Physician's Statement

This form must be completed by a physician, physician assistant, or nurse practitioner.

Personal Data

Name_____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Medical Release Authorization

I, _____ do hereby authorize _____
Patient Name *Physician Name*
to release any information acquired during medical examination, relevant to employment, to Comfort Home Care.

Immunization Records

Comfort Health Care must receive a copy of the results of all vaccinations, and or chest x-ray reports (if applicable) before the employee is hired for the purpose of home health staffing. Vaccination dates, not titers, are required for home health staffing only.

	Date	Results	Immune
Hepatitis Vaccine 1	_____		
Hepatitis Vaccine 2	_____		
Hepatitis Vaccine 3	_____		
Polio Vaccine	_____		
MMR Vaccine	_____		
Diptheria -Tetanus (DT) Vaccine	_____	*(required every 10 years)*	
T.B. Skin Test (PPD)	_____	Neg. ☐ Pos. ☐	_____ MM
Chest X-ray (only if PPD pos.)	_____		
BCG Vaccine	_____	Yes ☐ No ☐	

(Vaccine given in foreign countries for TB, not given in USA)

Physical Examination

Temp _____ Pulse _____ Respirations _____ Blood Pressure _____

The above-named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to function without any physical limitations or weight lifting restrictions as a healthcare professional.

Physician Name (please print) _____ License Number _____

Physician Address _____

City/State/Zip Code _____ Phone _____

Physician Signature _____ Date _____

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Certified Nursing Assistant/Medication Technician Skills Assessment

Name: _____ **Date:** _____

License Type: CNA 5 CMT 5

The objective of this skills assessment is to determine your current level of knowledge and experience in general nursing skills. It's your responsibility to seek out opportunities to increase your experience and competency in these skills.

*Please complete by **TICKING** the column that best describes your current level of knowledge and competence for each skill.*

SKILLS	Have Knowledge (Yes)	Have Knowledge (No)	Comments	RN Initial
CARE ROUTINE				
General activities of daily living				
• AM/PM Care				
• Bathing				
• Use of shower chair				
• Oral Care				
Special Skin Care				
Range of Motion Exercises				
• Active				
• Passive				
Dressing Changes:				
• Sterile				
• Clean				
Nasopharyngeal Suctioning				
Wound Care				
Universal Precautions				
SAFETY AND ACTIVITY				
Determining Patient ID				
Identifying safety hazards				
Maintaining clean, orderly work area				
Disposing of sharp objects				
Handling hazardous materials				
Proper Body Mechanics				
Transferring to Bed, WC, Commode, etc.				
Turning and Positioning				
Use of Hoyer lift				
Use of Equipment:				
• Use of crutches				
• Use of walker				
• Use of cane				
• Use of wheelchair and locks				
• Use of transfer belt				
• Use of gait belt for ambulation				
COMMUNICATION				
Communicating to RN:				
• Changes in Patient Condition				
• Patient Needs, Complaints and Concerns				
• Unusual Incidents				
Recording and Reporting:				
• Charting				
• Vital Signs				

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SKILLS	Have Knowledge (Yes)	Have Knowledge (No)	Comments	RN Initial
• Bowel Movements				
• Medication Intake				
• Diet Intake, Calorie Count				
INFECTION CONTROL				
Use of gloves				
Use of gowns/wearing scrubs				
Use of masks/goggles				
Hand washing precautions				
Infectious or hazardous waste disposal				
Use of CPR mask or bag				
Isolation Techniques				
SPECIMEN COLLECTION				
• Collecting Sputum				
• Collecting Clean Catch Urine				
• Collecting Stool				
GI/GU				
Use of Catheter				
• Clamping Catheter				
• Emptying Foley Bag				
• Placing Condom Catheter				
Emptying and Replacing Ostomy Bag				
Administering Enemas				
NURITION				
Feeding Patients				
Aspiration Precautions				
Tube Feedings:				
• N/G Tube				
• Peg Tube				
MEDICATION ADMINISTRATION				
Intake and Output (I & O)				
Vital Signs Pre/Post Med. Admin				
Medical Asepsis with Medication Prep				
Administer Oral Tablets/Capsules				
Administer Liquid Medications				
Prepare/Admin. Powdered Oral Meds				
Prepare/Crush Tablets				
Administer NG / GT Medications				
Administer Ophthalmic Meds				
Administer Otic Medications				
Administer Nasal Medications				
Administer Vaginal Medications				
Administer Rectal Medications				
Admin Enema with Supervision				
Administer Control Medications				
Pain Assessment/Pain Scale				
Count/Document Control Meds				
Admin/Document PRN Meds				
Apply Topical Medications				
Apply Transdermal Patch				
Metered Dose Inhaler Meds				
Test/Report Results of Hemoccult				
Discontinue Peripheral IVs				
Observe/Report Med. Side Effects				

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Use the following form to conduct your CJIS background check for Comfort Home Care, LLC:

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 #: 1000003712

ORI # (if required):

Reason fingerprinted? Job Placement

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: _____