



ANKOD
Health Care Services

License# HHA299992515

1120 Park Ave
Orange Park, Florida 32073
Tel: 904-637-1392 Fax: 904-215-1462

Welcome to ANKOD Health Care Services! Enclosed you will find all of the paperwork necessary to have on file for each employee. Please fill out each form completely and be sure to sign the application where indicated. Please provide a copy of the below information.

- Your Florida Nursing License or Certificate
- Drivers License and/or Alien Registration Card
- Your original Social Security Card
- A current CPR Card (Expiration Date_____)
- A physical not older than six (6) months. (It must state that you are free of Communicable Diseases), to include a Negative Tuberculosis Test, (Date taken_____).
- Your original four (4) hour AIDS update certificate.
- Your current one (1) hour AIDS update.
- Proof of Automobile Liability Insurance
- Certificate of Domestic Violence Expiration_____
- A fee of \$23 for a Criminal Background Check. If a screening has already been done through another agency and a breach in service has not occurred that exceeds 180 days, the proof of compliance is not more than two (2) years old then we can request a Copy/Transfer from your previous home health agency.
- OSHA in-service
- Professional Liability/Malpractice Insurance
- Alzheimer's Training – 2 hours.

You will be required to take and pass a test applicable to each classification with a minimum score of 75%.

Thank you for applying with ANKOD Health Care Services. If you have any questions, please feel free to speak with a coordinator.

PERSONAL INFO APPLICATION

Name _____ Date _____
SS# _____

Address _____ City _____

State _____ Zip _____ Telephone No. _____

Emergency Contact and Phone Number _____

Do you have transportation or are you able to arrange for transportation to work _____

EMPLOYMENT DESIRED

Position _____ Date you can start _____

Salary Desired _____ Ever worked at ANKOD before ____ When ____ Where ____

Are you employed now ____ If so may we contact your employer _____

ANKOD is an equal opportunity employer. We do not discriminate on the basis of race, color, creed, national origin, veteran status, citizenship, age, disability or any other characteristic protected by federal, state or local law. ANKOD will make a reasonable accommodation to known physical or mental limitation of a qualified applicant or employee with a disability unless the accommodation would impose an undue hardship on our business.

EDUCATION

Grade Level	Name and Location	Subjects Studied
High School		
College		
Other (Trade, etc)		

INTEREST

Special Skills/Hobbies/Languages or Interests which might make a client's care better

List below your employers for the last 3 years, starting with the last one first. Please explain any gaps.

Date	Name & Address	Salary	Title	Reason Separated
From _____ To _____				
From _____ To _____				
From _____ To _____				

REFERENCES

List three persons unrelated to you, whom you have known at least one year.

Name	Address	Business	Yrs. Known

In case of an emergency notify _____

I hereby authorize ANKOD to conduct an investigation into my background including an investigation of my character, employment, record, military record, education and training and conviction records. I understand that this application is good only for sixty (60) days from today's date. If I still desire a position with the company after the application expires, it will be my duty to fill out a new application and file it with the company. Otherwise, the company will not consider me for employment after this application expires. I understand that if I am employed, any misrepresentation or omission of material facts on this application is sufficient cause for dismissal. I agree to conform to the rules and regulations of the company and understand that if hired, I will be a "terminable at will" employee and that my employment and compensation can be terminated with or without cause and with or without notice, at any time, at the option of either the company or myself. I understand that neither this document, nor any other documents or letters received by me during my employment with ANKOD nor any offer of employment from ANKOD nor any statement made by any of its agents or representatives constitute any employment contract unless a specific document to that effect is executed by the President and myself in writing.

By filling out this application, I am genuinely interested in working for ANKOD>

Applicant _____ Date _____

Interviewed by _____ Date _____

WORK REFERENCES

Name Of Reference _____

Name _____

Address _____

Phone _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION REQUESTED ON THIS FORM

Applicant Signature _____ Date _____

APPLICANT'S NAME

Name used while employed _____ SS# _____

Position held _____ Date started _____

Date employment ended _____ Reason for _____

_____ Did worker give proper notice _____

_____ Would you rehire _____ Please explain _____

Please rate the applicant on the following

	Above Average	Average	Below Average
Appearance			
Attendance			
Cooperation			
Dependability			
Initiative			
Job Knowledge			
Relation w/Others			
Quantity of work			
Quality of work			

Comments _____

Signature _____ Date _____

REQUEST FOR LEVEL 1 CRIMINAL HISTORY CHECK

Name of Agency/Facility _____				AHCA License # _____	
Address _____ () _____					
Street	City	State	Zip Code	Phone No.	
Name of Owner of Facility _____					
Address _____ () _____					
Street	City	State	Zip Code	Phone No.	

Type of Applicant

- | | |
|---|---|
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Employee |
| <input type="checkbox"/> Financial Officer | <input type="checkbox"/> Relief Person or Volunteer |
| <input type="checkbox"/> Owner or Operator with 5% interest or more | <input type="checkbox"/> Other (specify) |

Type of Facility: (Please select type of facility that corresponds with AHCA license number listed above)

- | | | |
|---|---|---|
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Nursing Home Facility | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Homemaker, Companion, Sitter Agency | <input type="checkbox"/> Adult Day Care Center | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Adult Family Care Home | <input type="checkbox"/> Health Care Service Pool |
| <input type="checkbox"/> Nurse Registry | <input type="checkbox"/> Hospice Provider | <input type="checkbox"/> Home Medical Equipment |
| <input type="checkbox"/> Other (specify facility type): _____ | | |

PRINT OR TYPE ALL INFORMATION

Applicant _____ THIS SPACE RESERVED
 Last First Middle Maiden FOR FDLE USE ONLY

Race ()W, ()B, ()I, ()A, ()
 Race codes are below

Sex _____ DOB _____

Social Security No. _____

Current Address

Street _____

City _____ State _____ Zip Code _____

Race Codes: W=White B=Black I=Amer, Indian or Alaskan A=Asian or Pacific Islander U=Unkown

NOTE: Indicate Hispanic as Black or White based on skin color

Solicitenies hispanos deben mearar, en el codigo de race. Blanco (white) o Negro (black) besedo en su color depel