The

Emergent Enterprises

Corporation

P.O. Box 40851

Baton Rouge, Louisiana, 70835

Tel: (225)733-9314

**Please Provide the Following Documents:**

Driver’s License

Social Security Card

Nursing License

CPR Card

Current TB

Hepatitis B titers, if applicable

ACLS, PALS, NALS, if applicable

Certifications, if applicable

**Contact Information Form**

**Name**(last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(first)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mi)\_\_\_

**Social Security Number**\_\_\_\_-\_\_\_-\_\_\_\_

**Are you 18 years or older**? \_\_\_\_Yes \_\_\_\_ No

**Are you a Legal U.S. citizen**? \_\_\_\_ Yes \_\_\_\_ No

**Date of Birth** \_\_\_/\_\_\_/\_\_\_\_\_ **Gender** \_\_\_Male \_\_\_Female

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street State Zip code

**Driver’s License Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number**: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day: Evening

Additional contact numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of emergency**:

* Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_

**Email**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position applied for**: **Please Check one of the following**

Registered Nurse\_\_\_\_\_\_ Licensed Practical Nurse\_\_\_\_\_

Certified Nursing Assistant \_\_\_\_ Direct Staff Worker\_\_\_\_ Medical Assistant\_\_\_

PCA\_\_\_

**Work History**

Please list Work History for the past 3 years (beginning with most current)

* **Employer Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position held:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates employed:** from \_\_\_\_ /\_\_\_\_ to \_\_\_\_ / \_\_\_\_

**Supervisor name:**  **Title:**

* **Employer Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position held**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates employed:** from \_\_\_\_ /\_\_\_\_ to \_\_\_\_ / \_\_\_\_

**Supervisor name:**  **Title:**

* **Employer Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position held:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates employed:** from \_\_\_\_ /\_\_\_\_ to \_\_\_\_ / \_\_\_\_

**Supervisor name: Title:**

* **Employer Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position held:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates employed:** from \_\_\_\_ /\_\_\_\_ to \_\_\_\_ / \_\_\_\_

**Supervisor Name: Title:**

**(**May use back if more space is needed**)**

**Education**

**High School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Year graduated**:\_\_\_\_\_\_

**Diploma:** Yes\_\_\_ No \_\_\_

**College/University:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Year Graduated:**\_\_\_\_\_\_\_

**Degree earned:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Level of Education/Degree Earned:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all licenses or Certifications** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been convicted of a felony offense? \_\_\_\_ Yes \_\_\_\_ No**

**Have you ever been involved in a malpractice suit? \_\_\_\_ Yes \_\_\_\_ No**

**Has Your License ever been suspended by the State Board? \_\_\_\_ Yes \_\_\_\_ No**

If you answered yes to any of the above questions, please provide a brief explanation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide appropriate documents.**

\_\_\_ (**initial**) I agree that all information provided, is given truthfully and accurate to the best of my(applicant’s) knowledge.

**Print Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_

**References**

**Please List 3 References**

Name Address Phone# Title Yrs Known

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hepatitis B Vaccine**

\_\_\_\_I do not wish to take the Hepatitis B vaccination series, at this time. I understand that I am at risk of acquiring Hepatitis B when I am working with patients. I will not hold T.E.E.C. liable if I am exposed while working as an independent contractor.

\_\_\_\_I have received the Hepatitis B series and will provide a copy of my titers when I receive them.

\_\_\_\_I will take the Hepatitis B series. I understand that this agency does not provide the series and any expense incurred for the series will not be paid by T.E.E.C. and Services.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA**

Match the following terms with the correct definition below.

* Security \_\_\_\_\_\_\_\_
* Privacy \_\_\_\_\_\_\_\_
* Covered entities \_\_\_\_\_\_\_\_
* Protected Health Information (PHI) \_\_\_\_\_\_\_
* Business Associates \_\_\_\_\_\_\_
* HIPAA regulations protect an individual’s right to the privacy of his/her medical information, that is, to keep it from falling into the hands of people who would use it for commercial advantage, personal gain or malicious harm.
* Any health care providers, health plans or clearinghouses that electronically transmit medical information such as billing, claims. Enrollment, or eligibility verification must meet HIPAA regulations.
* Covered Entities cannot get around HIPAA by using other associates to handle their electronic transactions. Covered entities must ensure that their associates have security measures in place and technology sufficient to avoid accidental disclosure of and individuals PHI.
* A covered entity’s specific efforts to protect the integrity of the health information it holds and prevent unauthorized breaches of privacy.
* HIPAA regulations apply to medical information that contains any number of patient identifiers including name, social security, telephone number, medical record number, or zip code.

True or False

1.\_\_\_\_\_\_\_\_ The HIPAA privacy regulations require providers to obtain a signed consent form in order to use and disclose PHI for activities related to treatment, payment, and healthcare operations and to obtain a separate authorization to use or disclose PHI for any other purposes such as marketing.

2.\_\_\_\_\_\_\_\_ HIPAA includes 3 separate set of rules that cover transactions, security, and privacy of health care data.

3.\_\_\_\_\_\_\_\_ Faxing is the most common cause of confidential information.

4.\_\_\_\_\_\_\_\_ HIPAA carries severe civil and criminal penalties for noncompliance.

5.\_\_\_\_\_\_\_\_ Every practice, regardless of its size will have to comply with the HIPAA security, privacy, and transactions regulations.

I have been fully informed of HIPAA’s rules and regulations. I understand that as a healthcare professional, I have access to health information that shall be protected under HIPAA rules and regulations. I will not disclose any information to any unauthorized person or leave PHI unattended or accessible for others to view. I will not gain or attempt to gain access to any information that is not directly related to the care of my patients.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Answer Key**

Matching

1.D

2.A

3.B

4.E

5.C

True or False

1. TRUE

2. TRUE

3. TRUE

4. TRUE

5. TRUE