Preventative Care Health Services, Inc.

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General Staff Application

Date: ________________

Position applying for: ____

APPLICANT NAME: ____
[Last] [First] [Middle] [Maiden]

P.O. Box : ____
[City] [State] [Zip]

Telephone No.: ______________________ Cell Phone: ______________________

RESIDENCE ADDRESS: ____
[Street] [City] [State] [Zip]

SOCIAL SECURITY NUMBER: ________/__________/__________ DOB: __________
(To be used for identification purposes only)

Please provide a Photo ID with the application

EDUCATION

UNDERGRADUATE / TECHNICAL EDUCATION

____
School/College or University Address

____
[City] [State] [Zip]

Dates of Enrollment: ___/___/___ to ___/___/___ Degree: ______________________

Date of Graduation: ____/____/____

GRADUATE EDUCATION

____
[Graduate School]

____
[Address] [City] [State] [Zip]

Dates of Enrollment: ______________________________

Degree: ______________________ Date of Graduation: __________

PROFESSIONAL EDUCATION

____
[Name of Institution]

____
[Address] [City] [State] [Zip]

Dates of Enrollment: ______________________________

Degree: ______________________ Date of graduation: __________

LICENSURE

____________	____________	____________	___/___/___
[State]	[Date Issued]	[Number]	[Expiration Date]
____________	____________	____________	___/___/___
[State]	[Date Issued]	[Number]	[Expiration Date]
____________	____________	____________	___/___/___
[State]	[Date Issued]	[Number]	[Expiration Date]
____________	____________	____________	___/___/___
[State]	[Date Issued]	[Number]	[Expiration Date]

PROFESSIONAL SPECIALIZATION CERTIFICATION

Are you certified by a Professional Board or Association? ☐ Yes ☐ No

If yes, please answer the following (**PLEASE ATTACH A COPY TO APPLICATION**):

Name of Board(s) or Association(s): ____

____

Type of Certification: ____

Issued: _____/______/______ Expiration Date: ______/______/_______

MILITARY SERVICE

Have you served in the Military? ☐ Yes ☐ No
If yes, please answer the following:

____

[Branch] [Rank]

______________________ ____

[Dates] [Type of Discharge]

CONTINUING EDUCATION

Please attach a list of the continuing education programs that you have attended or presented for the period since last license renewal.

☐ CPR
☐ Basic Life Support for Healthcare Providers
☐ Advanced Life Support
☐ Instructor

OTHER CERTIFICATION:

____

Type of Certifications [Date of Certification]

____

Type of Certifications [Date of Certification]

____

Type of Certifications [Date of Certification}

Employment/Privileges History

Please list (most recent first) all companies/organizations where you have practiced, had staff privileges or been employed. Also, please explain any periods of time not accounted for since graduation from professional educational program. Use additional page(s) if necessary. *All time periods must be accounted for, including periods of unemployment and vacations between employments.*

1. Company Name: ____________________
Contact: ____________________ Telephone #: (___) __________

____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: ____________________ Dates: ___/___/___ to ___/___/___
Reason for Leaving: ____________________
Pay Rate ____________________

2. Company Name: ____________________
Contact: ____________________ Telephone #: (___) __________

____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: ____________________ Dates: ___/___/___ to ___/___/___
Reason for Leaving: ____________________
Pay Rate ____________________

3. Company Name: ____________________
Contact: ____________________ Telephone #: (___) __________

____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: ____________________ Dates: ___/___/___ to ___/___/___
Reason for Leaving: ____________________
Pay Rate: ____________________

4. Company Name: ____________________
Contact: ____________________ Telephone #: (___) __________

____
[Address] [City] [County] [State] [Zip]

Position/Title/Status: ____________________ Dates: ___/___/___ to ___/___/___
Reason for Leaving: ____________________
Pay Rate: ____________________

Professional References

Please list the names, full mailing addresses, and telephone numbers of three professional references.

Professional References (persons not related to you and with first-hand knowledge of your professional work).

1. Name: ____ Title: ______________________
Employer: ____

____
[Address] [City] [State] [Zip]

Telephone #: (_____) ___________________

2. Name: ____ Title: ______________________
Employer: ____

____
[Address] [City] [State] [Zip]

Telephone #: (_____) ___________________

3. Name: ____ Title: ______________________
Employer: ____

____
[Address] [City] [State] [Zip]

Telephone #: (_____) ___________________

1. Are you currently taking controlled substances by prescription or otherwise?

☐ Yes ☐ No

For purposes of the above questions:

☐ The term "currently" means recently enough so that the use of the substance may have an ongoing impact on one's functioning, or within the past two (2) years;

☐ The term "controlled substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the licensed prescriber's direction, as well as those substances used illegally;

☐ The phrase "ability to provide health care services" includes the following:

(a) The cognitive capacity to make appropriate assessments and judgments and learn and keep abreast of health care services developments;

(b) The ability to communicate those judgments and health care information to patients and other health care providers with or without the use of aides or devices, such as voice amplifiers; and

(c) The physical capability to perform health care services tasks such as checking vital signs and assigned portions of the physical examination procedures and tasks that may fall within your scope of practice, with or without the use of aides or devices, such as corrective lenses or hearing aids.

If you answered, "yes," to any of the questions above, please answer(i) and (ii), below.

(i) Does your use of controlled substances in any way impair or limit your ability to provide health care services with reasonable skill and safety? ☐ Yes ☐ No

(ii) Are you currently participating in a professionally supervised program that monitors you in order to assure that you are not illegally utilizing the controlled substances? ☐ Yes ☐ No

2. Do you have a medical condition that would require special accommodations for you to provide health care services with reasonable skill and safety? ☐ Yes ☐ No

For purposes of this question, the term "medical condition" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities as defined in the American with Disabilities Act ("ADA"), HIV/AIDS, tuberculosis, drug addiction and alcoholism.

If you answered "yes", please answer questions a and b below.

(a) Are any limitations that may be related to your medical condition ameliorated by current ongoing treatment or participation in a monitoring program? ☐ Yes ☐ No

(b) Are any limitations that may be related to your medical condition overcome by the manner in which you have chosen to provide health care services?

☐ Yes ☐ No

3. Have you ever been convicted of a crime (not including traffic violations)?

☐ Yes ☐ No

4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?

☐ Yes ☐ No

If you answered "Yes" to any of the above, please attach explanation and related documents.

I have reviewed and hereby submit my application. With my signature, I attest that with this information my application is complete and correct to the best of my knowledge and belief.

By: ____

[Applicant's Signature] [Date]

APPLICANT/EMPLOYEE AUTHORIZATION

Print Name:____
First   Middle   Last

Maiden Name: ______________________ Other last names used: ______________

Signature: ______________________________ Date: ______________

List all cities and states where you have lived for the past 7 years – Attach additional sheet if necessary

Street | City | County | State | ZIP | How Long?

Current: ____

2.____

3.____

4.____

Present Phone Number: _____/_____________ Social Security Number: _________-_______-_________

Date of Birth* (for identification purpose only): ______________________________

Sex*: Male ________ Female __________ Driver's License Number: ______________________

State: ___________

*This information will be used for background screening purposes only and will not be used as hiring criteria.

Preventative Care Health Services (dba) Presidio County Health Services, Inc.

PCHS

Mandatory COVID-19 Vaccination Policy Acknowledgment of Receipt and Review

I, ________________________________ acknowledge that on __________________________,
(print name) (date)

I received a copy of PCHS's Mandatory COVID-19 Vaccination Policy and that I read it, understood it, and agree to comply with it. I also understand that at the time of vaccination I will be provided with a consent form from the vaccine administrator that includes information about the benefits and risks of the COVID-19 vaccine, and that signing this acknowledgment does not constitute consent to receiving the vaccine. I understand that PCHS has the maximum discretion permitted by law to interpret, administer, change, modify, or delete this policy at any time, with or without notice. No statement or representation by a supervisor or manager or any other employee, whether oral or written, can supplement or modify this policy.

I understand that neither this policy nor any other communication by a management representative or any other employee, whether oral or written, is intended in any way to create a contract of employment. I understand that, unless I have a written employment agreement signed by an authorized PCHS representative, I am employed at will and this policy does not modify my at-will employment status. If I have a written employment agreement signed by an authorized PCHS representative, I understand that this policy complies with the terms of my employment agreement and is applicable to me.

____________________________ Signature ____________________________ Date

Implemented: 11/2021

PREVENTATIVE CARE HEALTH SERVICES

Category: RISK MANAGEMENT **Code: RM-003**

Effective Date: December 2021

Subject: CMS Covid-19 vaccine requirement **Revised: January 2022**

PURPOSE: Center for Medicare Services (CMS) is requiring workers at health care facilities participating in Medicare or Medicaid to have received the necessary shots to be fully vaccinated – either two doses of Pfizer or Moderna, or one dose of Johnson & Johnson – by April 21, 2022.

POLICY:

This policy is based on guidance from the CDC and the Equal Employment Opportunity Commission and is designed to comply with all applicable federal, state, and local laws that protect the health and safety of the PCHS Workforce. This policy is not intended to create a new class of protected individuals, or grant, expand, provide or protect the rights of persons not otherwise protected under current state or federal employment laws or by county or city ordinances protecting the rights of employees.

This policy only applies to individuals for whom the COVID-19 vaccine has been authorized by the FDA. This policy does not apply to individuals for whom the COVID-19 vaccine has not been Authorized by the FDA.

Compliance with this policy is mandatory for all "Members of the Workforce." Workforce, as used herein, is a term used to refer to employees, part-time or temporary employees, volunteers which (including Board Members), students and independent contracts with PCHS. Employees must comply with this policy as a condition of initial or continued employment.

PROCEDURE:

This Mandatory Vaccination Policy is a key part of our overall strategy healthy workplace in light of the COVID-19 pandemic and, to our Workforce and patients against infections while at PCHS. This policy is designed for us to work together with, and not as a substitute for, other COVID-19 prevention measures, including PCHS's prevention measures:

- Face Mask
- Social Distancing
- Self-monitoring and reporting of any influenza type symptoms
- Cleaning and Sanitation
- Health and Safety
- Any other COVID-19 Prevention measures adopted by PCHS

We need your full cooperation and compliance with this and other health and safety workplace policies and measures to make them effective.

Category: RISK MANAGEMENT **Code: RM-003**

Effective Date: December 2021

Subject: CMS Covid-19 vaccine requirement **Revised: January 2022**

Vaccination Requirements

Consistent with the CDC's guidance to prevent the infection and spread of COVID-19, and as an integral part of its public health and safety measures, PCHS requires that all Member of the Workforce, for whom the COVID-19 vaccine is Authorized by the FDA, get Fully Vaccinated against COVID-19 and show proof of an FDA-approved COVID-19 vaccination before April 21, 2022. This Policy applies unless an exemption from this policy has been granted as an accommodation or otherwise, as provided below. Any Member of the Workforce who is Fully Vaccinated must comply with new recommendations from the CDC within 30 days of notice from the Human Resources Department that new recommendations have been posted for Fully Vaccinated People.

After the implementation of this policy any new Member of the Workforce must begin their vaccine regiments prior to their first day at PCHS, and be Fully Immunized within 30 days.

Members of the Workforce who fail to comply with these requirements will be barred from entering the worksite and subject to disciplinary measures, up to and including termination. In addition, employees may be terminated or placed on unpaid leave subject to reasonable accommodation and other requirements of applicable federal, state, and local law or as provided in this policy.

VACCINE ADMINISTRATION:
PCHS will make the COVID-19 vaccine available to all Members of the Workforce covered by this policy during regular business hours.

PROFF OF VACCINE:
If you already have, or subsequently receive, a vaccine from another health care provider, you must provide written proof of vaccination from the vaccine administrator or a CDC issued vaccination card, including the vaccination place, date(s), and name, by April 21, 2022 or within 30 days, whichever is applicable. Do not include any medical or genetic information with your proof of vaccination.

VACCINE EXEMPTIONS:

The rule requires health care facilities to allow for exemptions to staff with recognized medical conditions or religious beliefs, observances or practices. Facilities must establish a process for staff to request either exemption and ensure that the requests are appropriately documented and evaluated. In instances of medical exemption requests, providers must ensure that all documentation confirming recognized clinical contraindications are signed and dated by a licensed health-care practitioner other than the individual requesting the exemption. **Staff who previously had COVID-19 are NOT exempt from the vaccination requirements.**

In instances where a staff member meets the requirements for an exemption and is therefore unvaccinated, PCHS is developing a process for implementing additional precautions to mitigate transmission and spread of COVID-19. This could include reassigning the non-vaccinated staff to non-patient care settings depending upon the availability of such a position. Further, when granting an exemption or accommodation, PCHS is in the process of adopting steps to minimize the risk of COVID-19 transmission to at-risk individuals.

While the regulation does not require testing for unvaccinated staff, PCHS is considering such a requirement in the future.

Any employee seeking exemption status eligibility for medical conditions or religious beliefs, observances or practices need to make an appointment with Human Resources prior to the April 21, 2022 deadline. Anyone seeking exemption status will need to meet the requirements of the exemption, evaluated and approved.