TRIUMPH
HEALTH CARE & SUPPORT SERVICES LLC

HEPATITIS B VACCINE

DECLINATION

_____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) infections. I have been given the opportunity to be vaccinated with hepatitis B vaccination at this time, by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____I have elected to voluntarily be vaccinated with Hepatitis B vaccine offered by agency. I have received vaccine information regarding risk associated with this vaccination.

_____I have completed the Hepatitis B vaccination series.

Name of Employee (printed): _____

Signature: _____ Date: _____

4010 Glengyle Ave, Suite 2 Baltimore MD 21215
Email: triumphhealthllc@gmail.com Phone: +14439912262, +13472572823

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APPLICATION FOR EMPLOYMENT

(Please Fill Out Completely)

Date of Application_____social security number _____

Print full name _____

Home phone:_____ Email: _____

Address: _____

City: _____ state: _____ Zip code: _____

Position Applied For _____

Documents required with this application (All)	**Check if attached**
1. Thoroughly completed employment application	( )
2. Current professional license	( )
3. Current CPR/First Aid (signed)	( )
4. PPD/Chest X-ray/Physical	( )
5. Employment eligibility verification (form I-9)	
6. Two professional reference form or letter (phone # included)	( )
7. One personal reference for or letter (phone # included)	( )
8. Driver's license/ state issue ID card	( )
9. Copy of Social Security Card (Bring original signed copy to interview)	( )
10. Background Check (**a must**)	( )
11. DDA trainings, MANDT training & Blood borne Pathogen	( )
12. Any other information you have for employment	( )

If you do not have all the document above, please tell us when it will be available below:_____

_____

_____

_____

PHYSICIAN'S STATEMENT

This form must be completed by Physician, Physician assistant, or Nurse Practitioner.

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Personal Data

Name: _____ Social Security # _____

Address _____

City _____ state _____ zip code _____

Phone _____Email _____

Medical Release Authorization

I _____ do hereby authorize _____

To release any information acquired during medical examination, relevant to employment with Triumph Health care LLC.

Immunization Records- Triumph HealthCare LLC must receive a copy of the result of all vaccinations, and or chest x-ray report (if applicable) before employee is hired for the purpose of home health staffing. Vaccination dates, not titers, are required for home health staffing only.

	Date	Result	Immune
Hepatitis vaccine 1	_____		
Hepatitis vaccine 2	_____		
Hepatitis vaccine 3	_____		
Polio vaccine	_____		
MMR vaccine	_____		
Diphtheria-Tetanus (DT) vaccine	_____ (required every 10 years)		
T.B skin test (PPD)	_____	Neg.____ Pos.___	
Chest x-ray (only if PPD pos.)	_____		
BCG vaccine	_____	Yes.____ No.___	

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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SUPPORT STATEMENT
Please indicate all relevant experience, skills, and work history that relate to the job description of which you have applied.

MEDICAL HISTORY
What absence due to illness have you had from work for the last 2 years?

Do you have any illness that will present you from performing the duties of the position of which you have applied?
Yes/No

If yes, please indicate below

Can you lift a weight of 50 pounds? Yes/ No

REFERENCES
Please list three character references of which we may contact.

Name	Relationship	Years of affiliation	Telephone

DECLARATION
by signing below **I,**_____, on the date of _____ hereby certify that all information included in 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 any immediate disqualification from the selection process and dismissal from any position appointed to by agency after discovery.

Name: _____ Date: _____

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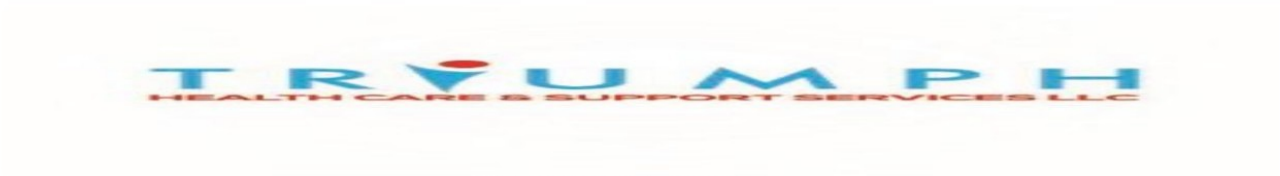

CONFIDENTIAL AGREEMENT

READ CAREFULY AND SIGN BELOW IF YOU AGREE TO THESE TERMS OF EMPLOYMENT

I agree that except at the request and for the benefit of **Triumph HealthCare & Support Services LLC** I will not disclose to anyone or use for my own purpose any **Triumph HealthCare & Support Services LCC** confidential or proprietary information, either during or after my employment. I understand and agree that **Triumph HealthCare & Support Services LLC** bidding, cost, pricing and marketing information and techniques, customer names and information and employee name and information are confidential and proprietary to **Triumph HealthCare & Support Services LLC.**

I certify that this application contains no willful misrepresentation or falsification and that this information given by me is true and complete to the best of my knowledge and belief. I Authorize **Triumph HealthCare & Support Services LLC** to contact all sources to verify the information on this application. I understand that any falsification, misrepresentation or fraudulent information provided by me in connection with my application for employment is sufficient ground for withdrawal of an employment offer or immediate discharge.

I understand that this application is not a contract of employment.

I authorize and request my former employer, references and educational institutions which have information about me to give **Triumph HealthCare & Support Services LLC** any and all information and opinions about me in their possession and which may lawfully be disclosed. I hereby waive written notice of such release of information and opinion, and release such former employer, reference and educational institutions from any liability or claim relating to such release of information and opinion. I also authorized and request that federal, state and local government agencies to release to **Triumph HealthCare & Support Services LLC** any information requested, concerning any criminal conviction on my record. A copy of this signed authorization and waiver shall be valid as an original.

Signature of applicant: _____ Date: _____

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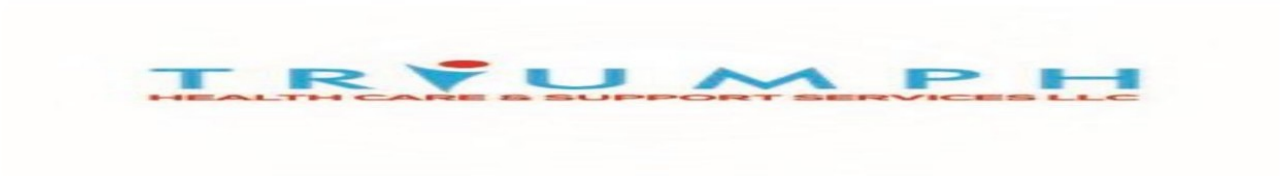

CONFLICT OF INTEREST

I acknowledge that I have read the company policy statement concerning conflict of interest and hereby declare that neither I, nor any other business to which I may be associated, nor, to the best of my knowledge, any member of my immediate family has any conflict between our personal affair or interest and the proper performance of my responsibilities for the company that would constitute a violation of that company policy. Furthermore, I declare that during my employment, I shall continue to maintain my affairs in accordance with the requirement of said policy.

_____ _____

Signature of Applicant Date

RELEASE OF INFORMATION

I hereby authorize all prior employers, schools, credit bureaus, Social Security administration. Law enforcement agencies and investigative agencies to give **Triumph HealthCare & Support Services LLC** any and all information concerning any previous employment and any pertinent information they may have personal or otherwise, concerning my qualifications for the position applied for. I release to **Triumph HealthCare & Support Services LLC** and all its employees form all liability for any damage that may result from furnishing information to **Triumph HealthCare & Support Services LLC.** I also release **Triumph HealthCare & Support Services LLC** and all its employee from all liability for any damage that may result from reliance on the information furnished. I understand that if a consumer investigative report is requested, I have the right under the fair credit reporting act to request in writing, within a reasonable time, a complete and accurate disclosure of the nature and scope of investigation. This written request should be addressed to the location where this application is filled.

Full Name (please print) _____

Signature of Application _____ Date: _____

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EMPLOYMENT APPLICATION FORM

PERSONAL INFORMATION Title: Mr./Miss/Mrs. Other (Please specify)	First Name:	Last name:
Telephone:	Address:	
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 If you are under the age of 18, do you have an employment/age certificate? Yes/No	
Have you ever been convicted of a misdemeanor or felony? Yes/No If yes, please explain the circumstance of the conviction below.		

AVAILABILE HOURS

DAYS	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

High school name & address	Date Attended:	Diploma Received? Yes/No	Area of Study
College/Training School	Date Attended:	Diploma Received? Yes/No	Area of Study

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Present or most recent employer and address:	Date(M/Y)	Position Held & Duties	Reason for leaving
Start salary: End salary:		May we contact this employer? Yes/No If no, please state reasons.	
Employer and address:	Date(M/Y)	Position Held & Duties	Reason for leaving
Start salary: End salary:		May we contact this employer? Yes/No If no, please state reasons.	
Employer and address:	Date(M/Y)	Position Held & Duties	Reason for leaving
Start salary: End salary:		May we contact this employer? Yes/No If no, please state reasons.	
Employer and address:	Date(M/Y)	Position Held & Duties	Reason for leaving
Start salary: End salary:		May we contact this employer? Yes/No If no, please state reasons.	

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