HORIZON
MEDICAL STAFFING

Name _____ Home Tel. ( ) _____

Street Address _____ Cell ( ) _____

City, State, Zip _____ E-Mail _____

Position Applying for _____ Salary Desired: _____

WORK HISTORY

Current or Last Employer

_____ Dates Worked: From _____ To _____

Street Address Supervisor _____

_____ Job Title _____

City/State/Zip Name Used While Employed _____

_____ Reason for Leaving _____

Phone: _____ May we contact this employer for a reference?
☐ Yes ☐ No

Prior Employer

_____ Dates Worked: From _____ To _____

Street Address Supervisor _____

_____ Job Title _____

City/State/Zip Name Used While Employed _____

_____ Reason for Leaving _____

Phone: _____ May we contact this employer for a reference?
☐ Yes ☐ No

EDUCATION

High School _____ **College/Nursing School** _____

Street Address _____ Street Address _____

City, State, Zip _____ City, State, Zip _____

Name Used While Attending _____ Degree/Course/Certificate/Date _____

DORA Number _____

EMPLOYMENT APPLICATION

PLEASE READ AND SIGN: I hereby authorize Horizon Medical Staffing, and also authorize and request each former employer and person, firm or corporation given as a reference to answer all questions that may be asked and give all information that may be sought in connection with this application specifically concerning my work, skill or my professional performance and reliability in the form of a reference. My employment with Horizon Medical Staffing will not begin until such references are received.

I agree, in consideration of your employing me that I will not seek or accept employment from any client of Horizon Medical Staffing without first obtaining permission from Horizon Medical Staffing. I understand that if I am in violation of this agreement, I am subject to legal action and monetary damages up to 30% of my annual salary provided by the client if I was employed by that facility as a permanent employee.

I understand that this employment application is not a contract and that if hired, my employment with Horizon Medical Staffing can be terminated with or without cause, and with or without notice, at any time, at the option of Horizon Medical Staffing. I also understand that any and all benefits received pursuant to employment with Horizon Medical Staffing may be changed or eliminated at will without prior notice.

I consent to having a criminal background check done on my history, including a social security number verification, and I understand that my employment might hinge on this check, including termination if after I am hired, information is acquired that precludes my employment with Horizon Medical Staffing.

I understand that all applicants will be required to pass screening for the presence of illegal drugs or alcohol as a condition of employment at Horizon Medical Staffing. I may be required to voluntarily submit to a drug test chosen by the company and by signing this consent agreement I release Horizon Medical Staffing from liability. I understand that with positive test results I may be denied employment at this time, but I may initiate another inquiry with Horizon Medical Staffing after 6 months, provided that a drug retest is performed and negative results are received. Horizon Medical Staffing will not discriminate against applicants for employment because of past abuse of alcohol/drugs if a current drug test is negative. However, Horizon Medical Staffing will not tolerate the current abuse of alcohol/drugs. I may also be asked to voluntarily submit to drug tests for post incident screening and random drug testing at any time in the future due to a past positive drug test.

I authorize Horizon Medical Staffing to copy and forward my personnel file contents, including all health related documents (Physical exam, TB, Flu Shot, Immunizations, Drug Screens, Covid-19 test results, etc.) to any and all client facilities which require this of Horizon Medical Staffing. I hereby certify that all of the above information is true and correct. I understand that any misrepresentation or false information given on this application will result in rejection or termination of employment.

I authorize the obtaining of references unless otherwise indicated on page 1 of this application.

Applicant Signature: _____ Date: _____

Print Name: _____

Driver's License No: _____ **State:** _____

EMERGENCY CONTACT INFORMATION

(1) Name_____ Relationship_____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

(2) Name_____ Relationship_____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

HORIZON
MEDICAL STAFFING

Equal Employment Affirmative Action Program
Employee Questionnaire for Self-Identification of Race/Ethnicity

INSTRUCTIONS
PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM

Anti-Discrimination Notice: It is an unlawful employment practice for an employer to fail or refuse to hire or discharge any individual, or otherwise to discriminate against any individual with respect to that individual's terms and conditions of employment, because of such individual's race, color, religion, sex, or national origin.

This employer is subject to certain nondiscrimination and affirmative action recordkeeping and reporting requirements which require the employer to invite employees to voluntarily self-identify their gender and race/ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable federal laws, executive orders, and regulations, including those which require the information to be summarized and reported to the Federal Government for civil rights enforcement purposes. If you choose not to self-identify your gender and/or race/ethnicity at this time, the federal government requires this employer to determine this information by visual survey and/or other available information. All information will be reported in the same seven race/ethnicity categories identified below.

INVITATION TO SELF-IDENTIFY
PLEASE ANSWER THE FOLLOWING QUESTION

GENDER: MALE _____ FEMALE _____

What is your race/ethnicity? Please mark the **one box** that describes the race/ethnicity category with which you primarily identify.

____ **Hispanic or Latino**: a person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

____ **White (not Hispanic or Latino)**: a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

____ **Black or African American (not Hispanic or Latino)**: a person having origins in any of the black racial groups of Africa.

____ **Asian (not Hispanic or Latino)**: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

____ **Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)**: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

____ **American Indian or Alaska Native (not Hispanic or Latino)**: a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

____ **Two or More Races (not Hispanic or Latino)**: a person who primarily identifies with two or more of the above race/ethnicity categories

APPLICANT NAME: _____ ***DATE:*** _____

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REFERENCE REQUEST

Employee Information

I hereby authorize Horizon to contact the following references on behalf of my application

Name of Applicant (printed) _____

Name used while employed _____ Position _____

Dates of Employment: From _____ to _____

Signature of Applicant: _____ Date _____

Reference 1

Name of professional reference: _____ Title: _____

Relationship to applicant: _____

Location you worked together: _____

Phone:_____ Email: _____

Reference 2

Name of professional reference: _____ Title: _____

Relationship to applicant: _____

Location you worked together: _____

Phone:_____ Email: _____

HORIZON
MEDICAL STAFFING

HEPATITIS B STATUS DECLARATION

Do not sign both the Acceptance and Declination portions of this form. If you have any uncertainty regarding your current status, please contact your Horizon Medical Staffing representative for clarification. If you are unable to provide the required vaccination information at this time, please sign the declination portion of this document.

Hepatitis B Declination

I understand that my occupation may result in exposure to blood or other potentially infectious materials, and that I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I understand that my failure to receive this vaccine may subject me to the risk of acquiring Hepatitis B disease or, I am in the process of receiving inoculations for Hepatitis, but I have not completed them yet. Therefore, for now I decline and I will furnish you proof of my inoculations when they are completed.

Print Name Date

Signature

Hepatitis B Acceptance

I have already received 3 vaccinations required for Hepatitis B Vaccination Series and I am able to provide the vaccination records as proof of these inoculations at this time.

Print Name Date

Signature

HORIZON
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Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Horizon Medical Staffing LLC to initiate automatic deposits to my account at the financial institution named below. I also authorize Horizon Medical Staffing LLC to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Horizon Medical Staffing LLC responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Horizon Medical Staffing LLC receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

MANDATORY: You MUST attach a voided check, deposit slip or bank form to ensure accuracy of Routing and Account numbers. You will be responsible for any charges related to incorrect information given to Horizon. Please return this form to Horizon Medical Staffing by fax to 720-306-5254 or email to info@horizonmedstaff.com. Thank you!

Account Information

Employee Name: (please print) _____

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ ☐ Checking | ☐ Savings

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

COLORADO
Adult Protective Services
CAPS Check Unit

Written Authorization to Request a CAPS Check

A check of the Colorado Adult Protective Services (APS) data system (CAPS) is required for you (individual) because you are:

- A potential employee/contractor who will provide direct care to at-risk adults, or
- A person who may be appointed as a conservator or guardian of an at-risk adult.

An employer may also request a CAPS check for you if you provide direct care to an at-risk adult and you:

- Were hired/contracted prior to the CAPS check requirement (1/1/2019), or
- Are a volunteer, or
- Will provide services to a CDASS recipient

The CAPS check will alert the employer or court (agency) whether you have or have not been substantiated in an APS case of mistreating an at-risk adult, to include physical abuse, sexual abuse, caretaker neglect, exploitation, and/or harmful act.

More information on the CAPS check requirement can be found in Colorado Revised Statute (26-3.1-111, C.R.S.) and in the Colorado code of Regulations (12 CCR 2518-01).

Written authorization is required from the individual being checked, using this form. Please complete this form in its entirety. Knowingly providing inaccurate information on a CAPS check request is a class 1 misdemeanor pursuant to 18-1.3-501, C.R.S.

AGENCY INFORMATION (To be completed by the agency.)

Agency Name: Horizon Medical Staffing

Agency Address: 7899 South Lincoln Ct Ste 207 Littleton CO 80122

INDIVIDUAL'S INFORMATION (To be completed by the individual being checked.)

First Name: _____ Middle Name: _____ Last Name: _____

Maiden Name/Previous Name(s)/Alias: _____

Date of Birth: _____ SSN (Last 4 digits): _____ DORA License #: _____
(required for all licensed professionals)

Provide the Name(s) of Your Previous Employer(s) Over the Past Five (5) Years: _____
_____

You must provide at least one (1) personal phone number and one (1) email address.

Personal Email Address: _____

Work Email Address: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone Extension: _____

All individuals are required to provide five (5) years of residential history, regardless of whether in the U.S. or abroad. If you lived outside the US in the past five (5) years, provide the international address(es), including the name of the city and country. If you have lived at your current address less than 5 years, please list your previous addresses for the past 5 years. Use another sheet of paper, if necessary.

Current Address Start Date *(DD/MM/YYYY)*: ______________________________

Current Street and Number *(No PO boxes)*: ______________________________

Current Address City: ______________ Current State: ________ Current Zip/Postal Code: ________

Previous Address Start Date *(DD/MM/YYYY)*: __________ Previous Address End Date *(DD/MM/YYYY)*: __________

Previous Street and Number *(No PO boxes)*: ______________________________

Previous City *(City & country for international addresses)*: ______________________________

Previous State *(Not required for international addresses)*: ______ Previous Zip Code *(Use "00000" for international addresses)*: ______

Previous Address Start Date *(DD/MM/YYYY)*: __________ Previous Address End Date *(DD/MM/YYYY)*: __________

Previous Street and Number *(No PO boxes)*: ______________________________

Previous City *(City & country for international addresses)*: ______________________________

Previous State *(Not required for international addresses)*: ______ Previous Zip Code *(Use "00000" for international addresses)*: ______

Previous Address Start Date *(DD/MM/YYYY)*: __________ Previous Address End Date *(DD/MM/YYYY)*: __________

Previous Street and Number *(No PO boxes)*: ______________________________

Previous City *(City & country for international addresses)*: ______________________________

Previous State *(Not required for international addresses)*: ______ Previous Zip Code *(Use "00000" for international addresses)*: ______

Previous Address Start Date *(DD/MM/YYYY)*: __________ Previous Address End Date *(DD/MM/YYYY)*: __________

Previous Street and Number *(No PO boxes)*: ______________________________

Previous City *(City & country for international addresses)*: ______________________________

Previous State *(Not required for international addresses)*: ______ Previous Zip Code *(Use "00000" for international addresses)*: ______

I, ______________________, by my signature below, authorize the agency referenced above to request a CAPS check to determine if I have a substantiated finding as a perpetrator of mistreatment of an at-risk adult. I acknowledge that a substantiated finding resulting from such a check, unless the finding was expunged through a successful appeal, shall be provided to the person directly involved in the employer's hiring process or the court's hearing process and may be used to inform their decision. I acknowledge notification may occur through CAPS to this agency, for the duration of my employment, volunteer assignment, or authority as an appointed or potential conservator or guardian with them, of any future substantiated findings against me. I understand that willfully providing false information on this form is a misdemeanor 1 penalty, punishable as outlined in §18-1.3-501, C.R.S. I declare under penalty of perjury under Colorado Law that this CAPS Check Request Form, including supporting documents, has been examined by me and is true, correct, and complete.

Signature: ______________________________

Date: ______________________________

CLEAR FORM PRINT

COLORADO
Adult Protective Services
CAPS Check Unit