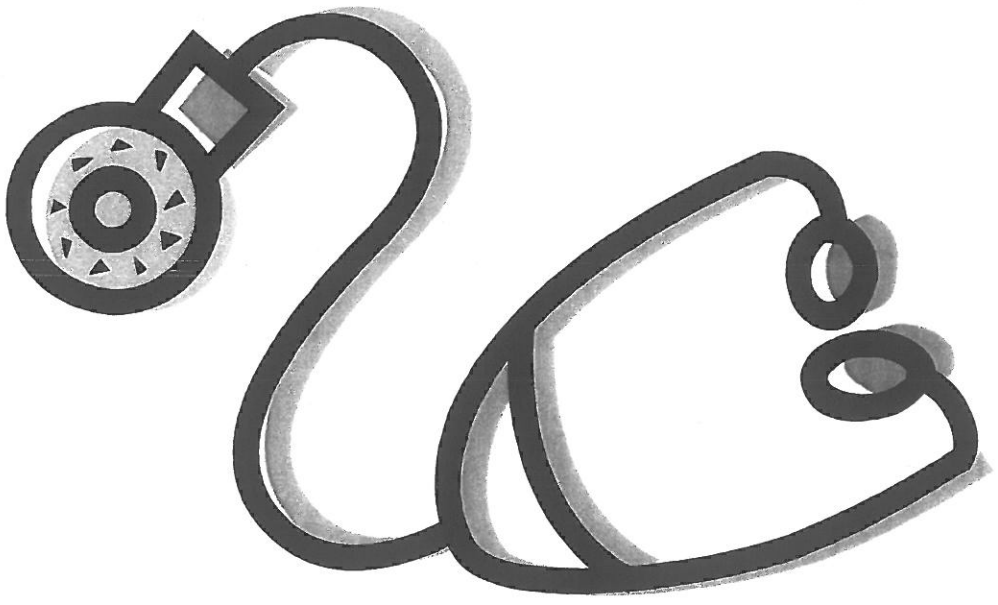
# LBA MEDICAL SERVICES, LLC

# EMPLOYEE APPLICATION PACKET



# INSTRUCTIONS:

1. Please complete forms for background check and provide a copy of your Social Security card, Professional License and Driver's License.

2. Also enclosed are reference forms for permission for us to contact your former employer. Please complete the contact information and sign the release, then return the form to us and we will contact that company or person.

3. Included is the employee handbook for LBA Medical Services, LLC. Please sign the last page of the handbook stating that you have received the handbook. You may keep the handbook itself but return the last page with your signature to us.

**LBA Medical Services, LLC**
**109 Taylor Dr**
**Dayton, TN 37321**
**Phone :(423) 775-0771 Fax: (423) 834-9059**

| **PERSONAL INFORMATION** | **Date of Application:** |
|---|---|
| **Name (Last, First, Middle)** | **EMAIL address:**<br><br>**Phone Numbers:**<br>**Home:**<br><br>**Cell:** |
| **Name on licensure,( Maiden), etc.** | **Social Security Number:** |
| **Address, City, State, Zip** | **Emergency Contact (Phone number)** |

| **POSITION REQUESTING** | **SHIFT REQUESTING** |
|---|---|
| ☐ **RN** ☐ **LPN** ☐ **CNA** | ☐ **1ST SHIFT** ☐ **2ND SHIFT** ☐ **3RD SHIFT**<br>☐ **PRN** ☐ **PART TIME** ☐ **FULL TIME** |
| **Days available to work:** ☐ **SUN** ☐ **MON** ☐ **TUES** ☐ **WED** ☐ **THURS** ☐ **FRI** ☐ **SAT** | |

| **EDUCATION** | | | | |
|---|---|---|---|---|
| **NAME OF** | **ADDRESS** | **YEARS ATTENDED** | **DEGREE OR DIPLOMA** | **Contact person** |
| HIGH SCHOOL | | | | |
| COLLEGE | | | | |
| OTHER | | | | |

| PERSONAL REFERENCES | | | | | |
|---|---|---|---|---|---|
| **Name of person** | **ADDRESS** | **TELEPHONE** | **How long have you known this person?** | **Relation-ship to you** | **For office use** |
| | | | | | |
| | | | | | |
| | | | | | |

| WORK EXPERIENCE | | | | | | |
|---|---|---|---|---|---|---|
| **Name of company** | **ADDRESS** | **SUPERVISOR NAME & TELEPHONE** | **Position & duties** | **Salary / wages** | **Dates of employ-ment** | **For office use** |
| | | | | | **From:** **To:** | |
| | | | | | **From:** **To:** | |
| | | | | | **From:** **To:** | |
| | | | | | **From:** **To:** | |

☐ May we contact the above previous employers?

☐ Can you, after employment, submit proof of verification of legal right to work in U.S.?

☐ Can you, after employment, submit proof of license and proof of required immunizations required for employment?

☐ I understand that this facility is a non-smoking facility.

# DISCLOSURE AND AUTHORIZATION FORM TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

***Please Read Carefully Before Signing the Authorization***

## DISCLOSURE

In considering you for employment and, if you are employed, in considering you for subsequent promotion, assignment, reassignment, retention, or discipline, [ LBA MEDICAL SERVICES] ("the Company") may request and rely upon one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency, such as IntelliCorp Records, Inc.

For explanation purposes:

- a "consumer report" is a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in making an employment-related decision about you. Such information may include, for example, credit information, criminal history reports, or driving records; and

- an "investigative consumer report" is a consumer report in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your prior employers, neighbors, friends, or associates, or with others who may have knowledge concerning any such items of information. In the event an investigative consumer report is requested about you, you are entitled to additional disclosures regarding the nature and scope of the investigation requested, as well as a written summary of your rights under the Fair Credit Reporting Act ("FCRA").

Under the FCRA, before the Company can obtain a consumer report or investigative consumer report about you for employment purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

## AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize the Company to obtain and rely upon consumer reports or investigative consumer reports in considering me for employment and, if I am employed, in considering me for subsequent promotion, assignment, reassignment, retention, or discipline. By my signature below, I authorize the Company to obtain any such reports and to share the information received with any person involved in the employment decision about me.

I do _____do not_____ authorize you to contact *my current* employer for Employment and Reference Verifications

(This will authorize immediate inquiries to the Human Resources Department and to any listed supervisors or references in the Employment/Reference Section of your application.)

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports or investigative consumer reports that may be requested about me by or on behalf of the Company.

_____ _____

Applicant Signature Date

## *Personal Data*

Last Name _____ First Name _____ Middle Name _____

Current Address _____ Dates Lived Here _____

Addresses for the Past Seven Years: (include street, city, state, zip code) Dates of Residence:

_____ _____

_____ _____

_____ _____

Date of Birth _____ Other Names Used (including maiden name) _____ Years Used _____

Social Security Number _____ Driver's License # _____ State _____

Email address (may be used for official correspondence) _____

I have the right to make a request to **IntelliCorp Records, Inc**, upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including sources of information, and the recipients of any reports on me which **IntelliCorp Records, Inc** has previously furnished within the two year period preceding my request.

I certify that all elements of the personal data I have provided are true, accurate and complete. I understand and agree that any omission, false statement, misleading statement, or answer made by me on my application or any supplements to it and in any interviews will be sufficient grounds for rejection of employment and my discharge after employment.

Printed Name _____ Applicant Signature _____ Date _____

## APPLICANT'S STATEMENT

1. The information I am presenting in this application is complete, true and correct to the best of my knowledge, I understand that any falsification, misrepresentation, or omissions could result in the denial of my application, withdrawal of any offer of employment, or immediate discharge.

2. I understand that in connection with the application process, LBA Medical Services, LLC may contact my former employers, educational institutions, references, and other relevant third parties to obtain additional information related to the information given by me in this application. I hereby request, release and consent to the release and disclosure of such information. I further release and hold harmless LBA Medical Services, LLC and its representatives, officers or employees and agents inquiring about, investigating, furnishing, communicating, reviewing, or evaluation such information from any and all potential claims, demands, damages, liabilities, and/or actions of any kind arising from such activities, whether known or unknown to me presently, that I may have, now or in the future.

3. If employed, I agree to conform to the rules and regulations of LBA Medical Service, LLC and understand that I will be an employee at will and my employment may be terminated at any time by me or LBA Medical Services, LLC with or without notice, for any reason.

**Applicant's Signature:** **Date:**

Dear:

One of your former employees has applied for work with our company. We ask that you verify and complete this form at your earliest convenience and return it to our office at the address below. Thank you for taking the time needed to complete this reference form.

Sincerely;

LBA Medical Services, LLC
109 Taylor Dr
Dayton, Tn. 37321

Fax# 423- 834- 9059

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I release the above named employer, LBA Medical Services, LLC, their agents, employees from any liability or claims I may have which arise or result from any reference provided pursuant to this authorization or any authorization or any authorized disclosure therefore.

Applicant's Name: _____

Signature: _____ Date: _____

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Position applied for : _____ Date applied: _____

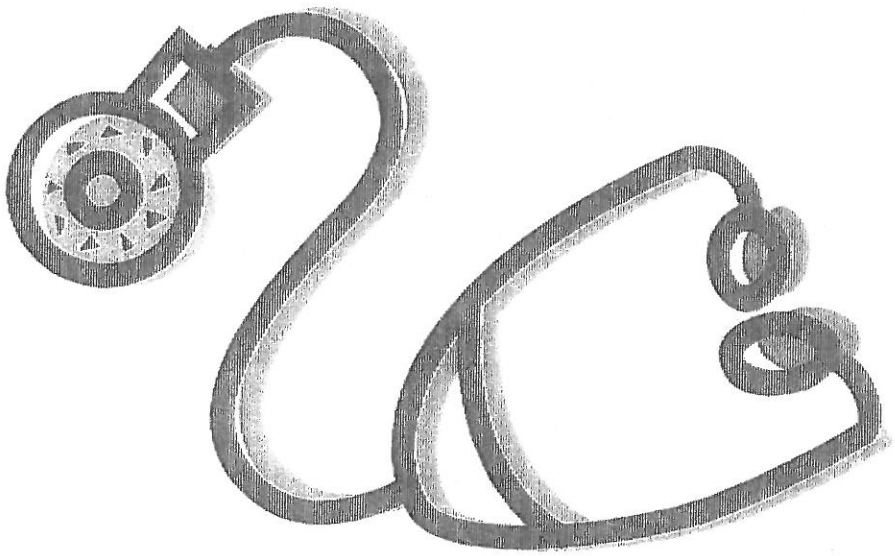
| EVALUATION | EXCELLENT | GOOD | AVERAGE | POOR |
|---|---|---|---|---|
| **Dependability** | | | | |
| **Punctuality** | | | | |
| **Knowledge** | | | | |
| **Quality of Work** | | | | |
| **Attitude** | | | | |

Dates of employment with your company_____
Reason for leaving: _____
Eligible for rehire: Yes No
If no please explain:

_____
_____
_____

Signature _____ Date: _____

# *LBA Medical Services, LLC*
# *Employee Handbook*



## ATTENDANCE

If you agree to work a shift, you are expected to show up on time for the start of the shift. No show, no call, no work. Two no shows and no calls will be reason for termination of employment. If you are sick, a call in is required with a minimum of four (4) hours prior to the start of the shift.

Promptness is required. Being late means the other team members must do your work for you and does not foster team spirit. Tardiness is when you clock in after the start of your shift. Leaving early is leaving more than 7 minutes prior to the end of your shift. Leaving late is leaving 7 minutes after the end of your shift.

For business accounting purposes, each day begins at 6:00 a.m. every morning for all shifts. For example, if you are scheduled to work during the third shift on December 16, 2012 (e.g. Sunday night), your entire shift will be considered as a Sunday shift.

## DRESS, MAKE UP, and MISCELLANEOUS

1. Matching Medical type uniform- white dress or pant suit (uniform color) or Uniform scrubs any color. No shorts, capris
2. Shoes: well -polished, low heels, no open toes, no flip flops/sandals, and no platform.
3. A pen is an essential part of work attire. (Black ink only)
4. Lab coat of solid white or white coat for use on the floor if cold. No other color allowed over uniform.
5. Jewelry – For the safety of residents, we allow no necklaces, no earrings, no bracelets, or no jewelry of any kind except for a wedding band.
6. Hair must be an appropriate length and hair bands need to be used to keep hair off shoulders and away from face.
7. Employee badge must be worn and visible to staff and visitors.
8. Make up should be so it is not noticeable and natural looking.
9. No chewing gum while at work.
10. No cell phones while at work.
11. No listening to audio or watching video devices while at work.

## PERFORMANCE APPRAISAL

You will be given performance feedback on an as-needed basis and at least once a year.

## EMPLOYMENT CLASSIFICATION

**FULL TIME (FT) EMPLOYEE:** An employee who is scheduled to work more than 32 hours a week on a regular basis.

**PART TIME (PT) Employee:** An employee who is not a full time employee but is scheduled to work on an as-needed basis. PT employees are not guaranteed any certain number of hours.

## PAID TIME OFF (PTO) POLICY

For every **regular hour** you work and **every PTO hour you take not cashed out**, you will earn 0.082 PTO hours up to 160 PTO hours per calendar year. You can cash out PTO hours in 1 hour increments but no less than 8 hours. Any excess hours in your PTO bank above 160 hours on December 31 will be cashed out on the first full payroll period after December 31. You will not lose your earned PTO hours.

## BREAK TIME

**Short Break:** You will be given 10 minutes for a short break for every four (4) consecutive worked hours. It is not accumulative. It cannot be taken at the beginning or at the end of your shift.

**Lunch Break:** In accordance with Tennessee State regulations, you are provided a 30 minutes off-the clock lunch break within the first six (6) consecutive worked hours.

## HANDBOOK GUIDELINE

This handbook has been prepared to provide you with a general guideline of our philosophies, policies, rules, current employee benefits, and safety programs. It is not a contract of employment, and the policies, procedures and benefits described in the handbook are subject to modification, addition or deletion by the company at any time, with or without notice. Your continued employment will constitute your acceptance of such modifications, additions or deletions. Changes will be communicated to you. Should you have any questions which this handbook does not answer, please contact your manager.

Additional work rules, procedures and performance standards may be contained in other manuals specific for certain jobs or learned through on- the- job training. In addition to our work rules, all employees are expected to obey local, state and federal laws.

## TELEPHONE and VEHICLE

A telephone number where you can be reached is required for employment. Dependable transportation is required for employment.

## TIME CARDS

Your time will be recorded by a computerized time clock. You must clock in using the badge that is assigned to you. If you lose your badge, there will be a charge to replace it. You can clock in up to 7 minutes before your shift starts. You can clock out up to 7 minutes after your shift ends.

## JURY DUTY

LBA Medical Services, LLC will pay the difference between jury duty pay and what you would be paid working for the day if you are scheduled to work. Documentation must be turned in regarding jury service.

## EMPLOYMENT-AT-WILL

The Company puts forth its best effort to treat all employees fairly. Sometimes employees leave despite the Company's best efforts, or employees leave because they want to leave, move, find themselves different environment, or simply want a change. As an employee of this Company, you have the right to terminate your employment at any time.

Likewise, your employment with us has always been "employment-at-will." Generally this means that the Company may legally hire, fire, suspend, or discipline any employee at any time and for any reason – good or bad – or for no reason at all.

If you choose to resign, we would appreciate as much advance notice as possible, preferably two (2) weeks. This will allow us time to find and train your replacement before you leave the Company.

## ACKNOWLEDGEMENT OF RECEIPT OF HANDBOOK

I have received a copy of the Employee Handbook, which outlines the benefits, polices, and employee's responsibility to LBA Medical Services, LLC.

I understand that this handbook is not a contract of employment, but is only a set of guidelines for the implementations of the Company's employment policies. I understand that LBA Medical Services, LLC can terminate my employment at any time for any reason – good or bad – or for no reason at all.

I understand that the provisions of this handbook may be modified by the Company in the future and that my continued employment will constitute my acceptance of such changes.

_____ _____

Name Date