Bermuda Health Council

Name of Employee: _____

Employee Screening Questions – if any employee answered "YES" to any of the below, submit with your application, a separate document with the person's name, and further explanation for answering "YES" to the specific questions, and the agencies rationale for employment.			
1.	Have you been convicted of, pled guilty or no contest to a crime in Bermuda or any other country?	☐ YES	☐ NO
2.	Have you had any disciplinary or probationary action taken against you by any licensing authority in Bermuda or another country? This includes: probation, suspension, revocation, or denial of a license.	☐ YES	☐ NO
3.	Have you had any form of pending court action, investigation or disciplinary action by any health or social services related agency/employer in Bermuda or another country?	☐ YES	☐ NO
4.	Do you have a mental or physical condition, and/or an alcohol or drug dependency which could interfere with your current ability to provide care?	☐ YES	☐ NO

Declaration Statement (Employee) Check each box after reading and sign below

By my signature:

☐ I agree the information in this application and the information in any required or following documentation is true and accurate to the best of my knowledge. I understand that false statements may result in the denial or removal of my registration.

☐ I understand registration with Bermuda Health Council (BHEC) is required for private caregivers delivering home care services to clients that are paid for, in part or in full, by the following government departments:

- Health Insurance Department (Future Care and HIP Personal Home Care Benefit)
- Department of Financial Assistance
- Department of Social Insurance (War Veterans Benefit)

☐ I understand my application for registration as a caregiving provider in the community, if approved, may be suspended or revoked at any time there is significant concern, evidence, or allegation regarding fraudulent activities, abuse or neglect

☐ I understand this registration is valid for 2 years only and will require re-registration.

☐ I agree to notify Bermuda Health Council of any changes to the information provided in this registration form.

☐ I agree for Bermuda Health Council to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided in this application.

☐ I understand that the Health Insurance Department will issue electronic versions of their Explanation of Payments Statement for any claims submitted to them, to the Agency. Notifications will be emailed to the agency email address.

_____ _____

Employee Signature Date