

Application Package

Applicant's Name: _____



License #: _____ Application date: _____

Address: _____

Phone: _____ Cel: _____ Bp: _____

Specialty (if any): _____

SS #: _____ Driver Lic. #: _____

Employee Signature: _____

DOCUMENTS REQUIRED: Aide

1. State required education hours
2. CNA certificate if Applicable
3. CPR Card
4. HIV/AIDS Certificate (lifetime training)
5. OSHA Certificate (Update)
6. Alzheimer's training
7. Driver License
8. Auto Insurance
9. Proof of Citizenship/Residency (Voter registration, Resident Card, etc)
10. Social Security Card
11. Physical Examination (less than twelve (12) months or new request)
12. Criminal Background check (less than 5 years, or Live Scan)

EMPLOYEE/STAFF'S LOG

Employee/staff's Name: _____ Street Address: _____ City/State/Zip Code: _____ Job Title: _____				email _____ Cell: _____ Soc. No: _____ Telephone: _____ Date of Hire: _____		
DESCRIPTION	YES	DESCRIPTION	YES			
IRS from W-4 or W-9		SIGNED PPLICATION				
INS Form I-9		SIGNED JOB DESCRIPTION				
HIPAA/Confidential Form		PROBATIONARY PERIOD				
Alzheimer's Training		EMPLOYMENT REFERENCES (2)				
REVIEW-PERSONNEL POLICY [signed]		COMPLETED ORIENTATION [date]				
TRANSPORTATION RESPONSIBILITY		PROFESSIONAL LIABILITY SHEET				
TAX EXEMPT FORM (If applicable)		CONFIDENTIALITY STATEMENT				
CONTRACT AGREEMENT (Direct or Independent)		HIV - AIDS Certificate				
AFFIDAVIT CRIMINAL BACKGROUND		C.P.R. CARD				
STATEMENT OF COMMITMENT		INFECTION CONTROL				
DESCRIPTION	NUMBER	EXP. DATE	EXP. DATE	EXP. DATE	EXP. DATE	EXP. DATE
Professional License						
Certificate [CNA]						
Driver's License						
Prof. Liability Insurance (if applicable or required)						
Physical Exam, Free of Com. Disease, Mantoux test or X-Ray Criminal Background						
Automobile Liability Insurance [PIP and PD]						
H.H.A. 40 hours / C.N.A. 20 hrs.						
Form of Verification: RN/LPN/Therapists						
O.S.H.A. (Mandatory) YES () NO () ____ Domestic Violence ____ Emergency Inservice ____ Fall Prevention						
Comments: ____ Handbook Signature: _____						
ID badge ____ Inservices: ____ TB ____ Staff Safety						
Evaluation: ____ Probation ____ Annual (write year): ____ Initial Interview						
____ Competency (written/practical) ____ Exit Interview						

APPLICATION FOR EMPLOYMENT

PRINT CLEARLY AND LEGIBLY

SECTION I - Name/Address

Last:	First:	MI:	
Address:			
City:	State:	Zip:	Telephone:
Social Security #-		DOB:	

SECTION 2- Desired Employment

Position:	Date you can start:
Are you currently employed?: <input type="checkbox"/> yes <input type="checkbox"/> no If employed, may we inquire of your current employer?: <input type="checkbox"/> yes <input type="checkbox"/> no	
Have you applied to this agency before?: <input type="checkbox"/> yes <input type="checkbox"/> no If so, when:	

SECTION 3 - Education

HIGH SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE UNDERGRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE GRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Course study:

SECTION 4- Employment History

Employer:	Job Title:	
Address:	Duties:	
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:

Employer:	Job Title:	
Address:	Duties:	
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:

Employer:	Job Title:	
Address:	Duties:	
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:

Staff Name:

SECTION 5- Personal References

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

SECTION 6- Physical Record

Do you have any physical disabilities that would prevent you from performing the work for which you are applying?: <input type="checkbox"/> yes <input type="checkbox"/> no If so, please describe:	
Have you ever been injured? <input type="checkbox"/> yes <input type="checkbox"/> no	Provide Details:

SECTION 7- Licenses/Certification

TYPE	LICENSE / CERT. #	EXPIRATION DATE	STATE ISSUED

SECTION 8- Additional Areas of Expertise

Areas of specialized study, research or additional experience:		
List the foreign languages you speak fluently:	Read:	Write:
U.S. Military Service:	Separation Rank:	
Present Membership in National Guard or Reserves: <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION 9- Emergency Contact Information

Name:	Relation:
Address:	Telephone:
Name:	Relation:
Address:	Telephone:

I voluntarily give to the Agency the right to make a thorough investigation of my past employment. I agree to cooperate in such an investigation. I understand that my employment will be based in part on the accuracy of the information provided on this application.

Signature: _____ Date: _____

AGENCY AUTHORIZED REPRESENTATIVE INTERVIEWER		
HIRED? YES <input type="checkbox"/> NO <input type="checkbox"/>	SIGNATURE:	DATE:

Staff Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
Staff ACKNOWLEDGMENT OF PROBATION	<p>I UNDERSTAND THAT I AM ON PROBATION AS A Staff FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STARTED ON _____ FOR THE PURPOSE OF THE STATE "UNEMPLOYMENT COMPENSATION LAW". I UNDERSTAND IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE UNDER THE STATE "UNEMPLOYMENT COMPENSATION LAW" HE WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE DETERMINED FOR IN THE FUTURE.</p> <p>I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.</p>	
NOTICE TO APPLICANTS	<p>We comply with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability, to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. If required, all entering Staff in the same job category will be subjected to the same medical questionnaire and/or examination and all information will be kept confidential and in separate files.</p> <p>We are an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, or marital status. We assure you that your opportunity for employment with us depends solely upon your qualifications.</p> <p>PLEASE READ AND SIGN STATEMENTS BELOW</p> <p>I understand that in accordance with industry standard, if hired, I will be placed on a 90 day probationary period. I further understand that if I am terminated for unsatisfactory work performance within the 90 day probationary period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination.</p> <p>I understand and agree that all policies, procedures, and the Staff Handbook may be modified, amended, or deleted by my employer with or without notice to me of such amendment, modification or deletion; that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and that my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president.</p> <p>I understand that I may be required to undergo blood and/or urinalysis screening for drug or alcohol use as part of the pre-employment process. In addition, all Staff are subject to blood and/or urinalysis screening for drug or alcohol use.</p> <p>I certify that all information given on this employment application, any resume that I submit to the company, and any related papers and answers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such information requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation of any derogatory information discovered as a result of this investigation may subject me to immediate dismissal. I hereby release from liability all persons who provide information to my employer during the course of any such investigation.</p>	
TRANSPORTATION RESPONSIBILITY CONTRACT	<p>It has been explained to me that I am being offered employment by This Home Health Agency with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability of \$ 10,000.00 / \$ 20,000.00 for bodily injury and \$ 5,000.00 in property damage.</p> <p>I also agree not to use my vehicle to transport any patient.</p>	

Employee/Contractor Signature: _____ Date: _____

Staff Name: _____

Position: _____

ITEM	DESCRIPTION	INITIALS
CONFIDENTIALITY STATEMENT	I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF THE MEDICAL RECORDS AND UNDERSTAND THAT THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE, EITHER INSIDE OR OUTSIDE THE AGENCY (EXCEPT AN NEEDED TO CONDUCT THE BUSINESS OF THE DAY). I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE HOME HEALTH AGENCY UNLESS A "RELEASE OF INFORMATION" FORM HAS BEEN COMPLETED AND SIGNED BY THE PATIENT. IT IN MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL. I HAVE BEEN FORMALLY INSTRUCTED IN THE POLICIES AND PROCEDURES OF THIS HOME HEALTH AGENCY, ALSO INFORMED REGARDING THE AGENCY'S POLICY FOR HIPAA COMPLIANCE, AND I HAVE READ AND SIGNED A JOB DESCRIPTION FOR MY SPECIFIC CLASSIFICATION.	
PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY <hr/> SIGNATURE OF INDIVIDUAL MAKING PLEDGE <hr/> SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE	<p>I, the undersigned, have read and understand the this Home Health Agency, (hereinafter "this Home Health Agency") policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation.</p> <p>I also acknowledge that I am aware of and understand the Policies of the this Home Health Agency, regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.</p> <p>In consideration of my employment or association with this Home Health Agency, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with this Home Health Agency, or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside this Home Health Agency, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and this Home Health Agency, policies governing proper release of information.</p> <p>I understand that my obligations outlined above will continue after my employment/contract/association/ appointment with this Home Health Agency, ends.</p> <p>I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with this Home Health Agency, or with any of the entities, which have an association with this Home Health Agency</p> <p>If for any reason I must complete any clinical documentation of any of my patient at later time, or at my residence, I assure that no Protected Health Information will be left unattended in my vehicle. In my residence, it will be placed in a secure location where children or any family member will not have access to it at any time. All family members will be alerted about the Confidentiality status of such records.</p> <p>I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant state and federal legislation, and a report to my professional regulatory body.</p>	
POLICY ON JOBS	<p>As a Staff of this home health agency, I understand that the job I am being hired to perform belongs to this Agency. I also understand that it is illegal for me to transfer or attempt to transfer any case to another Agency or take ownership of any job that I am employed in.</p> <p>Should I act underhandedly and take over such a job so that I may be paid directly by the client, to the exclusion of my employer, or transfer any case to another Agency. I will be in violation of State, Federal and agency rules and will accordingly pay \$10,000.00 to This Home Health Agency</p>	

Employee/Contractor Signature: _____

Date: _____

Staff Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
<p>NON DISCRIMINATION POLICY</p> <p>ANTI-HARASSMENT POLICY</p>	<p>As a recipient of Federal financial assistance, our Agency does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by our Agency directly or through a contractor or any other entity with which our Agency arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.) In case of question please contact the Agency Section 504 Coordinator.</p> <p>Our Agency strives to maintain a work environment that is free of discrimination, intimidation, hostility, or other offenses that might interfere with work performance. In keeping with this desire, we will not tolerate any unlawful harassment of Staff by anyone, including any supervisor, co-worker, vendor, client, or customer.</p> <p>What Is Harassment?</p> <p>Harassment consists of unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's protected status, such as color, disability, gender, national origin, race, religion, age or other legally protected status. We will not tolerate harassing conduct that affects tangible job benefits, that interferes unreasonably with an individual's work performance, or that creates an intimidating, hostile, or offensive working environment. Harassment can take many forms, including, but not limited to: words, signs, jokes, pranks, intimidation, physical contact, or violence.</p>	
<p>UNIVERSAL PRECAUTIONS</p>	<p>It is the policy of our Agency that home health care providers will adhere to the following, when delivering care to all patients. By adhering to the following universal precautionary measures, the risk of transmission of disease, is decreased when the infection status of the patient is unknown.</p> <p>Gloves must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids. Gloves or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes. Gloves are to be worn when handling all specimens to prevent contamination from body specimen fluids or blood.</p> <p>Mask and protective eyewear or face shield must be worn during procedures that are likely to generate droplets of body fluids, blood or when the patient is coughing excessively.</p> <p>Hand washing: Hands must be washed before gloving and after gloves are removed. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood and after all patient care activities.</p> <p>Home health care providers, who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.</p>	
<p>CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM</p>	<p>I have been formally instructed that my Physical Examination Form, and any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency (except as needed to conduct the business of the day).</p> <p>I understand that no medical/criminal data are to be removed from the home health agency unless a "Release of Information" form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Agency to release my Physical/Background Information data to State/Federal surveyors at their request if needed for conduct the annual survey or any necessary investigation.</p> <p>I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.</p>	

Employee/Contractor Signature: _____ Date: _____

Staff Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
INFECTION CONTROL	<p>For your well being, and the well being of your patient, we outline the following procedures to guard against infection.</p> <ol style="list-style-type: none"> 1. Please wash your hands before and after each procedure. 2. In the event of an exposure to a pathogen please make an immediate report to the RN in charge. This office must be notified immediately and the staff involved must report to the nearest hospital emergency room and will return to work only after a physician has cleared him/her of any communicable infection. 3. When working with an AIDS and other high risk infection's patient, remember to avoid any and all contact with the patient's body fluids, especially blood and blood products. Read and be familiar with the attached pamphlet on how to prevent catching the AIDS or any other virus. 4. This agency is not liable for our health care worker who contracts AIDS virus in the course of performing his/her professional duties. <p>For more policies on infection control our agency asks all of its Staff to read the accompanying scripts which are summaries from the CDC and the Department of Health and Rehabilitative Services. I hereby acknowledge that I have read and understand the <u>Infection Control</u> Policy contained in the Field Staff Procedure Manual. I am familiar with the procedures appropriate to my position as a field Staff.</p>	
USE OF PERSONAL PROTECTIVE EQUIPMENT	<p>I, the undersigned, understand and agree that as a condition of employment I am required to wear/use the following personal protective equipment supplied and/or required by my employer: Company Supplied: _____</p> <p>_____</p> <p>Company Required (Supplied by Employee/Contractor): _____</p> <p>_____</p> <p>I agree to inform my employer immediately upon the failure of any of the above listed equipment so the same can be promptly repaired or replaced.</p> <p>In the event I sustain an on-the-job injury as a direct result of my failure to wear/use the personal protective equipment listed above, my workers' compensation benefits could be substantially reduced.</p>	
WAIVER OF RIGHTS	<p>I, the undersigned, understand that the hazards of my job; have been fully explained to me by my supervisor: _____</p> <p>I further acknowledge that my employer has supplied me and/or I have supplied the following Personal Protective Equipment: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>I understand that it is necessary for me to use this Personal Protective Equipment to fully protect myself from the hazards of my job.</p> <p>I realize that in the event I do not use all of this Personal Protective Equipment and I sustain a personal injury caused by my failure to use/wear said Personal Protective Equipment, I may be denied up to 25% of the indemnity portion of my claim. As provided by this State's Workers' Compensation statutes.</p>	
PERSONNEL POLICIES SAFE AND ADEQUATE CARE OF THE PATIENT (SAFETY OF THE PATIENT'S IMMEDIATE ENVIRONMENT)	<p>This Home Health Agency, hereby sets forth the following guidelines to be adhered to by all Staff of this agency:</p> <p>* Upon arrival at a patient's home, the nurse/Staff shall make physical checks of the essential safety devices such as proper locks on doors, proper ventilation, proper beds/chairs, proper bedding, adequate bathroom systems, adequate kitchen with all electrical devices, to be sure they are in good working condition.</p> <p>* The Staff shall also check the appropriate boxes on our "Patient Safety Checklist" and make the appropriate report to our offices as soon as possible</p> <p>* Upon receipt of such report, the RN in charge shall take necessary action to ensure that any safety deficiencies are corrected.</p> <p>I have received, read, (or it has been read to me) and understand the "Company Policy and Safety Rules and Regulations", and agree to abide by them. I further understand that failure to do so could result in disciplinary action or termination.</p>	

Employee/Contractor Signature: _____ Date: _____

Staff Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
Staff STATEMENT OF COMMITMENT	<p>I have read and understand The Agency, Personnel Policy Manual. In compliance with those policies I agree to conform to the following:</p> <ul style="list-style-type: none"> -I will always maintain professionalism in the home to which I am assigned. -I will immediately contact The Agency, regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by The Agency -I have read and understand the Agency, job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by The Agency -I will abide with the Agency Standard Code of Dress as described in the Personnel Policy Manual. -I will arrive in time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the Agency, office of the situation and expected arrival time. -I will not accept any money or gifts from The Agency's Clients. I will receive payment for services rendered directly from The Agency -I will notify The Agency, immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand the Agency, office will then contact the client. I also understand that not calling The Agency, office when I am unable to meet my assignment commitment will be grounds for immediate termination. -I will not make or accept personal telephone calls on the client's home. -I will not transport a patient or family member in my personal vehicle. -I will not smoke in a patient's home. 	
VOLUNTARY SUBSTANCE TESTING	<p>In order to protect myself and my employer, I _____ voluntarily authorize blood and urine testing for alcohol and/or drug use. I agree to allow such samples and testing to be completed at a time and place to be chosen by my employer. I understand should such samples and testing be requested it is either due to the company's Drug Free Workplace Program, suspicion that I am under the influence of alcohol/drugs which could result in an on-the-job injury, or may affect the quality of my work. I further authorize the results of samples/testing to be released to my employer.</p>	
POLICY ON PATIENT'S PROGRESS NOTES	<p>It is the policy of The Agency that weekly Progress Notes shall be written on each of our patients, preferably each Friday. Such a Progress Note, to be written on our standard "Progress Notes" form, shall be written by a Skilled Nurse/Professional/field staff, who also should supervise the case in review, together with Supervisor RN/Staff if applicable. Completed progress notes, along with other pertinent patient records, shall be submitted to the RN in charge (at the office) once every week (Tuesday before 5:00 pm). During that period a note faxed from Staff may be use in place of the original, until the regular 1 week delivery time frame, progress note is received in the office. Home health care staff members will ensure complete concise documentation of services, issues and conditions occurring during the period of services rendered to the client. It is our Policy that we allow the use of automatic mechanism to help our staff to complete their Progress Notes report like typing by Typewriter, Word Processor, or Computer Software, in compliance with the following steps:</p> <ol style="list-style-type: none"> 1- Ensure the compliance of HIPAA regulations and guidelines, including the care of the Patient's Privacy Rights 2- Don't allow any other person access to any Patient Information needed to complete the work, if necessary finish the Notes at the staff's residence. 3- Destroy all Patient Information after completing the Progress Notes 4- Inform immediately to the Agency's Privacy Officer if any breach of HIPAA guidelines for Patient's Privacy Rights is suspected. 5- In the use of Computer Software or any electronic device to help complete the progress note, the staff can not save any Patient Information in the Staff Personal Computer/tablet, is the patient's information is used, the Staff must delete that information, immediately after completing their work. 	

Employee/Contractor Signature: _____ Date: _____



ATTESTATION OF COMPLIANCE with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes**, which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:

Health Care Provider/ Employer Name:

Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.

- (g) Section 782.071, relating to vehicular homicide
- (h) Section 782.09, relating to killing of an unborn child by injury to the mother.
- (i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (j) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (k) Section 784.03, relating to battery, if the victim of the offense was a minor.
- (l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (h) Section 817.234, relating to false and fraudulent insurance claims.
- (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
- (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
- (k) Section 817.505, relating to patient brokering.
- (l) Section 817.568, relating to criminal use of personal identification information.
- (m) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (o) Section 831.01, relating to forgery.
- (p) Section 831.02, relating to uttering forged instruments.
- (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (s) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- (u) Section 895.03, relating to racketeering and collection of unlawful debts.
- (v) Section 896.101, relating to the Florida Money Laundering Act.

- ☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

- ☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

****A copy of the Exemption from Disqualification decision letter must be attached****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screening conducted by: _____ Date of Prior Screening: _____

- ☐ Agency for Healthcare Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities

- ☐ Department of Elder Affairs
- ☐ Department of Financial Services
- ☐ Department of Children and Families

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature

Title

Date

www.pnsystem.com

REFERENCE

DATE: _____

TO: _____

Dear Sir or Madam,

_____ SS#: _____ is applying to our office as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

APPLICANT SIGNATURE

To be completed by Previous Employer:

Position _____ Date from _____ to _____

Reason for leaving: _____

Would you rehire? Yes ____ No ____ If no please advise why: _____

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY. BELOW AVERAGE, OR COMMENTS.

Punctuality & Attendance _____

Appearance (Grooming) _____

Judgement _____

Performance _____

Ability to Perform _____

Organization of Time _____

Compatibility _____

Accepts Direction _____

Signed _____ Title _____ Ph _____

Print Name: _____ Thank you for your courtesy

REFERENCE

DATE: _____

TO: _____

Dear Sir or Madam,

_____ SS#: _____ is applying to our office as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

APPLICANT SIGNATURE

To be completed by Previous Employer:

Position _____ Date from _____ to _____

Reason for leaving: _____

Would you rehire? Yes ____ No ____ If no please advise why: _____

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY. BELOW AVERAGE, OR COMMENTS.

Punctuality & Attendance _____

Appearance (Grooming) _____

Judgement _____

Performance _____

Ability to Perform _____

Organization of Time _____

Compatibility _____

Accepts Direction _____

Signed _____ Title _____ Ph _____

Print Name: _____ Thank you for your courtesy

Staff Name:

HOME CARE AND ALZHEIMER'S

Alzheimer's disease is a progressive, degenerative disorder that attacks the brain's nerve cells, or neurons, resulting in loss of memory, thinking and language skills, and behavioral changes. Alzheimer's disease is the most common cause of dementia, or loss of intellectual function, among people aged 65 and older.

Home care is a very helpful choice for both the person with Alzheimer's disease and their families because it provides the very kind of care that is most important – service in the comfort and familiarity of the patient's own place of residence. Criteria for home care admission, for persons with end stage dementia, may not always be well known - the issues of mobility, nutrition and weight, verbal communication, problems with infection and overall decline are evaluated. The psychological and physical support provided by home care teaching and supportive equipment can greatly relieve the family caregiver. Caring for a person with Alzheimer's Disease (AD) is a challenge that calls upon the patience, creativity, knowledge, and skills of each caregiver.

Our home health agency treats patients with every kind of terminal condition and many different forms of dementia, including persons with ADRDs. A proper assessment of a patient addresses the needs of the person and his or her caregivers and family in a comprehensive fashion. This is especially important to the family of a person suffering from ADRDs, since this person may have difficulty communicating his or her needs to family members. More than those with other diseases, these patients spend a long period at the end of their lives bed bound, mostly unresponsive, and in need of total care. As with all of our patients, it is the goal of our home care program to care for the ADRD patient while supporting and comforting family and loved ones regardless of the setting or the patient's daily abilities. These communication challenges become part of the task of you, the caregiver.

It's common for people with Alzheimer's disease to have trouble with language. Perhaps the individual may try describing an object rather than using its name because of difficulty thinking of the correct word. For example, the person might refer to the telephone as "the ringer", or "that thing I call people with". It takes much patience to communicate with individuals who forget names, struggle for the words they want to use, never finish a sentence, or repeat the same phrase over and over--all problems that may be experienced by people with Alzheimer's disease. To facilitate communication, try these strategies:

- * Relax. People with Alzheimer's communicate better when they do not feel pressured.

- * Keep distractions to a minimum. Turn off the radio and television. If others are in the room, find a quiet spot.

- * When the person has trouble expressing a thought, guess what may be meant by asking questions they can answer with a yes or no. For example, " Do you mean...?" or "Do you want to go...."?

- * Sometimes people forget what they are saying and stop in the middle of a sentence. To help them start again, calmly repeat the last few words they said. If they can't continue, ask a question that relates to what they had been saying.

- * Make sure you understand what they have said. Questions like, " You want to leave now, is that right?" or " You want some milk, don't you"? will verify what's been said.

- * You may have to decipher a meaning from a few words. The person's tone of voice and body language may also help you figure out what they mean. For example, a shaky voice and fidgeting behavior may convey fear more than their words can. Many people have limited access to the words they want to use. "Walk now" may mean a person is uncomfortable and wants to leave the room.

Staff

Date

Prepared by the Florida Health Care Association with the assistance of the Alzheimer Resource Center of Tallahassee, Florida to meet the statutory requirement of 400.4785(1) (a) F.S.

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is *not* normal aging and is *not* dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitably need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years.

NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places

- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings
 People are “out to get them”
 Fear that caregiver is going to abandon (results in AD person never leaving caregiver’s side)
 Current living space is not “home”

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question
 Repetitive action such as wringing a towel

Wandering

Pacing
 Sundowning: trying to get “home”
 Generally feeling uncomfortable or restless
 Increased agitation at night

Losing thing/Hiding things

Simply do not remember where items are
 Might hide things so that people don’t “steal” them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked to many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification

Alzheimer Resource Center of Tallahassee: (850) 561-6869 Website: www.arc-tallahassee.org

Alzheimer's Foundation of America Website: <http://www.alzfdn.org>

Staff Name: _____

STAFF CODE OF CONDUCT/ETHIC

To outline a standard of conduct for all Staff, contractors and members of the Board of Directors. To establish and retain the highest possible level of public confidence.

CODE OF ETHICS:

- The Code of Ethics contains standards of ethical behavior and practices that impact all dealings with colleagues, patients, the community and society as a whole.
- The Code of Ethics also incorporates standards governing personal behavior particularly when that conduct directly relates to the role and identity of the organization.
- The Code of Ethics outlines principles focused on maintaining and enhancing excellence within OUR AGENCY
- The Code of Ethics serves as notice to government officials that our Agency expects its personnel to abide by all applicable laws and regulations.
- OUR AGENCY has an ethical responsibility to the patients and the community it serves, and fulfills this responsibility through ethical care, treatment, services and business practices.
- Whenever possible, patients/families/legal guardians are included in decisions about the patients' care, treatment and services, including ethical issues.
- Should the patient require or request care, treatment or services not available or inconsistent with the organization's mission, an offer to refer/transfer the patient to an organization that can fulfill this need will be made and if in agreement, the patient will be referred/transferred appropriately.
- The patient/family will be notified of any financial benefit, if any, to our Agency as a result of the referral/transfer process.
- Contracted providers/staff of healthcare services must meet and adhere to the quality (QAPI program) and ethical standards of this organization.
- Billing practices of our Agency shall adhere to and be compliant with usual and acceptable standard ethical and legal business billing practices.
- The effectiveness and safety of care, treatment and services provided by our Agency is consistent for all patients and is not dependent on the patient's ability to pay.

STAFF MEMBERS' AND BOARD OF DIRECTORS' RESPONSIBILITY TO THE ORGANIZATION:

- Uphold the values, ethics and mission of the organization.
- Conduct all personal and professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect positively upon the organization and in the best interest of the patient population and community served.
- Comply with all applicable local, state and federal laws and regulations in the conduct of organizational or personal activities.
- Respect confidences including confidential business information.
- Assure that no conflict of interest exists in any dealings involving the organization.
- Provide healthcare services consistent with available resources and assure the existence of a resource allocation process that considers ethical ramifications.
- Respect of the customs and practices of those served, consistent with the organization's philosophy.
- Be truthful in all forms of communication, including receivables and avoid information that would create unreasonable expectations.
- Assure the existence of a process to evaluate the quality of care or services rendered (QAPI program).
- Avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices.
- Advise patient of rights, responsibilities and risks regarding care and services provided.

VIOLATIONS: Staff, Administrators and volunteers who violate this code shall be subject to disciplinary action, up to and including termination of employment.

Employee/Contractor Signature: _____

Date: _____



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (See instructions)	
<p>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	<p>QR Code - Section 1 Do Not Write In This Space</p>

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)		Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town		State ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)		First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
--	---------------------------	---

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A	OR	LIST B	AND	LIST C
Documents that Establish Both Identity and Employment Authorization		Documents that Establish Identity		Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

AGENCY ZERO FRAUD TOLERANCE POLICY

PURPOSE:

To ensure Staff participate in the Agency's effort to avoid/prevent any FRAUD activity that may conflict with the interests of the agency, and any State/Federal/Private programs.

POLICY:

The Agency expects all of its Staff to understand and be aware of potential situations where the FRAUD will be not tolerated.

PROCEDURE:

1. All Staff will report to their immediate supervisor any actions/omission in/or employment, services that interacts with the Agency Fraud prevention Policy, but not limited to:
 - A. Staff participation in any business transactions where there might appear to be a conflict between the Staff personal interest and that of the Agency's effort to prevent fraud.
 - B. Staff participation in any activity/cover for services not provided.
 - C. Outside employment that interferes with satisfactory performance of an Staff duties and responsibilities for the Agency.
 - D. Any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of a Staff duties and responsibilities for the Agency.
 - E. Acceptance/giving of gifts, kick back, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence a Staff in the performance of the employee's duties and responsibilities for the Agency. (Illegal remuneration)
 - F. Participated in any action to Alter Costs.
 - G. Use un-licensed person to perform their duties, or licensed without authorization (misrepresentation).
 - H. Not report any sign of Abuse: verbal, physical, economical or any other form.
 - I. Participate in any act of Identity/Insurance ID theft.
 - J. Permit unnecessary or Duplicate services.
 - K. Altering Claims, Billing forms, Invoices, Expenses, or any other accounting related issue. (Over-billing)
 - L. Non-compliance with approved/ordered scheduled of visits, and Reporting Guidelines, including technically corrected transcribing services if used.
 - M. Participate in fraudulent Records, Notes, Signatures, Reports.
2. If a fraud action is discovered or suspected the supervisor/manager and Staff will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the Staff to end his/her association with the entity or the Agency within a specified period of time, including the correspondent report to any Regulatory Agency.
4. The failure of a Staff to cease activity that management determines to be a fraud action will subject the Staff to disciplinary action up to and including termination.
5. Upon hire, agency staff will sign a Agency Zero Fraud Tolerance Statement.

Staff Name & Title: _____

Staff Signature

Date

Staff Name:

STAFF CONFLICT OF INTEREST

PURPOSE:

To ensure Staff avoid any personal interest that may conflict with the interests of the agency.

POLICY:

The Agency expects all of its Staff to understand and be aware of potential situations where their personal interests may conflict with the business interests of the Agency.

PROCEDURE:

1. All Staff will report to their immediate supervisor any interests in or employment with an entity that interacts with the Agency including, but not limited to:
 - A. Staff participation in any business transactions where there might appear to be a conflict between the Staff personal interest and that of the Agency.
 - B. Staff participation in any entity which buys services from or provides services/products to the Agency.
 - C. outside employment that interferes with satisfactory performance of an Staff duties and responsibilities for the Agency.
 - D. any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an Staff duties and responsibilities for the Agency.
 - E. acceptance/giving of gifts, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence a Staff in the performance of the Staff duties and responsibilities for the Agency.
2. If a conflict of interest is discovered or suspected the supervisor/manager and Staff will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the Staff to end his/her association with the entity or the Agency within a specified period of time.
4. The failure of a Staff to cease activity that management determines to be a conflict interest will subject the Staff to disciplinary action up to and including termination.
5. Upon hire, agency staff will sign a Conflict of Interest Statement.

Explain any possible conflict of interest (Example working for another Agency, Hospital, etc):

Staff Signature

Date

STAFF CONTRACT

Please select: ☐ Direct Employee ☐ Independent Contractor

This contract is made this _____ day of _____, _____ between our Home Health Agency _____ herein named the "Agency" and _____ herein named the "Employee/Contractor".

TERMS

By this contract, both the Agency and the Employee/Contractor agree to the following terms:

(I) The Agency is the Employer and _____ is the Employee/Contractor.

(II) The Employee/Contractor is a contract employee (☐ Direct Employee ☐ Independent Contractor).

(III) The Employee/Contractor shall perform **all such duties/services** as are assigned to him/her by the Agency: _____

(See **Job Description** attached), following the Agency's Policy & Procedures.

(IV) The Agency ☐ shall ☐ shall not deduct all taxes from the Employee/Contractor's salary.

(V) The Employee/Contractor shall maintain a proper liability insurance and make copy available to Our Agency, if applicable. ☐ Required ☐ Not Required

Contractor shall be responsible for obtaining and maintaining appropriate levels of worker's compensation (exemptions) to cover contractor's performance hereunder. Contractor is required to provide the company a valid Certificate of Insurance reflecting worker's compensation insurance or Certificate of Election to be Exempt showing coverage immediately upon the request of company. The company is not responsible at any time for the insurance of the contractor.

(VI) The Agency shall evaluate the Employee/Contractor performance at the end of the 90 days probation period, and yearly thereafter, following all Agency and Personnel Policy and Procedures.

(VII) Whenever applicable, the Employee/Contractor shall be required to submit progress and clinical notes to the Agency's Administrator or RN in charge, within 2 weeks of service rendered, no later than the following Tuesday during regular business hours, that notes must verify provision of services/procedures and visit completion (must include the weekly time-sheet signed by the patient or patient representative if applicable). The bill-sheet or related information for reimbursement for care and service provided must be received in our office within 2 weeks (not later than the following Tuesday before 5:00 pm)

(VIII) Jobs to be performed by the Employee/Contractor shall be assigned by the Agency only, the contracted staff (Direct or Independent), or the contingency staff (under emergency/shortage staff) will be in placement within 1 business day (24 hours) after referral order is received.

(IX) Both parties to this contract understand and agree that patients are accepted for care only by this Agency.

(X) Both parties agree that the Employee/Contractor shall participate in developing of the Plan of Care, conform to all applicable Agency policies, including personnel qualifications. All Patient's health information must maintained as CONFIDENTIAL as HIPAA requirements.

(XI) Both parties agree that this Agency shall coordinate all job-related activities of the Employee/Contractor, control all job-related activities of the Employee/Contractor, and shall evaluate the Employee/Contractor's job performance just as we do that of other Employee/Contractors.

(XII) Both parties agree that the Employee/Contractor shall be paid an hourly rate of \$ _____ or per visit rate of \$ _____, during regular pay period of: ☐ weekly ☐ biweekly ☐ monthly

(XIII) The duration of this contract is one year commencing from the date both parties sign this contract. Upon termination or disciplinary action, this contract is canceled, and a new contract must be reinstated.

- (XIV) This contract is subject to automatic annual renewal, if not canceled for any party.
- (XV) Our Agency has full responsibility over all contracted services. Employee/Contractor agree to adhere to all Federal/State/Local and other applicable regulations, standards and laws.
- (XVI) Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract and will be in compliance with all Medicare Conditions of Participation.
- (XVII) The second party must submit evidence of liability and insurance, evidence of current licensure, education or certification, if applicable.
- (XVIII) Section 1861(w)(1) of the Social Security Act states that an Home Health Agency (HHA) may have others furnish covered items or services through arrangements under which receipt of payment by the HHA for the services, discharges the liability of the beneficiary or any other person to pay for the services. This holds true whether the services and items are furnished by the HHA itself or by another arrangement. Both must agree not to charge the patient for covered services and items and to return money incorrectly collected.
- (XIX) The contracted agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program.

PROFESSIONAL RESPONSIBILITY

Nothing in this Agreement shall construed to interfere with or otherwise affect the rendering of services by the Employee/Contractor in accordance with his independent and professional judgment. This Agreement shall be subject to our Policies and Procedures, the rules and regulations of any and all professional organizations or associations to which Employee/Contractor may from time to time belong and the laws and regulations governing said practice in this State.

Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract.

Both parties agree that the Employee/Contractor shall submit clinical notes and progress reports to the RN in charge once every one week or more often if requested, and shall conform with prescribed scheduling of visits and, periodic patient evaluation. Both parties agree that this Agency shall coordinate all job-related activities of the Employee/Contractor, and control all job-related activities of the Employee/Contractor.

Both parties agree that the Employee/Contractor participate in our Performance Improvement Program (QAPI), by suggest according they daily practices, ways to improve our services, treatment, relationship with patients/family/physicians, report needs and expectations of patients and families, participate in the PI data collection and analyzes, participate as needed in the Clinical Record review committee to complete and analyzes results and trends, participate in the Infection Control Effectiveness and other programs.

Both parties agree that patients are accepted for care, the service will be controlled, coordinated, and evaluated, only by our Agency, the Employee/Contractor must comply with all scheduling of visits according Physician order and initial admission assessment, and report any need of schedule change to the Agency immediately identified the need. Participate in periodic patient evaluation to improve our services and the goals of the Patient Plan of Care compliance, including but no limited to Participate in Case Conference, create progress/deterioration reports, periodic communication with the Agency's Supervisor and Care Managers. Participate in the Developing of the Plan of Care, suggest any change needed to achieve the treatment goals, make suggestion for improving services and patient care and safety, following QAPI guidelines.

SIGNATURES

Our Agency. (Employer): Administrator
or RN in charge.

Employee/Contractor: _____
Title: _____

Date: _____

Date: _____

JOB DESCRIPTION HOME HEALTH AIDE/ CNA

Staff Name: _____

Title: _____

TITLE: Home Health Aide/ CNA

"Home health aide" means a person who is trained or qualified, as provided by rule, who has successfully completed: a training and competency evaluation program as specified in State and Federal Regulations (CoPs) respectively, and is currently listed in good standing on the state nurse aide registry. A Home health aide or nurse aide is not considered to have completed a program, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual were for compensation. If there has been a 24 months lapse in furnishing services for compensation, the individual must complete another program, before providing services. Home health aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a registered nurse, or a licensed practical nurse who is under the supervision of a registered nurse. and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or assists in administering medications as permitted in rule and for which the person has received training established by Federal and State regulations.

Lines of authority and reporting responsibilities: Report to the RN in charge, Nurse Supervisor, Administrator. Must be complete at least forty hours (40) of **training** (75 hours home health training, required by care of medicare beneficiary, a minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours.) in: communication skills (including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff), observation, reporting, and documentation of patient status and the care provided (including recognizing and reporting changes in skin condition, including pressure ulcers), reading and recording temperature, pulse, and respiration, basic infection control procedures, basic elements of body functions, that must be reported to the registered nurse supervisor, maintenance of a clean, safe, and healthy environment, recognizing emergencies and the knowledge of Agency's emergency procedures and their application, physical, emotional, and developmental needs of and ways to work with the populations served by the agency including the need for respect for the patient, his or her privacy, and his or her property, appropriate and safe techniques in personal hygiene and grooming task, including bed bath, sponge, tub, and shower bath, tub or bed, hair shampooing in sink, tub, and bed, nail and skin care, oral hygiene, toileting and elimination. Safe transfers techniques and ambulation, normal range of motion and positioning, adequate nutrition and fluid intake, recognizing and reporting changes in skin condition, including pressure ulcers, the role of the aide in the home, differences in families, food and household management, and any other task that the HHA may choose to have an aide perform as permitted under state law.

Home Health Aides/CNA assisting with self-administered medication, must receive a minimum of 2 hours of training (which can be part of the 75 hour home health training, required by care of medicare beneficiary), prior to assuming this responsibility. Training must cover state law and rule requirements with respect to the assistance with self-administration of medications in the home, procedures for assisting the resident/patient with self-administration of medication, common medications, recognition of side effects and adverse reactions and procedures to follow when residents/patients appear to be experiencing side effects and adverse reactions.

Training must be performed by or under the general supervision of a registered nurse. The HIV and AIDS educational requirements also must meet, a minimum of 2 hours of initial lifetime training. The training should include universal precautions and infection control procedures to ensure proper practices are followed. Training must be provided to obtain and maintain a certificate in cardiopulmonary resuscitation.

Each home health aide must be able to read the prescription label and any instructions. Individuals who cannot read must not be permitted to assist with prescription medications. Ensure HIPAA guidelines and procedures are maintained.

The Home Health Aide/CNA must provide services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. **Shall perform the following duties:**

1. All the personal care activities contained in a written assignment by a licensed health professional employee, or contractor, and which include activities such as:
 - a. Assisting the patient with personal hygiene, following appropriate and safe techniques, that include bed bath, sponge, tub, **and** shower bath; hair shampooing in sink, tub, **and** bed; nail and skin care; oral hygiene.
 - b. Assisting the patient with ambulation/physical transfer, following safe transfer techniques
 - c. Assisting the patient with eating
 - d. Assisting the patient with dressing
 - e. Assisting the patient with shaving
2. Maintenance of a clean, safe and healthy environment, which may include light cleaning and straightening of the bathroom, straightening the sleeping and living areas, washing the patient's or client's dishes or laundry, and such tasks to maintain cleanliness and safety for the patient or client. Patient related activities as taught to the Home Health Aide/CNA by a Licensed Health Professional employee for specific patient. Such activities include:
 - a. Assisting with change of colostomy bag, reinforcement of dressing
 - b. Measuring temperature, pulse, respiration, or blood pressure
 - c. Measuring intake and output of fluids
 - d. Assisting with the use of devices for aid to daily living example, a walker or wheelchair.

- e. Assisting with prescribed range of motion exercise (such exercise are limited to those taught to the Home Health Aide/CNA and the patient by a professional employee)
- f. Assisting with prescribed ice cap or collar
- g. Doing simple urine tests for sugar, acetone, and albumin.
- h. Measuring and preparing special diets.
- 3. Keeping records of personal health care activities
- 4. Observing appearance and gross behavioral changes in the patient and reporting to the registered nurse.
- 5. Supervision of self-administered medication in the home limited to: obtaining medication container from the storage area for the patient, ensuring that the medication is prescribed for the patient, remind the patient that is time to take the medication as prescribed, and observing the patient self-administering the medication.
- 6. The Home Health Aide/CNA may also provide the following assistance with self-administered medication, as needed by the patient, in accordance with regulations:
 - a. Prepare necessary items such as juice, water, cups, or spoons to assist the patient in the self-administration of medication.
 - b. Open and close the medication container or tear the foil of prepackaged medications
 - c. Assist the resident/patient in the self-administration process, such as steadying of the arm, hand, or other parts of the patient's body so as to allow the self-administration of medication
 - d. Assist to the patient by placing unused doses of solid medication back into the medication container.

Assisting with tasks associated with elimination:

- i. Toileting
- ii. Assisting with the use of the bedpan and urinal
- iii. Providing catheter care including changing the urinary catheter bag
- iv. Collecting specimens
- v. Emptying ostomy bags, or changing bags that do not adhere to the skin
- 7. THE HOME HEALTH AIDE/CNA SHALL **NOT** PERFORM THE FOLLOWING TASKS
 - a. Changing of sterile dressings.
 - b. Irrigating body cavities such as giving enema
 - c. Irrigating a colostomy or wound
 - d. Performing a gastric irrigation or enteral feeding
 - e. Catheterizing a patient
 - f. Administering medications
 - g. Applying heat by any method
 - h. Caring for a tracheostomy tube
 - i. Any personal health service which has not been included by the Registered Nurse in the patient care plan

PHYSICAL REQUIREMENTS: 1. Able to speak, read and write in English. 2. Able read assignments, follow directions. 3. Able to communicate and respond clearly on telephone and respond to patient's spoken needs. 4. The ability to physically transfer, lift or assist patients whose average weight is 160 pounds with or without the aid of mechanical devices. 5. Able to spend 80% of the work standing and/or moving about. 6. Able to walk, climb stairs, stoop, twist, bend and squat to perform essential job functions.

This Job Classification will have a Potential risk for Occupational Exposure to Blood and other Potential Infections body fluids, protective equipment will be provided by our Agency to limit the exposure and will promote self protection practices in the delivery of the Home Health Care, to provide appropriate treatment to home health care workers in the event of exposure incident and to promote compliance with the universal precautions.

MENTAL REQUIREMENTS:

- 1. Able to concentrate on detail with frequent interruptions.
- 2. Able to follow, complete and remember daily routines and requirements.
- 3. Able to comprehend and utilize professional education materials.
- 4. Able to cope with the mental and emotional stress of the position.

In cases where a home health aide or CNA will provide assistance with self-administered medications, an assessment of the medication for which assistance is to be provided shall be conducted by a licensed health care professional to ensure the unlicensed caregiver provides assistance in accordance with their training and with the medication prescription. A licensed health care professional shall inform the patient/caregiver, that the patient may receive assistance with self-administration medication by unlicensed person. The patient/caregiver must given written consent for this arrangement.

Home Health Aide shall be supervised by the Registered Nurse, Registered Therapist, or the RN in charge at all times.

Staff Signature

Administrator/Designate signature/title

Date

ORIENTATION PROGRAM HHA/CNA

NAME: _____ DATE OF EMPLOYMENT: _____

POSITION: _____

I:

DATE

SIGNATURE

1. Job Description _____
2. Contractual Items _____
3. Orientation of Agency _____
(Philosophy, Policies, Organization Chart)
4. Time slips for services Provided _____
5. Developing Plan of Treatment _____
6. Daily Report and Clinical Notes Requirement _____
7. Lines of Communication & Supervision _____
8. Visit Defined _____
9. Case Conference _____
10. Mileage _____
11. Safety Management _____
12. Infection Control _____

II:

DATE

SIGNATURE

1. Introduction to Office Personnel _____

III:

1. Personnel Policies _____
Review & Discussion Payroll Procedure
2. Schedule of Pay, Time, Hours of Work _____
3. Coordination of Services _____
4. Dress Code _____
5. Insurance Benefits _____
6. Reporting Illness _____
7. Staff in-service meetings _____

IV:

1. Field Assignments Days and Type of Patient Services, Pain Rating _____
2. Criteria of Admission of Patients to Home Health Agency _____
3. Completion of necessary form for admission to service _____
4. Skilled care vs. non-skilled _____

Staff Name: _____

SESSION TWO:

DATE

SIGNATURE

I. Discussion of Referral Sources

1. Hospital: Social worker, liaison
discharge planner
2. Doctor
3. Family
4. Social Agencies (ie. HRS)
5. Staff

II.

1. Hospital: Social worker, liaison,
discharge planner
2. Contractual agreement with Rn's
3. Contractual agreement w/LPN's
4. Contractual agreement with HHA
5. Contractual agreement with PT

III. Regulations governing unskilled staff:

1. Type of care to be provided
2. Supervision of care
3. Necessary unskilled staff forms

IV.

1. Format of Documentation of services provided
to patient.
2. Charting for Home care patients
2. Charting to contract agency

**V. Discharge of patients from
Home Health**

**VI. Explanation of the role of supervisor and the
methods which will be used for evaluating
Performance and identifying needs.**

Also I was oriented about: Patient's Rights, Advance Directives, Professional Boundaries, Agency's Performance Improvement Plan, Incident/Variance reporting.

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION.

I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

Staff SIGNATURE/TITLE (HHA/CNA)

DATE

WITNESS SIGNATURE

DATE

NURSE AIDE QUIZ Staff Name:

Please match each word with the correct definition.

_____ Ambulatory	1. Temperature, pulse, and respiration
_____ Catheter	2. At liberty
_____ Stool	3. Immediately
_____ TPR	4. Sugar and acetone
_____ BP	5. Nothing by mouth
_____ Ad Lib	6. Able to Walk
_____ Stat	7. Intake and output
_____ S & A	8. Blood Pressure
_____ NPO	9. Waste, bowel movement
_____ I & O	10. Tube to remove urine

Directions: Please circle the letter next to the best answer to the question. There is only one correct answer.

1. If a patient who is recovering from a long illness is cranky and puts on his signal light frequently for little things, which of these actions by the aide would be most helpful to the patient and the nursing staff?

- a. Leave the mans room as quickly as possible each time you answer the light.
- b. Go to see him sometimes when he has not signaled and asked if there is anything he would like.
- c. Ask him why he is so fussy, or suggest that he needs to be more reasonable.
- d. Say as little to him as possible.

2. Mrs. T. has been in bed for several days, and he is now supposed to wake up. Before she gets up, she will be helped to sit on the side of the bed and "dangle" for a few minutes. THE MOST IMPORTANT reason for this is to:

- a. Prevent dizziness or fainting.
- b. Make it easier to put on her robe and slippers.
- c. Make her feel less afraid to get up.
- d. Provide time to get a chair and pillows to proper position.

3. In turning over a weak, elderly patient to rub his back, the aide finds a slightly red area about the size of a quarter at the base of his spine. The aide will report, this. What would it be best to do for the patient before reporting the finding?

- a. Omit the back rub and just powder his back.
- b. Rub his back well and tape a large doughnut around the red spot.
- c. Apply an antiseptic to the spot and avoid rubbing the lower part of the back.
- d. Rub his back thoroughly and leave him supported on his side.

4. If pulse beats occur at the rate of two per second for a few beats, then one per second, then two per second again, the pulse is called:

- a. Irregular
- b. Bounding
- c. Compressible
- d. Thready

5. When a person breathes in and then breathes out, the breathes in and out again, this is counted as:

- a. One respiration
- b. Two respirations
- c. Three respirations
- d. Four respirations

6. On her way to the bathroom, Mrs. C. falls and complains she has much pain in her leg and hip.

You should:

- a. Get her up before she gets cold.
- b. Rub her hip and leg.
- c. Go get a neighbor to help get her up.
- d. Call an ambulance or the emergency number.

7. Mr. X. wakes up having trouble breathing and pain in his chest. He starts to sweat. You should:

- a. Just pretend everything is all right.
- b. Get him up to walk.
- c. Call an ambulance or the emergency number.
- d. Open the windows to cool him off.

8. Mr. T. has had his morning insulin. That afternoon he becomes shaky, nervous and weak. You should:

- a. Let him sleep.
- b. Give him orange juice or sugar water, agnate call a doctor.
- c. Wait a few hours to see if it passes.
- d. Tell him to behave himself.

9. The first thing you do when you start to move a patient from bed to chair or back again is:

- a. Make sure the furniture will not move.
- b. Keep your knees locked and pull.
- c. Grab from behind and lift.
- d. Do not try unless there are two people in the house.

10. Which is the best breakfast for Mrs. Z., who is on a low salt diet?

- a. Fried eggs, crisp bacon, buttered toast, milk orange juice.
- b. Hot cereal made without salt and fresh orange juice.
- c. Toast, jelly, and tea.

11. Mr. L. has a stroke and is paralyzed on the right side. He gets up in a chair twice a day for a short time. When he is in bed, you should:

- a. Keep him on his right side so he can do things with his left hand.
- b. Keep him on his back for left side, with his swollen right arm and leg up on the pillows.
- c. Tie his paralyzed arm in a sling.
- d. Keep him lying on his back.

DATE

NAME

SIGNATURE

OFFICE USE ONLY

SCORE _____

REMARKS _____

HOME HEALTH AIDE/CNA COMPETENCY TEST (*PRACTICAL PART*)

Competency shall be determined through Observation of the Aide's Performance of each Activity

HHA/CNA Name: _____

ACTIVITY	Observed Date	Competent Date	Comments/Initials
Done in the Patient's Home Office/Dummy Patient			
1- Demonstrate Vital Signs Reading and Recording: Temperature - Oral (adult/pediatric), Pulse - Apical - Radial, Blood Pressure, Respirations			
2- Observation, reporting and documentation of patient status and the care or service furnished. Recognizing and reporting changes in skin condition, including pressure ulcers.			
3- Appropriate and safe techniques in personal hygiene and grooming that include: bed bath, sponge, tub, and shower bath, shampoo, foot, nail and skin care, oral hygiene, Toileting and elimination. Assist with dressing.			
4- Adequate nutrition, feeding, diet and fluid intake			
5- Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor			
6- Basic infection prevention and control procedures			
7- Demonstrate safe techniques for assisting with ambulation, normal ROM, positioning, transfer technique			
8- Assisting with self administration of Medication. Medication reminder.			
9- Demonstrate Safe Techniques for Assisting with Personal Care, hygiene, grooming & ADL's, including all types of baths: Bed, Sponge, Tub, Shower, Chair. Hair shampooing in sink, tub, and bed.			
10- Demonstrate Use of Assistive Devices: Cane, crutches, walker, W/C, Hoyer lift (optional)			
11- Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff and supervisors.			
12- Maintenance of a clean, safe, and healthy environment			
13- Recognizing emergencies and knowledge of Agency emergency procedures, and their application			
14- The physical, emotional, and developmental needs of and ways to work with the populations served, including the need for respect for the patient, his or her privacy and his or her property.			
15- Demonstrate Proper Body Mechanics: Transferring self, Transferring patient			
16- Weight, Pain Management			
17- Record Intake/Output. Catheter/Ostomy care.			
18- Light housekeeping, wash clothes			

(All competency evaluations must be performed by a Registered Nurse in consultation with other skilled professionals)

Comments: _____

RN in charge/Qualified RN Signature: _____ Staff Signature: _____

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ► _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number									
				-				-	
or									
Employer identification number									
				-					

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ►	Date ►
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

TAX EXEMPT FORM

I, _____ hereby acknowledge that I am an Independent Contractor. Therefore, I am responsible for my social security and other taxes, and will receive an IRS 1099 Form for the preceding year by February of each year which is also sent to the Internal Revenue Services (IRS).

Signature

Date

Social Security number

Position

www.pnsystem.com

**STAFF AFFIDAVIT
PROHIBITION OF PROVIDE SERVICES TO A FAMILY MEMBER**

Staff Name: _____ Credential: _____

To prevent Regulations non compliance about to provide any services to a family member from our Agency staff.

Background:

The State regulatory Agency (AHCA) does not allow a relative nor a member of a Beneficiary's household to be employed by a Home Health Care Agency or Nurse Registry to receive payment for providing home health care services to a Beneficiary.

As regulated "Excluded Services":

Home health visits, private duty nursing, or personal care services furnished by parents, grandparents, stepparents, spouses, siblings, sons, daughters, relatives, household members, or any person with custodial or legal responsibility for a Medicaid recipient. Exceptions to this exclusion are for:

- Parents or legal guardians authorized by the State Regulatory Agency (AHCA) to provide private duty nursing services to their children.
- Children enrolled in the developmental disabilities home and community-based services Medicaid waivers under the 1915j State Plan amendment authorizing self-directed care, can receive personal care services provided by the relatives listed above who are also enrolled as state plan providers.

Procedure:

- 1) As part of application process, all new employees will sign an affidavit stated that if any patient is assigned to he/she, and is a family member, immediately will inform the agency, and the patient will assigned to another, non relative agency's staff.
- 2) As part of staff record audits human resources staff must check the existence of this affidavit signed by all active field staff. If a signature is missing, must be immediately corrected and the affidavit must be signed and incorporated to staff record.
- 3) Violation, provide false statement in this affidavit constitute a grave violation of the Agency's Policy & Procedures and may be a reason for end of employment and possible monetary remuneration, legal prosecution.

I _____ certify that I'm not providing services to any family member, and I will alert the agency if any client/patient is assigned to me and is a relative.

Staff signature: _____ Date: _____

DECLARACIÓN JURADA DEL PERSONAL SOBRE PROHIBICIÓN DE PRESTAR SERVICIOS A UN FAMILIAR

Staff Nombre: _____ Credenciales: _____

Para prevenir el incumplimiento de la Normativa sobre la prestación de cualquier servicio a un familiar por parte del personal de nuestra Agencia.

Antecedentes: La Agencia Reguladora del Estado (AHCA) no permite que un pariente ni un miembro del hogar de un Beneficiario sea empleado por una Agencia de Atención Médica Domiciliaria o un Registro de Enfermeras para recibir pago por brindar servicios de atención médica domiciliaria a un Beneficiario.

Como "Servicios Excluidos" regulados:

Visitas de salud en el hogar, enfermería privada o servicios de atención personal brindados por padres, abuelos, padrastros, cónyuges, hermanos, hijos, hijas, parientes, miembros del hogar o cualquier persona con responsabilidad legal o de custodia de un beneficiario de Medicaid. Las excepciones a esta exclusión son para:

- Padres o tutores legales autorizados por la Agencia Estatal de Reglamentación (AHCA) para prestar servicios de enfermería privada a sus hijos.

- Los niños inscritos en las exenciones de Medicaid de servicios en el hogar y en la comunidad para discapacidades del desarrollo en virtud de la enmienda 1915j del Plan estatal que autoriza el cuidado autodirigido, pueden recibir servicios de atención personal proporcionados por los familiares mencionados anteriormente que también están inscritos como proveedores del plan estatal.

Procedimiento:

- 1) Como parte del proceso de solicitud, todos los nuevos empleados firmarán una declaración jurada en la que se establece que si se le asigna un paciente y es un miembro de la familia, informará de inmediato a la agencia y el paciente será asignado a otra agencia que no sea pariente, personal.

- 2) Como parte de las auditorías de registros del personal, el personal de recursos humanos debe verificar la existencia de esta declaración jurada firmada por todo el personal de campo activo. Si falta una firma, debe corregirse inmediatamente y la declaración jurada debe firmarse e incorporarse al registro del personal.

- 3) Infracción, proporcionar declaraciones falsas en esta declaración jurada constituye una infracción grave de la Política y los Procedimientos de la Agencia y puede ser motivo de finalización del empleo y posible remuneración monetaria, enjuiciamiento legal.

Yo _____ certifico que no estoy brindando servicios a ningún miembro de la familia y alertaré a la agencia si algún cliente/paciente me es asignado y es un familiar.

Firma del personal: _____ Fecha: _____

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POST HIRING MEDICAL QUESTIONNAIRE

Name: _____ Height: _____ Weight: _____

This Home Health Agency, is committed to encouraging the employment of physically disabled persons but it also wants to protect its rights to seek reimbursement from the Special Disability Trust Fund in the event that an Staff pre-existing condition contributes to a subsequent injury by that Staff in the course of employment. Your answers to this Questionnaire will not be used as the bases for deciding whether to employ you and your response to this questionnaire will be considered and treated as a confidential medical record which will not be included in your personnel file. Warning! This Home Health Agency, and its insurance carrier intend to rely upon the information provided by you in this Questionnaire. It is your obligation to provide truthful and complete information in response to the questions presented below. If it is later determined that you gave an intentional false response, you may be disqualified from receiving workers' compensation benefits. In addition, you may be subject to termination of employment in the event that it is later determined that you deliberately falsified your responses to this Questionnaire.

INSTRUCTIONS: Answer YES or NO to the following questions. If your answer is YES, list the approximate date of injury or treatment.

Question	Yes/No Date	Question	Yes/No Date
1. Have you ever had a back injury?		26. Do you have or have you ever had hyperinsulinism?	
2. Have you ever had a hematite intervertebral disc in your back?		27. Do you have or have you ever had chronic osteomyelitis?	
3. Have you ever had a back surgery for a removal of a disc?		28. Do you have or have you ever had thrombophlebitis?	
4. Have you ever had a neck injury?		29. Do you have or have you ever had a total dizziness?	
5. Have you ever had a hematite disc in you neck?		30. Do you have or have you ever had a magmatic fever?	
6. Have you ever had a neck surgery for removal of a disc?		31. Do you have or have you ever had a varicose veins or leg ulcer?	
7. Have you ever had a knee injury?		32. Do you have or have you ever had tuberculosis?	
8. Have you ever had a surgery on either of your knees?		33. Do you have or have you ever had allergies or asthma?	
9. Have you ever had a shoulder injury?		34. Do you have or have you ever had skin trouble?	
10. Have you ever had a surgery on either of you shoulders?		35. Do you have or have you ever had reactions to serum or drugs?	
11. Have you ever had an elbow injury?		36. Do you have or have you ever had kidney trouble?	
12. Do you have or have you ever had an amputation of your foot, leg, arm or hand?		37. Do you have or have you ever had muscular dystrophy?	
13. Do you have or have you ever had epilepsy?		38. Do you have or have you ever had ulcers?	
14. Do you have or have you ver had diabetes?		39. Do you have or have you ever had a head injury?	
15. Do you have or have you ever had cardiac disease (heart trouble)?		40. Do you have or have you ever had a mental retardation?	
16. Do you have or have you ever had Marie-Strumpell disease?		41. Do you have or have you ever had cancer?	
17. Do you have or have you ever had total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally?		42. Do you have or have you ever had any permanent physical condition which constitutes a 20% impairment of a member of the body as a whole?	
18. Do you have or have you ever had a cerebral disability from poliomyelitis?		43. Are you new or have you ever been obese (30% over normal body weight)?	
19. Do you have or have you ever had a cerebral palsy?		44. Do you have or have you ever had arthritis or rheumatism?	
20. Do you have or have you ever had multiple sclerosis?		45. Have you ever been treated/advised to seek treatment for alcoholism?	
21. Do you have or have you ever had Parkinson's disease?		46. Have you ever had a hernia? If the answer is yes, where is the location of the body?	
22. Do you have or have you ever had vascular disorder?		47. Have you ever been treated for substance abuse or addiction?	
23. Have you ever had psychoneurotic disability following treatment in a recognized Medical or mental institution, in excess of 6 months?		48. Have you ever had any injury, surgery, or disability which has not been described in the questions above? (If so, state in detail the nature of the injury, surgery or disability).:	
24. Do you have or have you ever had hemophilia?			
25. Do you have or have you ever had ankylosis of a major weight-bearing joint?		49. Do you have or have you ever had a high blood pressure?	

All statements and information given in this application are true, to the best of my knowledge and belief.

HEPATITIS B DECLARATION FORM

Hepatitis B is a major infectious occupational health hazard in the Health-Care industry. The critical risk for health personnel is contact with blood and other body fluids. Persons previously infected with hepatitis B virus are immune to the disease, for persons who have not had the disease, Hepatitis B vaccine will provide immunity. The vaccine is given in three separate doses and failure to receive all doses may cause the vaccine to be ineffective and not result in immunity. Clinical studies have shown that 85 to 96 percent of those vaccinated evidence immunity. Periodic testing of vaccinated persons for antibody to Hepatitis B will confirm immune status.

I understand that due to my risk or occupational exposure to blood or other potentially infectious material I may be at risk of acquiring Hepatitis B virus (HBV) infections, I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to my self.

I have read the above information and have received verbal and written instructions regarding the efficacy, risk and complications of receiving the vaccine. Any questions I had have been answered. I acknowledge that I am aware of the availability of the Hepatitis B vaccine and the benefit that such vaccination provides in the prevention of infection with Hepatitis B virus.

☐ I decline Hepatitis B vaccination at this time because I have been previously immunized with a complete series (three injections) of the Hepatitis B vaccine or I have been diagnosed as having the Hepatitis B virus disease and I am immune.

☐ I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I continue to have occupational exposure to blood or other potentially infectious material and I want to be Vaccinated with Hepatitis B vaccine, I may receive the vaccination series at no charge to me (DOH may have a list of free vaccination places)

☐ I accept vaccination with the hepatitis B vaccine.

1st injection: _____ 2nd: _____ 3rd _____

Staff Signature

Date



Screening Validation for LiveScan Vendor

Present this form to any LiveScan Vendor approved to submit Level 2 Background Screenings through the Florida Department of Law Enforcement as provided on their website at:

<http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx>

You will be required to present a valid picture ID at the time of screening.

Employee/Contractor Name: _____

Employee/Contractor Address: _____

Employer/Provider Name: _____

Employer/Provider Address: _____

AHCA # (as provided on the FloridaHealthFinder.gov provider pages see other side for details): _____

(Vendors: Use FDLE OCA# field to submit AHCA#.)

LIVESCAN VENDORS:

Please ensure that the results of this screening are submitted on behalf of the Agency for Health Care Administration (AHCA) at **ORI EAHCA020Z**. If you have any questions please contact the Background Screening Section at (850)412-4503 or email at: bgscreen@ahca.myflorida.com.

Important Requirement: All information regarding the applicant (Employee/contractor) must be submitted including Full Name, Address, Social Security Number, Date of Birth, Race, Sex, Height, and Weight. Incomplete information may result in rejection of screening requests.

Form available at: http://ahca.myflorida.com/MCHO/Long_Term_Care/Background_Screening/index.shtml

August 6, 2010

See Reverse for Instructions for locating a provider/facility AHCA #.

PHYSICAL EXAMINATION FORM

In my opinion, _____ is
physically and mentally able to perform the duties of _____
_____ and is free of communicable disease.

PHYSICIAN SIGNATURE

DATE

Mantoux Test OR CHEST X-RAY

Staff NAME: _____

TEST DATE: _____ NEGATIVE: _____ POSITIVE: _____

READING DATE: _____

READ BY: _____

RECOMMENDATIONS* _____

Staff SIGNATURE: _____

I Certify that I am free of any lower back ailments of any other ailment which could be prevent me from
performing my duties in a satisfactory manner.

I further certify that he/she does not appear to be at risk of transmitting communicable disease.

Staff SIGNATURE: _____

DEPARTMENT: _____

MEDICAL EXAMINATION CERTIFICATE

Date: _____

Name: _____ Sex: _____ Marital Status: _____

Address: _____ Telephone: _____

The following information is required by the Department of Health, Title XXII, Chapter I, Section 70723, for all persons working in the health field:

PHYSICAL EXAMINATION (to be completed by physician)

Height Weigh Blood Pressure Pulse

Physical Exam:

MANTOUX Test Result _____

Chest X-ray (if indicated) _____ EKG (if indicated) _____ Date _____

Urinalysis _____

VDRL (RPR) _____ Other Lab/Results _____

Any Communicable Disease:

I have examined the above-named individual and I certify that he/she is mentally and physically able to perform the duties of his/her job. I further certify that he/she is free from communicable disease.

I further certify that he/she does not appear to be at risk of transmitting communicable disease.

Physician's Name _____ Physician's Signature _____ Date _____

Physicians Address _____

Telephone _____