PERSONNEL FILE SECTIONS

PERSONNEL FILE TOOL

Employee name: _____

Date of Hire: _____

Position: _____

SECTION 1

- **EMPLOYMENT APPLICATION**
- **RESUME**
- **INTERVIEW REVIEW FORM**
- **REFERENCES RECORDS (2)**
- **EMERGENCY CONTACT INFORMATION**
- **NEW HIRE FORM (STATE SPECIFIC Blank Form Is Provided)**

SECTION 2

- **LICENSE COPY with VERIFICATION for Professional Staff**
- **DIPLOMA/DEGREE/TRANSCRIPT OR CERTIFICATE**
- **SOCIAL SECURITY CARD**
- **CPR CARD**
- **DRIVER'S LICENSE**
- **AUTO INSURANCE (for Field Staff)**

SECTION 3

- **ORIENTATION CHECKLIST at Hire**
- **JOB ACCEPTANCE STATEMENT**
- **JOB DESCRIPTION**
- **PERFORMANCE EVALUATION (90 DAYS AND YEARLY)**
- **SKILLS COMPETENCY EVALUATIONS (ON HIRE AND YEARLY)**
- **TIME SLIP**
- **COUNSELING/DISCIPLINARY ACTIONS**

SECTION 4

- **IN-SERVICES REQUIRED ON-HIRE AND THEN YEARLY - INSERT CERTIFICATES AND TESTS**
- **PROOF OF ALZHEIMER'S TRAINING – SEE SEPARATE FOLDER FOR DETAILS**
- **OTHER STATE REQUIRED CERTIFICATES**
- **CEUS**

SECTION 5

- **CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION**
- **FIELD PRACTICES STATEMENT**
- **CONFIDENTIALITY STATEMENT**
- **HIPAA CONFIDENTIALITY AGREEMENT**
- **CORPORATE COMPLIANCE STATEMENT**
- **POLICIES AND PROCEDURES STATEMENT**
- **PROTECTIVE EQUIPMENT STATEMENT**

SECTION 6

- **EMPLOYEE SEPARATION RECORD**
- **EXIT INTERVIEW**
- **MISCELLANEOUS**

SECTION 7
(In a separate file marked "Confidential")

- **HEALTH STATEMENT**
- **PHYSICAL-FREE OF COMMUNICABLE DISEASE STATEMENT**
- **TB OR CHEST X-RAY RESULTS**
- **TB QUESTIONAIRRE ON YEARS BETWEEN CHEST X-RAYS**

- **HEPATITIS DECLINATION/ACCEPTANCE FORM (EVIDENCE OF HEPATITIS VACCINE COMPLETION IF THE EMPLOYEE MARKS THE FORM THAT THEY HAVE COMPLETED THE SERIES)**
- **PAYROLL FORMS (W-4 or 1099)**
- **CRIMINAL HISTORY ATTESTATION**
- **CRIMINAL HISTORY BACKGROUND RESULTS**
- **OTHER CONFIDENTIAL INFORMATION**

SEPARATE FILE

- **ALL I – 9s / ALPHABETIZED IN ONE FOLDER**

	Car Insurance Exp.	Driver's License Exp.	Initial Competency Evaluation	Annual Competency Evaluation	90 Day Performance Evaluation	Annual Performance Evaluation	Professional License Expiration	CPR Exp. Date	Criminal Background check	Misconduct
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										

EMPLOYEE Personnel File

Name_____ Date of Hire _____

Position Held_____

SECTION 1

- EMPLOYMENT APPLICATION
- RESUME
- INTERVIEW REVIEW
- REFERENCES CHECKS (Two)
- EMERGENCY CONTACT INFORMATION

APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural origin or handicap. All information provided herein will be kept confidential.

PERSONAL

Last Name	**First**	**Middle**	**Date**
Street Address			**Home Phone**
City, State, Zip Code			**Business Phone**

Emergency contact (person not living with you)_____

Have you ever applied for employment with this Agency? _____Yes _____ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____ No

How did you learn of our organization? _ Newspaper Ad __Agency employee ___Other

Are you willing to work: _____Evenings? _____ Weekends?

Position applying for: _____

EDUCATION:

School Name	Location of School	Course of Study/ Degree	Years	Diploma
College:				
_____	_____	_____	____	____
_____	_____	_____	____	____
Vo-Tech or Trade:				
_____	_____	_____	____	____
_____	_____	_____	_____	
High School:				
_____	_____	_____	____	____
_____	_____	_____	_____	____
Other:				
_____	_____	_____	____	____
_____	_____	_____	_____	____

Employment:
--List the last five years employment history, starting with the most recent employer.

1. Company Name: _____Telephone: _____
Address: _____Dates of Employment: _____
_____From_____To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____Reason for leaving:_____
_____ _____

2. Company Name: _____Telephone: _____
Address: _____Dates of Employment: _____
_____From_____ To _____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____Reason for leaving:_____
_____ _____

3. Company Name: _____Telephone: _____
Address: _____Dates of Employment: _____
_____From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____Reason for leaving:_____

APPLICATION FOR EMPLOYMENT

Was your last name different from your present name during the above listed jobs?
Yes_____ No_____

If yes, what was your name? _____

Are you currently employed? Yes _____ No _____

Do you have reliable transportation? Yes _____No _____

PROFESSIONAL REFERENCES
Persons who can furnish information about job performance

1. Name: _____Telephone:_____
Fax: _____
Address: _____

2. Name: _____Telephone:_____
Fax: _____
Address: _____

3. Name: _____Telephone:_____
Fax: _____
Address: _____

GENERAL
Have you ever been convicted of a crime in the past 5 years, barring employment in a Home Care and community support Agency? Yes _____No _____
Conviction will not necessarily disqualify an applicant from employment.
If yes, describe in full: _____
_____
_____
_____

Are you capable of performing the job set forth in the job description? Yes__No__
If you answered No, which job requirement can you not meet? _____
_____
_____
_____

APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience**.**

_____
_____
_____
_____
_____

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL.

I Authorize complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to the Agency.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time**.**

DATE: _____ SIGNATURE _____

INTERVIEW REVIEW

Applicant Name: Date_____

Days and Hours available M Tu W Th F Sa Su

Review:

Personality:	friendly	average	quiet
Verbal skills:	excellent	average	poor
Communicates:	clear	somewhat clear	not very clear
Flexibility:	very flexible	somewhat	not flexible
Skill level:	higher skilled	moderately skilled	lower skilled
Appearance:	professional	semi-professional	not professional

Good Candidate for employment: yes no

Overall
Interview:_____

_____ _____

Interviewer Date

APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities:
_____

_____

Reason for Leaving:
_____

_____

Rate of Pay: (weekly/biweekly/salary):
_____+_____

Additional comments (training/skills)
_____

Reference check performed by_____

APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities:
_____

_____

Reason for Leaving:
_____

_____

Rate of Pay: (weekly/biweekly/salary):
_____+_____

Additional comments (training/skills)
_____

Reference check performed by_____

Employee Emergency Contact Information

Employee Name: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

Next of kin: _____ Phone: _____

Relationship: _____ Address: _____

_____

*In case of emergency, please contact:
Name: _____ Phone: _____

Relationship: _____ Address: _____

_____

*Please notify this Agency immediately if any of the emergency contact information changes.

INSERT NEW HIRE FORM HERE

SECTION 2

- **LICENSE COPY/VERIFICATIONS FOR PROFESSIONAL STAFF –SEE PERSONNEL POLICIES**

- **DIPLOMA/DEGREE TRANSCRIPT**

- **SOCIAL SECURITY CARD**

- **CPR CARD**

- **DRIVER'S LICENSE**

- **AUTO INSURANCE**

SECTION 3

- **ORIENTATION CHECKLIST AT HIRE**
- **ORIENTATION CHECKLIST WHEN NEW JOB IS ASSUMED**
- **JOB ACCEPTANCE STATEMENT** (See Job Description manual)
- **SIGNED JOB DESCRIPTION** (See Job Description manual)
- **PERFORMANCE EVALUATION AT 90 DAYS** (See Performance Evaluation manual)
- **PERFORMANCE EVALUATION YEARLY** (See Performance Evaluation manual)
- **SKILLS COMPETENCY FOR ALL FIELD STAFF AT HIRE** (Not required for office staff insert proper form from Competency Evaluation folder)
- **SKILLS COMPETENCY FOR ALL FIELD STAFF ANNUALLY** (Not required for office staff insert proper form from Competency Evaluation folder)
- **TIME SLIP (OPTIONAL)**
- **COUNSELING/DISCIPLINARY ACTIONS**
- **CORPORATE COMPLIANCE STATEMENT**

ORIENTATION PROGRAM			
	INITIALS		**INITIALS**
Agency Mission, Vision and Plan and Organizational Chart		Advance Directives	
Types of Care Provided by the Agency including Information Provided to consumers Regarding Charges		Policies and Procedures HIPAA TB	
Personnel Policies, Job Descriptions and Professional Boundaries of All Disciplines; completion of in-services required at orientation		Training Specific to Job Descriptions and mandatory in-services	
Cultural diversity		Consumer Rights and Grievance Policy	
Ethics, Conflict of Interest and Confidentiality of Consumer Information		Supervision and Evaluation	
Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)		Safety Issues in the Home (Including Security and Guns in the Home)	
Emergency Preparedness Plan/ Actions to Take in the Event of a Disaster		Actions to Take in Unsafe Situations	
OSHA Requirements, Safety and Infection Control in the Home/ Standard Precautions		Consumer Care Responsibilities Including Charges for Service/Care	
Incidences and Occurrences reporting		Understanding and coping with Alzheimer's Disease and Dementia	
Identifying and Reporting Abuse, Neglect and Exploitation		Fraud/Abuse/Corporate Compliance, False Claims, False Statements, Whistle Blowing	
Community Resources		Quality Assurance	
Documentation - Record keeping		Photo ID Badge Issued	
Medical Device/Hazards reporting		Exposure Control Plan	
PRINT NAME		**TITLE**	
EMPLOYEE SIGNATURE		**DATE**	

PRINT NAME	TITLE
EMPLOYER SIGNATURE/INITIALS	DATE

ORIENTATION CHECKLIST FOR CURRENT EMPLOYEES ASSIGNED TO A NEW JOB CLASSIFICATION	
	INITIALS
1. Review of all Agency policies and procedures related to new job duties.	
2. Review of Federal, and state regulations.	
3. Review confidentiality of consumer information.	
4. Review contracts for all programs, agencies and individuals related to new job duties.	
5. Review employee benefits.	
6. Review infection control, safety and disaster programs .	
7. Consult with and observes other staff in the same job classification regarding consumer job issues.	
8. Review implementation of consumer goals and objectives.	
9. Ensuring safe and effective services to consumers and families.	
10. Establishing and maintaining effective lines of communication.	
11. Practicing staff development including orientation, in-service education and continuing education.	
12. Following job description in performance of duties.	
13. Implementing and evaluating consumer care services related to new job.	
14. Participating in selected in-service programs related to new job.	
15. Encouraging staff participation in problem solving.	
16. Performing other duties as assigned by the Administrator.	

PRINT NAME	TITLE
EMPLOYEE SIGNATURE	DATE
PRINT NAME	TITLE
EMPLOYER SIGNATURE/INITIALS	DATE

INSERT APPROPRIATE JOB DESCRIPTION FROM JOB DESCRIPTION MANUAL

JOB ACCEPTANCE STATEMENT

I have read, understand and agree to the terms specified in this job description for the position I presently hold. A copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Employee Signature _____

Date_____

INSERT APPROPRIATE PERFORMANCE EVALUATION FROM PERFORMANCE EVALUATION MANUAL

Performance Evaluations are to be prepared for each employee at 90 days after hire and then annually.

They must be signed by the employee and the evaluator and they must include goal setting.

Skill Competency

Observation

Evaluations

INSERT THE APPROPRIATE COMPETENCY EVALUATION AT HIRE, BEFORE A STAFF MEMBER CAN VISIT A CONSUMER, AND THEN ANNUALLY

Note these are not required for office employees

(To be used at Agency's Option)

TIME SLIPS

Day _____Date: _____ □ 1st-15th □ 16th - 31st

Employee Name	Title	Time In	Lunch Out	Lunch In	Time Out	Total Hours	Overtime

Visit Notes	Consumer Name	Consumer Number	Code	Time In	Time Out	Comments

Codes

S= SOC	NB = Non Billable
E = Eval	M= Meeting Team
RV = Revisit	O = Orientation
DC = Discharge	ROC = Resumption
SUP = Supervisory	RC = Recert

*ALL OVERTIME MUST BE APPROVED BY MANAGER AHEAD OF TIME
Employee Signature: _____
Manager Signature _____

Certify that hours worked are correct for the date listed above
Reviewed By _____ Date: _____

EMPLOYEE COUNSELING REPORT

Employee: _____

Date: _____ / _____ / _____

Job Classification: _____

Reason for Conference/Report:
Commendation
Work Performance
Infraction of Policy
Other (Specify): _____

Type of Communication:
Telephone
Office Conference
Field Conference

Events leading to conference session: _____
_____
_____
_____

Handling of event/session: _____
_____
_____
_____

Recommendation to Employee: _____
_____
_____
_____

Employee Comments: _____
_____
_____
_____

Signature of Employee _____

Date: _____ / _____ / _____

Signature of Counselor _____

Date: _____ / _____ / _____

COMPLIANCE STATEMENT

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contract basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding.
As you know, our Home Care Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature and date:

SECTION 4

- ## IN-SERVICE TEST AND CERTIFICATES

Required:

Office Staff, at time of initial orientation: **Infection Control, HIPAA –**

All Field Staff**,** at time of initial orientation: **Infection Control, HIPAA, Bloodborne Pathogens, Medical Device Reporting, TB- Respiratory Disorders**

Individuals Performing Personal Care Duties**,** at time of initial orientation**: HIPAA, Bloodborne Pathogens, Medical Device Reporting, TB- Respiratory Disorders.**
Within one year: Three other in-services

Individuals (including CNAs) Performing Home Health Aide Duties, at time of initial orientation**: HIPAA, Bloodborne Pathogens, Medical Device Reporting, TB- Respiratory Disorders.**
Within one year: Seven other in-services

- ## OTHER TRAINING CERTIFICATES

- ## CEUS

EMPLOYEE IN-SERVICE LOG

DATE	EMPLOYEE NAME	SIGNATURE	IN-SERVICE

SECTION 5

- **CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI)**
- **FIELD PRACTICES STATEMENT**
- **CONFIDENTIALITY STATEMENT**
- **HIPAA CONFIDENTIALITY AGREEMENT**
- **CORPORATE COMPLIANCE STATEMENT**
- **POLICIES AND PROCEDURES STATEMENT**
- **PROTECTIVE EQUIPMENT STATEMENT (PPE)**

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both the Agency's and the employee's responsibility to ensure that every consumer's health information is protected at all times. By signing below you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding consumer's Protected Health Information will be provided to you upon hire.
I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations. I agree to protect all Electronic Medical Records including passwords as outlined in the HIPAA policy.

Employee: _____ Date: _____

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure consumer's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure consumer's records are protected by enforcing the following measures:

- Consumer Protected Health Information will be transported in a protected travel chart when traveling.

- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.

- Consumer Protected Health Information will be returned to the agency upon acknowledgement of the consumer being discharged.

I pledge to make every effort to keep consumer's Protected Health Information protected at all times.

Employee: _____ Date: _____

REQUIRED HIPAA CONFIDENTIALY AGREEMENT

EMPLOYEE CONFIDENTIALITY AGREEMENT of CONSUMERHEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS

For good consideration and as an inducement for _____(employer) to employ _____(employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any Protected Health Information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain.

The Employee agrees to not copy and to return all such Agency supplied Information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____

_____

Agency

FIELD EMPLOYEE STANDARDS AND PROCEDURES

This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the consumer's family. This includes personal hygiene, jewelry, hair and makeup.
2. **Please do not smoke in the presence of a consumer.**
3. Always wear your ID Badge.
4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR CONSUMER DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have any problem, incident or accident on the job, do not discuss it with the consumer, but call the Agency immediately.
6. If the consumer asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**
8. UNDER NO CIRCUMSTANCES are you to ask for, or accept any money from your consumer or take home property that belongs to the consumer.
9. There shall not be any involvement with the consumer's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any consumer information which is obtained in the regular course of your employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with the consumer family.
13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your consumer family. If you are requested to do so, please have the consumer contact us.
14. **It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule**. If the consumer is unable to sign your note, a family member or responsible party may sign.
15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

Employee Signature_____ Date_____

CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

The Agency requires that the Employee avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee agrees to refrain from prohibited competition with the Agency and to maintain the confidentiality of information regarding employees, consumers and the Agency business.

The Employee will have access to information not generally made available to the public, such as identity of consumers, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any consumer or entity to discontinue any relationship with the Agency, solicit any consumer of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee is required to return all of the Agency's property including keys, consumer records, forms, manual, beeper, etc. to the Agency and will not retain copies.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency. Employee will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

_____ _____ _____

Employee Date

EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel

policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and am bound by the Policy.

I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit consumers and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic consumer evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meeting and inservice training. Home health aides are required to have 12 hours of inservice training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding consumer and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any consumer will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of consumer/ employee confidentiality is subject to civil and criminal penalties.
If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will.

Employee Signature_____ Date_____

PERSONAL PROTECTIVE EQUIPMENT FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- Barrier Safety Goggles
- CPR Shield Face Barrier
- Fluid Resistant Gown
- Gloves
- Biohazard Bag
- Sharps Container
- 3M Respirator Mask (N95 or similar purchased from Uline.com)

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Signature/Title_____ Date_____

Compliance Statement

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contractual basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding
As you know, our Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature: Date:

SECTION 6

- **EMPLOYEE SEPARATION RECORD**
- **EXIT INTERVIEW**
- **MISCELLANEOUS**

EMPLOYEE SEPARATION RECORD
Employee Name:
Social Security Number:
Date of Hire:
Last day of work:
Reason for separation:
Is this employee eligible for rehire?
[ ] YES
[ ] NO
Comments:
Supervisor:
Date:

EXIT INTERVIEW

YOUR COMMENTS ARE IMPORTANT TO US. PLEASE COMPLETE THE QUESTIONS ON THIS FORM. YOUR ANSWERS WILL BE USED TO DEVELOP RECOMMENDATIONS FOR IMPROVEMENT. PLEASE BE CANDID WITH US.	
NAME:	TITLE:
DATE OF HIRE:	DATE OF RESIGNATION:
1. MOST IMPORTANT REASON FOR LEAVING:	
2. WAS THE INFORMATION GIVEN TO YOU ABOUT HOURS, SALARY, AND JOB DUTIES AN ACCURATE REFLECTION OF WHAT YOU FOUND ON THE JOB?	
3. WERE YOU ADEQUATELY PREPARED TO PERFORM YOUR JOB? IF NOT, WHAT COULD HAVE BEEN DONE TO HELP YOU PERFORM MORE EFFECTIVELY?	
4. WHAT DID YOU LIKE BEST ABOUT WORKING FOR THE AGENCY?	
5. WHAT DID YOU LIKE LEAST ABOUT WORKING FOR THE AGENCY?	
6. DID YOU RECEIVE SUFFICIENT INFORMATION ABOUT YOUR PERFORMANCE?	

SECTION 7

(Separate employee file marked '*confidential*')

- **HEALTH STATEMENT**
- **PHYSICIAN HEALTH STATEMENT**
  'FREE OF COMMUNICABLES'
- **IMMUNIZATIONS**
- **TB QUESTIONAIRE**
- **PAYROLL FORMS**
- **CRIMINAL HISTORY ATTESTATION**
- **CRIMINAL HISTORY CHECK RESULTS**
- **OTHER CONFIDENTIAL INFORMATION**

HEALTH STATEMENT

Applicant Name: _____Date_____

I, _____ hereby attest that the state of my health is such that it will enable me to perform the duties of a health care professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

AIDS	Anthrax	Chickenpox	Cholera
Diphtheria	Encephalitis	Hepatitis, Types A, B and C	Influenza
Leprosy (Hansen's Disease)	Leptospirosis	Malaria	Measles (Rubeola)
Meningitis	Mononucleosis	Mumps	Whooping Cough
Plague	Poliomyelitis	Psittacosis (Ornithosis)	Rabies
Rocky Mountain Spotted Fever	Rubella (German Measles)	Shigellosis	Smallpox
Tetanus	Tularemia	Tuberculosis	Typhoid Fever

HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

Request that I receive the Hepatitis vaccine.

Refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

Provide written proof of immunity (attach)

Provide written proof of previous vaccination (attach)

Provide written proof of medical contraindication (attach)

Signature: _____ Date: _____

TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____

Print Name YES NO

1. Have you ever had a positive TB skin test or history of TB infection? ____ ____

If the answer is YES, please answer the following:

2. Have you ever had the BCG vaccine? ____ ____

3. Do you have prolonged or recurrent fever? ____ ____

4. Have you recently lost weight? ____ ____

5. Do you have a chronic cough? ____ ____

6. Do you cough up blood? ____ ____

7. Do you have sweating at night? ____ ____

8. Do you have any of the following risk factors which may substantially? Increase the risk of tuberculosis?

____ a. Silicosis (Lung Disease)

____ b. Gastrectomy

____ c. Intestinal Bypass

____ d. Weight 10% or more below ideal body weight?

____ e. Chronic Renal Disease

____ f. Diabetes Mellitus

____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy

____ h. Hematologic Disorder i.e. leukemia or lymphoma

____ i. Exposure to HIV or AIDS

____ j. Other malignancies

_____
_____
Employee Signature Date

SEPARATE FILE

ALL I – 9s

ALPHABETIZED IN ONE FOLDER