



**PERSONNEL FILE
SECTION I**

Staff Name		Position:
Date of Applied:	Date of Hire:	Date of Termination:

GENERAL

	Application of Employment
	Insert Resume (if applicable)
	Contract (Independent Contractor only)
	Acknowledgment of Policies/Procedures and Alzheimer's Disease
	Tax Exempt Form (marked N/A for W-4 employee only)
	Transportation Responsibility Contract
	Acknowledgment of Probationary Period
	Statement of Commitment
	Infection Control/Standard Precautions
	Individualized Statement Regarding Conflict of Interest
	Non-Solicitation/Non-Compete Agreement
	Code of Conduct
	Electronic Documentation & Signature Authenticity
	Disclosure of Legal Action
	Confidential Statement
	Protected Health Information
	Two References <input type="checkbox"/> Reference # 1 <input type="checkbox"/> Reference # 2

Application for Employment PRE-EMPLOYMENT QUESTIONNAIRE EQUAL OPPORTUNITY EMPLOYER

Personal Information

DATE _____

NAME (LAST NAME FIRST)		SOCIAL SECURITY NO. _____	
PRESENT ADDRESS	CITY	STATE	ZIP CODE
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
PHONE NO.	SECONDARY PHONE NO.	REFERRED BY	

Employment Desired

POSITION	DATE YOU CAN START
ARE YOU EMPLOYED NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
EVER APPLIED TO THIS COMPANY BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE _____ WHEN _____

Education History

	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE	SUBJECTS STUDIED
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS, OR CORRESPONDENCE SCHOOL				

General Information

SUBJECT OF SPECIAL STUDY/RESEARCH WORK	
SPECIAL TRAINING	
SPECIAL SKILLS	
U.S. MILITARY OR NAVAL SERVICE	RANK

Former Employers (LIST BELOW LAST FOUR EMPLOYERS, STARTING WITH LAST ONE FIRST)

DATE MONTH AND YEAR	NAME & ADDRESS OF EMPLOYER	POSITION	REASON FOR LEAVING
FROM			
TO			
FROM			
TO			
FROM			
TO			
FROM			
TO			

References (GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.)

NAME	ADDRESS	BUSINESS	YEARS KNOWN

Authorization

"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 investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.

I understand that a consumer credit report or criminal records check may be necessary prior to my employment. If such reports are required, I understand that, in compliance with federal law, the company will provide me with a written notice regarding the use of these reports and will also obtain a separate written authorization from me to consent to these reports. I also understand that a poor credit history or conviction will not automatically result in disqualification from employment."

In compliance with federal law, all persons hired will be required to verify identity and eligibility to work in the United States and to complete the required employment eligibility verification document form upon hire.

DATE _____ SIGNATURE _____

Do Not Write Below This Line

DATE _____ INTERVIEWED BY _____

Remarks

NEATNESS			CHARACTER	
PERSONALITY			ABILITY	
HIRED	FOR DEPT.	POSITION	WILL REPORT	SALARY WAGES

APPROVED:

EMPLOYMENT MANAGER _____ DEPARTMENT HEAD _____ GENERAL MANAGER _____

This application for employment is sold only for general use throughout the United States. TOPS assumes no responsibility and hereby disclaims any liability for the inclusion in this form of any questions or requests for information upon which a violation of local, state, and/or federal law may be based. It is the user's responsibility to ensure that this form's use complies with applicable laws, which change from time to time.



NAME: _____

POSITION: _____

**ACKNOWLEDGMENT OF POLICIES AND PROCEDURES
AND
ALZHEIMER'S DISEASE**

I, the undersigned, hereby acknowledge that I have read, understood, and accept the Policies and Procedures as true and that I shall abide by the same while affiliated with **High Standard Health Services, Inc.** I also acknowledge that I received a copy of the "Alzheimer's Disease and Related Dementias" Handout on the date of hire.

Initial _____

TAX EXEMPT FORM

I, the undersigned, hereby acknowledge that I am an independent contractor. Therefore, I am responsible for my social security and taxes and I will receive an IRS 1099 form for the preceding year by February 1, of each year which is also sent to the Internal Revenue Service.

As an independent contractor, I am not eligible for any benefit such as vacation, disability or unemployment and will not be covered by Workmen's Compensation.

N/A Initial _____

TRANSPORTATION RESPONSIBILITY CONTRACT

It has been explained to me that I am being offered employment by **High Standard Health Services, Inc.** 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 for bodily injury and property damage insurance.

Initial _____

ACKNOWLEDGMENT OF PROBATIONARY PERIOD

I accept and understand that the first 90 days of employment will be considered my probationary period in accepting employment with **High Standard Health Services, Inc.** If for any reason my employment is terminated during this period, I understand and accept that this account will not be charged with any unemployment benefits that I may be eligible to receive under the State of Florida unemployment compensation law.

I also understand and accept that at the end of the 90 days period, I will receive a written evaluation of my work performance. Should the agency fail to provide this written evaluation, it shall be understood and accepted by all involved that the probationary period will have been completed satisfactorily.

Initial _____

STATEMENT OF COMMITMENT

I have read and understand **High Standard Health Services, Inc.** (“the Agency”) Personnel Policy Manual. In compliance with those policies I agree to conform to the following:

- 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 patient’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 which is 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 not accept any money or gifts from *the Agency’s* patient/caregiver. I will receive payment for services rendered directly from *the Agency*.
- I will arrive on time for the assignments I have accepted. In the event of an emergency which may cause me to be late or if I am unable to meet my assignment commitment, I will notify *the Agency’s* office of the situation and expected arrival time. I also understand that not calling *the Agency* will be grounds for termination immediately.
- I will not make or accept personal telephone calls on the patient’s telephone.
- I will not smoke in a patient’s home.
- I will not transport a patient or family member in my personal vehicle.

Initial _____

**INFECTION CONTROL/STANDARD PRECAUTIONS
BIOMEDICAL WASTE PROTOCOL
AND
SAFETY AND RISK MANAGEMENT**

I hereby acknowledge that I have read and understood the Infection Control/Standard Precautions Policy, Bio-Medical Waste Protocol and Safety/Risk Management contained in the field staff procedures manual. I am familiar with the procedures appropriate to my position as a field employee/contractor.

Initial _____

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST

I have read and am fully familiar with the **High Standard Health Services, Inc.’s** policy statement regarding conflict of interest. I am not presently involved in any transaction, investment or other matter in which I would profit or gain directly or indirectly as a result of my membership on the Agency Board of Directors or its committees or my employment. Furthermore, I agree to disclose any such interest which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the Agency’s business that might result in any profit or gain, directly or indirectly, for myself.

Initial _____

NON-SOLICITATION/NON-COMPETE AGREEMENT

As a staff of **High Standard Health Services, Inc.**, I understand that the job I am being hired to perform belongs to **High Standard Health Services, Inc.** I also understand that it is illegal for me to transfer or attempt to transfer any case to another home health agency or facility or take ownership of any job that I am employed in. Should I act underhandedly and take over such a job so that I may be paid directly by the patient/client, the exclusion of my employer or transfer any case to another agency. I will be in violation of State of Florida, Federal and Agency rules, and will according pay \$10,000.00 to **High Standard Health Services, Inc.**

Initial _____

CODE OF CONDUCT

It is the objective of **High Standard Health Services, Inc.**, to provide equipment, supplies and related service in accordance with all applicable laws, regulations and statutes. The agency believes that its employees and subcontractors share this objective and wish to perform their jobs in a competent, legal and ethical manners and thus, have established a Code of Conduct as a demonstration of that commitment.

I agree to:

- ▶ Always perform my duties and responsibilities to the best of my ability.
- ▶ Treat all patients with care, courtesy and respect and maintain patient confidentiality at all times.
- ▶ Protect all patient rights and report any failure to observe patient rights by any person promptly.
- ▶ Always speak truthfully to all persons with whom I have contact in the course of my duties, including patients, family members, other employees and government officials.
- ▶ Obey all laws which may apply to the performance of my duties.
- ▶ Make sure all documents or records which I prepare contain only accurate and truthful information.
- ▶ Observe all other standards of conduct which apply to my position.
- ▶ Report any activities that may violate this Code of Conduct to the agency's Administrator.

Initial _____

ELECTRONIC DOCUMENTATION & SIGNATURE AUTHENTICITY

I understand that **High Standard Health Services, Inc.**, staff may use an electronic signature on all computer-generated documentation. An electronic signature will serve as authentication on patient record documents and other agency documents generated in the electronic signature.

For the purpose of the computerized medical record and other documentation of the agency purposes, I acknowledge the combined use of my Electronic Signature Passcode and Log In authentication password will serve as my legal signature. I further understand that an agency-based administrator issues an initial employee password and that I will create an Electronic Signature Passcode within the software application.

Log In authentication passwords must be updated every 60 days by the user, as well as on an as-needed basis if system security is breached. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of an electronic signature, my documentation on the field - based or an office computer. I understand that I am responsible for the security and accuracy of information entered in Agency Manager, and as such, I will:

- ◆ Not share or otherwise compromise my electronic signature credentials (Log In authentication password or Electronic Signature Passcode)
- ◆ Exit the online application at the end of each working day or whenever the computer is not in my immediate possession.
- ◆ Not save my Log In password and Electronic Signature Passcode on the computer, but will enter them upon each access of the application.

- ◆ Review all of my documentation online prior to submit to the agency server.

Initial _____

DISCLOSURE OF LEGAL ACTION

I attest that I have NOT been excluded from participating in the Medicare and/or Medicaid Program. This includes the State of Florida as well as any other state. I also agree to notify **High Standard Health Services, Inc.** immediately if I do become excluded from participating in Medicare/Medicaid program in the future.

Initial _____

CONFIDENTIALITY STATEMENT

I have been formally instructed regarding **High Standard Health Services, Inc.'s** policy and procedures for maintaining the confidentiality and privacy of all information contained in patient/personnel files and records, as well as any information that is obtained verbally.

I understand that, except as needed to conduct business, patient and/or personnel information may not be discussed with anyone either inside or outside the agency.

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.

I understand that any breach of confidentiality may be grounds for immediate termination of employment.

I have been formally instructed in the policies and procedures of the Agency regarding full compliance with all HIPAA regulations.

Initial _____

PROTECTED HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY

I, the undersigned, have read and understand **High Standard Health Services, Inc.** (hereinafter "the Agency") policy on confidentiality of protected health information ("PHI") as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation.

I also acknowledge that I am aware of and understand the Policies of the Agency regarding the security of PHI including the policies relating to the use, collection, disclosure, storage and destruction of PHI.

In consideration of my employment or association with the 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 the Agency, or after my employment or association ends, access or use PHI, or reveal or disclose to any persons within or outside the Agency, any PHI except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and the Agency policies governing proper release of information.

I understand that my obligations concerning the protection of the confidentiality of PHI relate to all PHI whether I acquired the information through my employment or contract or association or appointment with the Agency or with any of the entities, which have an association with the Agency.

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 too relevant state and federal legislation, and a report to my professional regulatory body.

I have been informed of the contents of the Agency's PHI Confidential Policy and the consequences of a breach.

Initial _____

I have read, understood and will abide by the policy and procedures. Failure to comply with these policies may result in being placed under suspension or termination from work.

Signature/Title: _____ Date: _____

Print Name/Title: _____



Reference/Facility Name: _____
 Address: _____
 City/State/Zip Code: _____
 Telephone #/Fax #: _____

Your name has been given as a reference by the applicant listed below. Your assistance is important in the thorough screening of our applicant. This information is confidential.

Sincerely,

**High Standard Health Services, Inc.,
 Administration**

 Applicant's Signature

I hereby authorize the following information to be released to **High Standard Health Services, Inc.,**

Date of employment: From _____ To _____

Name of Applicant: _____ Social Security No. _____

Circle One: RN LPN HHA PT RT OT MSW Other _____

Evaluation Check:	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality of Work				
Quantity of Work				
Attitude				
Dependability				
Punctuality				
Personal Appearance				

Reason for leaving: _____ Wage Rate: _____ Eligible for re-employment YES/NO

If no, please explain: _____

To your knowledge does this applicant have any disability that would adversely affect the performance of his/her duties:

YES/NO If yes please explain: _____

Do you recommend this applicant: YES/NO If no please explain: _____

In your opinion will this candidate be suitable for independent assignment? YES/NO

If no please explain: _____

How would you rate this employee's technical skills: POOR FAIR GOOD EXCELLENT

Signature: _____ Title _____ Date: _____

In Office Use Only:	
Date Sent/Called:	Via <input type="checkbox"/> Mailed <input type="checkbox"/> Fax <input type="checkbox"/> Phone

10689 N. Kendall Drive | Suite 310 | Miami | Florida | 33176
 Telephone: (305) 271-6770 | Fax: (305) 271-6631
 E-Mail: highstandard317@gmail.com



Reference/Facility Name: _____
 Address: _____
 City/State/Zip Code: _____
 Telephone #/Fax #: _____

Your name has been given as a reference by the applicant listed below. Your assistance is important in the thorough screening of our applicant. This information is confidential.

Sincerely,

**High Standard health Services, Inc.,'s
 Administration**

 Applicant's Signature

I hereby authorize the following information to be released to **High Standard health Services, Inc.,**

Date of employment: From _____ To _____

Name of Applicant: _____ Social Security No. _____

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Punctuality				
Personal Appearance				

Reason for leaving: _____ Wage Rate: _____ Eligible for re-employment YES/NO

If no, please explain: _____

To your knowledge does this applicant have any disability that would adversely affect the performance of his/her duties:

YES/NO If yes please explain: _____

Do you recommend this applicant: YES/NO If no please explain: _____

In your opinion will this candidate be suitable for independent assignment? YES/NO

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How would you rate this employee's technical skills: POOR FAIR GOOD EXCELLENT

Signature: _____ Title _____ Date: _____

In Office Use Only:	
Date Sent/Called:	Via <input type="checkbox"/> Mailed <input type="checkbox"/> Fax <input type="checkbox"/> Phone

10689 N. Kendall Drive | Suite 310 | Miami | Florida | 33176
 Telephone: (305) 271-6770 | Fax: (305) 271-6631
 E-Mail: highstandard317@gmail.com



**PERSONNEL FILE
SECTION II**

Staff Name	Position:
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ORIENTATION/JOB DESCRIPTION, PERFORMANCE EVALUATION, COMPETENCIES, TRAINING AND/OR TEST

	Orientation Checklist
	Job Description

Description	90 days	Annual	Annual	Annual
Performance Evaluation (For All Staffs)				

Description	Initially	3 years
Competency Evaluation initially and every three years for all field staff except HHA including <input type="checkbox"/> Hand Hygiene <input type="checkbox"/> Bag Technique		
	Initial	Annual
Competency Evaluation for HHA (initially and annually) <input type="checkbox"/> Hand Hygiene <input type="checkbox"/> Bag Technique		

Description	Initially	Annual	Annual	Annual
Glucometer Competency (Nurses Only)				
Glucometer Written Test (Nurses Only)				
PT/INR Competency (Nurses Only)				
PT/INR Written Test (Nurses Only)				
Staff Training: Comprehensive Emergency Management (CEMP)				
HHA Test (Home Health Aide Only)				



ORIENTATION CHECKLIST

Name: _____

Position: _____

ORIENTATION TO:	YES	N/A
Agency's Mission and Vision		
Agency's philosophy, goals and objectives		
Organizational Structure/Chart		
Agency policies and procedures including, but not limited to	YES	N/A
Non-discrimination		
Complaint/Grievance Procedures/Concerns		
Patient's Bill of Rights and Responsibilities		
Admission Criteria/Acceptance of Patients		
Requirements of employment		
Job Description, including related to infection prevention and control and assessing and managing pain (Note: Assessing and managing pain is not required for home health aide staff)		
Contract Agreement (if applicable)		
Performance Evaluation (Probationary Period/Annually)/Competency Evaluation Requirement		
Assignments/Proper Documentation/Visit Note/Missed Vist/Charting		
Supervisory Visits		
Patient Privacy Rights / HIPAA Compliance/ Confidentiality of patient information		
Infection Control/Standard Precautions/Hand Hygiene/Bag Technique/TB/ OSHA/Influenza Vaccination Program		
Emergency Preparedness Training/CEMP		
Hours of Operations/Office Staff and 24 Hours Answering Service		
Incident/Accident Reporting (Patients and Staffs)		

Orientation Checklist

Page 2

Agency policies and procedures including, but not limited to	YES	N/A
Abuse Hotline and AHCA Consumer Hotline/Medicaid Fraud Hotline		
Non-Retaliation Policy: How to report concerns to The Joint Commission, State and/or Federal Agencies		
ORIENTATION TO:	YES	N/A
Screening for Abuse, Neglect, Abandonment and Exploitation		
Advance Directive/DNR		
Following Plan of Care/Care Plan and Physician Orders		
Medication Management		
Payment Schedule/Payroll		
Safety & Risk Management including the Fall Prevention Program, Oxygen Safety		
Ethical issues		
Hazardous Materials/Waste Management/Safety Data Sheet/Biomedical Waste Plan		
Quality Assessment and Performance Improvement ("QAPI")		
Unanticipated adverse events		
Registered Nurses/ Qualified Therapist Only	YES	N/A
Admission/Discharge/OASIS		
Coordination of Services/Care		
IV Administration (If applicable)		

I hereby verify that I have had all my questions answered to my satisfaction and that I understand all of the material covered.

Signature: _____ Date: _____

Supervisor/DON Signature: _____ Date: _____



HOME HEALTH AIDE JOB DESCRIPTION

JOB SUMMARY

The home health aide is a trained worker who gives personal care when a patient or patient's family cannot meet these responsibilities. The home health aide works under the supervision of the registered nurse or other appropriate skilled professional to provide a supplementary service in carrying out a service plan.

RESPONSIBILITIES AND DUTIES

1. Provision of hand-on personal care.
2. Performance of simple procedures as an extension of therapy or nursing services.
3. Assistance in ambulation or exercise.
4. Assistance in administering medications that are ordinarily self administered.

Note: If the home health aide provides assistance with self-administered medications, an assessment of the medications for which assistance is to be provided will be conducted by a licensed health care professional to ensure the unlicensed care giver provides assistance in accordance with their training and with the medication prescription. In addition, the CNA/home health aide needs to receive a minimum of 2 hours of training in assisting with self administered medication.

5. Hold membership on the interdisciplinary team.
6. Report changes in the patient's condition to registered nurse or other appropriate skilled professional
7. Complete pertinent records in compliance with the Agency's policies and procedures.
8. Follow the patient's plan of care for completion of tasks
9. Maintaining an open communication process with the patient, representative (if any), care givers, and family.
10. Demonstrate competency with assigned tasks.
11. Comply with infection prevention and control policies and procedures.
12. Honoring patient rights.

Certified Nursing Assistant/Home Health Aide
Page 2

13. Demonstrate competent on the following subject areas:
 - a. Communication skills, including ability to read, write and verbally report clinical information to patients, representatives and caregivers, as well as to other Agency staff.
 - b. Observe, report and document the patient status and the care or service furnished.
 - c. Able to read and record temperature, pulse and respiration
 - d. Basic infection prevention and control procedures
 - e. Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor
 - f. Maintenance of clean, safe and healthy environment
 - g. Recognizing emergencies and the knowledge of instituting emergency procedures and their application
 - h. Physical, emotional and development needs of and ways to work with population served by the Agency, including the need for respect for the patient, his or her privacy and his or her property
 - i. Appropriate and safe techniques in performing personal hygiene and grooming tasks that include -
 1. Bed bath;
 2. Sponge, tub and shower bath;
 3. Hair shampooing in sink, tub and bed;
 4. Nail and skin care
 5. Oral hygiene; and
 6. Toileting and elimination.
 - j. Safe transfer techniques and ambulation;
 - k. Normal range of motion and positioning
 - l. Adequate nutrition and fluid intake
 - m. Recognizing and reporting changes in skin; and
 - n. Any other task that the agency may choose to have an aide perform as permitted under state law.
14. Understands ethics and maintains confidentiality regarding patient and agency records.
15. The home health aide **DOES NOT** change sterile dressings, irrigate body cavities, such as giving an enema, irrigate a colostomy or wound, perform a gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, nor provide any personal health service which has not been included in the plan of care.
16. Attends and participates in Home Health Aide meetings, in-service programs, and other required agency meeting.
17. Has full understanding of, and is in compliance with, the agency policies, rules and job description.

Certified Nursing Assistant/Home Health Aide

Page 3

18. Follows the written Home Health Aide Care Plan which has been completed by the Registered Nurse or qualified therapist.
19. Performs other related duties as designated by the Director of Nursing and/or Clinical Manager.
20. Recognize emergencies and knowledge of emergency procedures.
21. Participates in patient case conference.
22. Respect the patient's and/or caregiver's home at all time.
23. Report any abuse/neglect and/or fraud to the Administrator and/or Director of Nursing.

QUALIFICATIONS

1. Successfully completed one of the following programs:
 - A training and competency evaluation program as specified 42 CFR 484.80 (b) and (c) or;
 - A competency evaluation program that meets the requirements of 42 CFR 484.80 (c); or
 - A nurse aide training and competency evaluation program approved by the state and is currently listed in good standing on the state nurse aide registry; or
 - The requirement of the state licensure program that meets the provisions of paragraphs 42 CFR 484.80 (b) and (c)
2. Most be certified by the state of Florida as a Certified Nursing Assistant with forty (40) hours of Home Health Aide Completion Certificate or seventy-five (75) hours of Home Health Aide Completion Certificate.
3. Ability to read, write and carry out directions.
4. Completion of twelve (12) hours of in-service training per calendar year.

WORKING ENVIRONMENT

May occasionally work indoors, in the Agency's office and patient's homes, and travels to/from patient homes.

LIFTING REQUIREMENTS

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical

Certified Nursing Assistant/Home Health Aide
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activity.

- Heavy lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.

REPORTS TO

Director of Nursing/Nursing Supervisor/Registered Nurse/Qualified Therapist.

I have read and understand the above position, and will abide all rules and regulations.

Applicant's Signature

Date

Print Name



**CERTIFIED NURSING ASSISTANT/HOME HEALTH AIDE
PERFORMANCE EVALUATION**

Name: _____ Date: _____

PROBATIONARY

ANNUAL

PERFORMANCE RESPONSIBILITIES:	BELOW	MEETS	EXCEEDS
Performance of all personal care activities contained in a written assignment by a licensed health professional employee or contractor of the agency.			
Maintains a clean, safe and healthy environment.			
Other activities as taught by a licensed health professional of the agency for a specific patient.			
Keeps records of personal health care activities.			
Provides personal care services assigned by and under the supervision of a registered nurse or therapist.			
Observes appearance and gross behavioral changes in the patient and reporting to the registered nurse or therapist.			
Assists with self-administered medication in the patient's home and needed by the patient. (If applicable)			
Teach household routine and skills to well members of the family.			
Understands ethics and maintains confidentiality regarding patient and agency records.			
DOES NOT change sterile dressings, irrigate body cavities, such as giving an enema, irrigate a colostomy or wound, perform a gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, nor provide any personal health service which has not been included in the plan of care.			
Attends and participates in Home Health Aide meetings, in service programs, and other required agency meeting.			
Has full understanding of, and is in compliance with, the agency policies, rules and job description.			
Follows the written Home Health Aide Assignment/Care Plan which has been completed by the Registered Nurse or qualified therapist.			
Performs other related duties as designated by the Administrator and the Director of Nursing.			

Performance Evaluation
Certified Nursing Assistant/Home Health Aide
Page 2

PERFORMANCE RESPONSIBILITIES:	BELOW	MEETS	EXCEEDS
Recognize emergencies and knowledge of emergency procedures.			
Participates in patient case conference.			
Meet the job description qualifications			

Comments: _____

CNA/HHA's Signature: _____

Date: _____

Supervisor's Signature: _____

Date: _____

Print Name/Title: _____



HOME HEALTH AIDE COMPETENCY EVALUATION

Competency shall be determined through an *RN's direct observation* of the aide's performance of each activity. A home health aide will not perform any activity without direct RN supervision until competency is determined for that activity.

Staff Name: _____ Title: _____ Date: _____

Type of Evaluation: On-Site Visit with a Patient MR # _____ : Initial Annual

Other (specify)

ACTIVITY	DATE	DEEMED COMPETENT (Circle One)		METHOD USED (Circle One)			RN Initials
Reading and Recording							
Temperature		Yes	No	Observation	Verbal	Demonstration	
Pulse		Yes	No	Observation	Verbal	Demonstration	
Respiration		Yes	No	Observation	Verbal	Demonstration	
Appropriate and Safe Techniques In Personal Hygiene and Grooming Tasks							
Bed Bath		Yes	No	Observation	Verbal	Demonstration	
Sponge Tub		Yes	No	Observation	Verbal	Demonstration	
Shower bath		Yes	No	Observation	Verbal	Demonstration	
Hair Shampooing in sink		Yes	No	Observation	Verbal	Demonstration	
Hair Shampooing in tub		Yes	No	Observation	Verbal	Demonstration	
Hair Shampooing in bed		Yes	No	Observation	Verbal	Demonstration	
Nail Care		Yes	No	Observation	Verbal	Demonstration	
Skin Care		Yes	No	Observation	Verbal	Demonstration	
Oral Hygiene		Yes	No	Observation	Verbal	Demonstration	
Toileting and Elimination		Yes	No	Observation	Verbal	Demonstration	
Adequate Nutrition and Fluid Intake		Yes	No	Observation	Verbal	Demonstration	
Proper Body Mechanics							
Safe Transfer Techniques and Ambulation		Yes	No	Observation	Verbal	Demonstration	
Normal Range of Motion and positioning		Yes	No	Observation	Verbal	Demonstration	
Proper Use of Assistive Devices							
Cane		Yes	No	Observation	Verbal	Demonstration	
Crutches		Yes	No	Observation	Verbal	Demonstration	
Walker		Yes	No	Observation	Verbal	Demonstration	
Wheelchair		Yes	No	Observation	Verbal	Demonstration	
Hoyer Lift		Yes	No	Observation	Verbal	Demonstration	
Other Medical Equipment (<i>List Below</i>):		Yes	No	Observation	Verbal	Demonstration	
		Yes	No	Observation	Verbal	Demonstration	
		Yes	No	Observation	Verbal	Demonstration	
		Yes	No	Observation	Verbal	Demonstration	

ACTIVITY	DATE OF OBSERVATION	DEEMED COMPETENT (Circle One)		METHOD USED (Circle One)			RN Initials
Additional Services (As Indicated):							
Maintenance of a clean, safe & healthy environment		Yes	No	Observation	Verbal	Demonstration	
Respect patient privacy and property.		Yes	No	Observation	Verbal	Demonstration	
Good Communication Skills including the ability to read, write and verbally report clinical information to patients, representatives and caregivers, as well as to other Agency staff.		Yes	No	Observation	Verbal	Demonstration	
Observation, reporting and documentation of patient status and the care or service furnished.		Yes	No	Observation	Verbal	Demonstration	
Basic infection prevention and control procedures		Yes	No	Observation	Verbal	Demonstration	
Recognizing and reporting changes in skin condition		Yes	No	Observation	Verbal	Demonstration	
Recognizing emergencies and the knowledge of instituting emergency procedures and their application.		Yes	No	Observation	Verbal	Demonstration	
Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.		Yes	No	Observation	Verbal	Demonstration	
Any other task (List Below)		Yes	No	Observation	Verbal	Demonstration	
		Yes	No	Observation	Verbal	Demonstration	
		Yes	No	Observation	Verbal	Demonstration	

Based on this competency, the HHA is competent to perform all the duties: Yes No

Requires additional training/experience in the following areas:

HHA Signature

Supervisor's Signature/Title

Print Name/Title

**** For any activity the home health aide receives an unsatisfactory evaluation, training will be provided specific to the activity and a satisfactory evaluation will be required prior to the home health aide performing the task without direct RN supervision.**



HAND HYGIENE COMPETENCY TESTING

Staff Name: _____

Discipline: _____

Method Keys: O = Observed V = Verbally

DATE	PERFORMANCE CRITERIA	Standard Met		METHOD	
		Yes	No	O	V
	PROCEDURE				
	1. Line a clean area by the sink with paper towel.				
	2. Place the soap and paper towel roll on the lined paper towel.				
	3. Turn on water.				
	4. Regulate temperature to warm water.				
	5. Wet hands, with fingers pointed downwards.				
	6. Get soap.				
	7. Apply soap to hands and wrists.				
	8. Rub hands in circular motion.				
	9. Interlace fingers, rub back and forth, rub fingernails.				
	10. Count up to 20 seconds doing # 8 and #9.				
	11. Rinse hands with water with fingers pointing down.				
	12. Dry hands with paper towel.				
	13. Turn off faucet with paper towel.				
	14. Leave area clean and neat.				
	COUGH ETIQUETTE				
	Cover your mouth and nose with a tissue when you cough or sneeze, or cough or sneeze into your upper sleeve, not in your hands.				
	ALCOHOL-BASED HAND RUB				
	Clean both hands with alcohol-based hand rub in place of hand washing with soap and water if your hands are not contaminated with blood or body fluids.				

Signature of Person Determining Competency/Title

Date

Signature of Employee/Subcontractor

Date



BAG TECHNIQUE COMPETENCY EVALUATION

Staff Name: _____

Discipline: _____

Method Keys: O = Observed V = Verbally

DATE	PERFORMANCE CRITERIA	Standard Met		METHOD	
		Yes	No	O	V
	PROCEDURE				
	Bag is place on clean and safe area (surface).				
	Barrier is utilized appropriate				
	Bag is placed out of reach of children and animals.				
	Plan ahead where to discard disposable items and sharps.				
	Prior of going inside bag, wash hands as per the agency's Hand Hygiene Policy.				
	After handwashing, remove supplies and/or equipment needed for patient care.				
	Close bag while performing patient care.				
	Need additional supplies from bag during patient care, wash hands again.				
	Clean and dirty supplies are maintained separately				
	When patient care visit finish, wash hands and clean reusable equipment and supplies, such as stethoscope, blood pressure cuff, etc. prior returning in bag.				
	Wash hands prior to returning clean equipment to bag.				
	Close bag.				
	OTHER PROCEDURE				
	Supplies are maintained in the bag and checked for expiration on a regular basis.				
	Clean and disinfect bag at least weekly.				

Signature of Person Determining Competency/Title

Date

Signature of Employee/Subcontractor

Date



STAFF TRAINING: COMPREHENSIVE EMERGENCY MANAGEMENT PLAN (CEMP)

Initial Training Annual/Updated Training At least every 2 years

Staff Name: _____ Title: _____ Date: _____

1. CEMP's Policy and Procedures.
2. Hazard Vulnerability Analysis (HVA) presented. (Facility-Based and Community Based Risk Assessment).
3. Testing/implementation of plan and staff roles reviewed and discussed:
 - Staffing notification.
 - Prioritized patients/Classification (D1-D4).
 - Agency's command structure/telephone tree.
 - Community command structure.
 - Roles and responsibilities before, after and during emergency or disaster
4. Communication plan reviewed and discussed
 - Communication during emergency, including back-up communication.
 - Alternate means of communication: radio, television, in-person.
 - Sharing patient information with other settings, per HIPAA regulations.
 - Emergency contact list.
5. Discussed the Memorandum of Understanding (MOU).
6. Staff educated to develop his/her own individual emergency operational plan.

Staff was deemed competent with the CEMP? Yes No

Staff Signature: _____

Instructor Signature: _____ Date: _____

Print Name: _____

PRUEBA DE CAPACIDAD PARA EL AYUDANTE DE SALUD EN EL HOGAR

Nombre: _____ Fecha: _____

SCORE: _____ PASS: _____ FAIL: _____

DON's Signature: _____

1.	V	F	25.	_____	49.	V	F	73.	_____	97.	_____		
2.	V	F	26.	_____	50.	V	F	74.	_____	98.	_____		
3.	V	F	27.	_____	51.	_____		75.	_____	99.	_____		
4.	V	F	28.	_____	52.	_____		76.	V	F	100.	_____	
5.	V	F	29.	_____	53.	V	F	77.	V	F	101.	_____	
6.	V	F	30.	V	F	54.	V	F	78.	V	F	102.	_____
7.	V	F	31.	V	F	55.	V	F	79.	_____	103.	_____	
8.	V	F	32.	V	F	56.	_____	80.	_____	104.	_____		
9.	V	F	33.	_____	57.	_____		81.	_____				
10.	V	F	34.	_____	58.	_____		82.	_____				
11.	_____		35.	_____	59.	_____		83.	_____				
12.	_____		36.	V	F	60.	V	F	84.	_____			
13.	_____		37.	V	F	61.	V	F	85.	V	F		
14.	V	F	38.	V	F	62.	V	F	86.	V	F		
15.	V	F	39.	_____	63.	_____		87.	V	F			
16.	V	F	40.	_____	64.	_____		88.	_____				
17.	_____		41.	V	F	65.	_____	89.	_____				
18.	_____		42.	V	F	66.	_____	90.	_____				
19.	_____		43.	V	F	67.	_____	91.	_____				
20.	_____		44.	_____	68.	V	F	92.	_____				
21.	_____		45.	_____	69.	V	F	93.	V	F			
22.	V	F	46.	_____	70.	V	F	94.	V	F			
23.	V	F	47.	_____	71.	_____		95.	V	F			
24.	V	F	48.	V	F	72.	_____	96.	_____				

Firma de la CNA/HHA: _____



**PERSONNEL FILE
SECTION III**

Staff Name	Position:
------------	-----------

Description	Expires	Expires	Expires
Liability Insurance			
Car Insurance			
Emergency Notification			

CONFIDENTIAL ENVELOPE Description	Date Done	Expires	Expires
FDLE/AHCA Background Screening (Level 2) Added to the AHCA Employee Roster: <input type="checkbox"/> Yes			
OIG Screening Result (initially and every 5 years)			
Copy of the Florida Driver License			
Copy of the Social Security Card			
Proof of Citizenship/Residence:			
Attestation of Compliance of Background Screening			

I-9/E-Verify Binder			
I-9 Form			
<input type="checkbox"/> W-4 (Direct) <input type="checkbox"/> W-9 (Contract)			
Medical Information Binder/Folder			
Physical Examination	Expires		
PPD/Chest X-Ray	Expires		
Hepatitis Declination Form			
Influenza Vaccination Form (Annually)	Expires		



EMERGENCY CONTACT NOTIFICATION

STAFF NAME: _____ Date: _____

In case of an emergency notify next of kin:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Telephone: () _____

Second Emergency Contact (*Friend or relative not living with you*)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Telephone: () _____



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



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 <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	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 <i>(See instructions)</i>	
<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. <i>(See instructions)</i>	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

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

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 <i>(mm/dd/yyyy)</i>	
Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>	
Address <i>(Street Number and Name)</i>		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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
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 High Standard Health Services, Inc.	
Employer's Business or Organization Address (Street Number and Name) 10689 N. Kendall Drive, Suite 310		City or Town Miami	State FL	ZIP Code 33176

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 Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 		<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ▶ **Give Form W-4 to your employer.**
 ▶ **Your withholding is subject to review by the IRS.**

2021

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____		
	Multiply the number of other dependents by \$500 ▶ \$ _____		
	Add the amounts above and enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ ▶ _____
Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)



PHYSICAL EXAMINATION FORM

Name: _____ Date: _____

Based on the examination, the above name is in reasonably good health and appears to be free from apparent signs or symptoms of communicable diseases including tuberculosis.

MANTOUX METHOD TUBERCULIN SKIN TEST

CHEST X -RAY

Test Date: _____

Test Date: _____

Date Read: _____

Date Read: _____

Test Results: _____

Test Results: _____

Any Limitations or Restrictions: _____

Physician Name: _____

Physician Address: _____

Physician Telephone: _____

Physician's Signature

Date

Employee/Contractor Signature

Date

10689 N. Kendall Drive, Suite 310, Miami, Florida 33176
Tel: (305) 448-8441 | Fax: (305) 448*2024
E-Mail: highstandard317@gmail.com



HEPATITIS B DECLINATION FORM

Name: _____ Discipline: _____

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 (HBV) 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 these vaccinated evidence immunity. Periodic testing of vaccinated persons for antibody to Hepatitis B will confirm immune status.

I understand that due to my risk of 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 myself.

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 completely the **three (3) doses** of the Hepatitis B vaccine . *I have attached a copy of Hepatitis B Vaccination Record.*
- [] 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, I will want to be vaccinated with Hepatitis B vaccine. I can receive the vaccination series at no charge to me.
- [] I **accept** vaccination with the Hepatitis B vaccine. I have read the above information concerning the Hepatitis B vaccine. I understand I must complete the three (3) doses series for full immunization. I can receive the vaccination series at no charge to me.

Signature of Applicant

Date



INFLUENZA VACCINATION FORM

Year: _____

Name: _____ Title: _____

Employee Contracted Staff Other: _____

I have received a copy of **High Standard Health Services, Inc.'s** policy for the administration of influenza vaccine to Agency employees found in the Influenza Vaccination Program, as well as information about the influenza virus and vaccine. I have also had a chance to have my questions answered about influenza vaccination.

I understand the benefits and risks to the vaccine, and:

I **AGREE** to have the influenza vaccine administered for this influenza season.

Complete the following **after** vaccine has been administered:

Date vaccine was administered: _____.

I have **ALREADY** received the influenza vaccine for this influenza season on _____.
Date

I **DECLINED** the influenza vaccine due to:

For Use Agency only

	An allergy	a-5
	A compromise immune system	a-6
	A previous adverse reaction	a-7
	Additional medical illnesses or contraindications	a-8
	Spiritual and/or religious belief	a-9
	Other reasons (Check below)	a-11
	Concerned about side effects and/or safety.	
	I believe the influenza vaccine gives a person the flu.	
	I don't believe the vaccine prevents the flu.	
	Other reason - Please specify reason(s) for the declination:	

I understand that I may rescind this declination at any time.

Signature: _____ Date: _____

Remainder to input the information in Kinnser system



**PERSONNEL FILE
SECTION IV**

Staff Name	Position:
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PROFESSIONAL LICENSE and CERTIFICATES/CEUs

Description	Expires	Expires	Expires
Professional License			
Professional License Verification Done on the date of hire and on or before the license expires	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Date Printed:			
CPR Card (Back of the card must be signed)			
HIV/AIDS			
Domestic Violence			
OSHA			
Medical Errors			
Alzheimer's Disease			
Florida Laws and Rules (Nurses)			
Other:			
Other:			
Other:			
	75 hours Home Health Aide Certificate		
	Certificate Verified for HHA Certificate only		
12 hours of in-service present for HHA yearly			