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 ☐ Reference # 1 ☐ 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? ☐ YES ☐ NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? ☐ YES ☐ NO
EVER APPLIED TO THIS COMPANY BEFORE? ☐ YES ☐ 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			

CONTINUED ON OTHER SIDE

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.

INDEPENDENT CONTRACT AGREEMENT

THIS INDEPENDENT CONTRACT AGREEMENT ("Agreement"), dated the _____ day of _____, 20 ____, between ***High Standard Health Services, Inc.,*** a Florida corporation ("hereinafter referred to as "the Agency") and _____, an independent contractor and a Licensed Practical Nurse (" hereinafter referred to as "LPN").

WITNESSETH

WHEREAS, the Agency is licensed by the State of Florida to provide Home Health Services in Miami-Dade and Monroe Counties, Florida;

WHEREAS, the LPN is licensed by the State of Florida to provide Home Health Services to the Agency's patients;

WHEREAS, the Agency desires to engage the LPN, as an independent contractor, to provide Home Health Services to the Agency's patients;

WHEREAS, the LPN agrees to be engaged by the Agency, as an independent contractor, to provide Home Health Services to the Agency's patient that are accepted for care only by the Agency; and

NOW, THEREFORE, it is agreed between the Agency and the LPN that:

1. **COMPENSATION/SERVICES.** The Agency will pay the LPN for Home Health Services rendered pursuant to this Agreement at the rate of $ _____ per hour or per patient visit. The Agency will not pay mileage to the LPN. Payment is based upon actual visit being performed. If the clinical/progress note(s) or other written materials are incomplete, the invoiced visit will not be paid unless, within fifteen (15) days after notice of the deficiencies, the necessary corrections are made by the LPN. No payment will be made for visits where care is refused by the patient.

   The services performed by the LPN will be controlled, coordinated and evaluated by the Agency. Supervision of visits shall be conducted at least monthly by the Agency's Registered Nurse. Performance evaluation of the services provided by LPN will be conducted as per Agency policy.

2. **POLICIES AND PROCEDURES.** The LPN shall render Home Health Services to each patient of the Agency in accordance with the approved standards and practices of his/her profession. In rendering home health services to each of the Agency's patients, the LPN shall participate in interdisciplinary patient care planning, in the development of the plan of care, case conferences, utilization review, and discharge planning with other Agency personnel for the planning and evaluation of patient care. The LPN shall comply on the Agency's policies and procedures including personnel qualifications, HIPAA compliance, participate in staff meetings and in-services training sessions of the Agency.

3. **PROGRESS NOTES.** The LPN shall provide the Agency within on week of each visit with a written or computerize clinical and progress notes, scheduling visits, periodic patient evaluation, and all other documentation required by the Agency policies and procedures to be incorporated in the patient's clinical record maintained by the Agency.

4. **DAILY SUMMARY OF SERVICES.** The LPN shall maintain a written daily summary of his/her patient visits and the Home Health Services which he/she has provided to the Agency's patients. Each patient (or an authorized member of the patient's household) shall sign the Weekly/Visit Time Record form, thereby confirming that the home health services were rendered by the LPN on the date specified therein. If unable to visit patient on the schedule visit, the LPN needs to provide adequate notice to the Agency.

5. **AUTOMOBILE PUBLIC LIABILITY INSURANCE.** Although the Agency is not the LPN's employer and, therefore, cannot be held liable in damages for the LPN's negligence, the LPN hereby undertakes, at his/her expense, to maintain in effect at all times automobile public

liability insurance covering his/her motor vehicle at the following minimum levels: bodily injury of $10,000.00 per person and $20,000.00 per occurrence, and property damage of $5,000.00.

6. **QUALIFICATIONS.** LPN to meet all Agency personnel requirements established by the Agency, including licensure, physical examination, transportation responsibility, orientation, criminal history checks, in-service education, supervision, competency evaluation, and other professional qualifications as may be required. LPN shall abide the specific job description and all the Agency policies and procedures that are applicable to the LPN. The LPN shall perform his/her work in accordance with the approved methods and practice of his/her profession and according to the Code of Ethics of his/her professional association.

7. **PROFESSIONAL PUBLIC LIABILITY INSURANCE.** Although the Agency is not the LPN's employer and, therefore, cannot be held liable in damages for the LPN's negligence, the LPN hereby undertakes, at his/her expense, to maintain in effect at all times professional public liability insurance at the following minimum levels: $1,000,000.00 per person and $3,000,000.00 per occurrence.

8. **NONASSIGNABILITY OF CONTRACTUAL AGREEMENT**. Neither the rights nor the duties prescribed by this Agreement can be assigned by the Agency without the written consent of the LPN. Neither the rights nor the duties prescribed by this Agreement can be assigned by the LPN.

9. **GOVERNING LAW.** This Agreement shall be governed by and interpreted in accordance with the statutory, regulatory and decisional law of the State of Florida.

10. **AMENDMENT.** No amendment to this Agreement shall be effective unless it is reduced to writing and signed by an authorized representative of the Agency and the LPN.

11. **SEVERABILITY.** The illegality, invalidity or unenforceability of any provision of this Agreement shall not affect the legality, validity or enforce ability of any other provision of this Agreement.

12. **DECLINATION OF WORKER'S COMPENSATION INSURANCE.** LPN is an independent contractor per Florida Statutes §440.02(15)(d)(1), and not an employee, of the Agency. The Agency is not require to provide worker's compensation coverage to the LPN.

    Per the Florida Statutes §440.02(15)(d)(b), "..... may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying ANY of the following conditions:"

    a. LPN performs or agrees to performs home health care services for a specific amount of money and controls the means of performing the services.
    b. LPN incurs the principals expenses related to the home health care services that he or she performs or agrees to perform.
    c. LPN is responsible for the satisfactory completion of the home health care services that he or she performs or agrees to performs.
    d. LPN receives compensation for home health care services performed as stated paragraph one (1) per job basis and not on any other basis.
    e. LPN may realize a profit or suffer a loss in connection with performing home health care services.

13. **NO WITHHOLDING OF TAXES.** the LPN is an independent contractor, and not an employee of the Agency, the Agency will not withhold federal income and social security taxes from its payments to the LPN for home health nursing services rendered to the Agency's patients. Moreover, the LPN is an independent contractor, and not an employee of the Agency, the Agency will not match the LPN's social security tax payments to the United State Government.

14. **SOCIAL SECURITY ACT 1861(w)** . LPN agrees to abide on requirement as outline in the Social Security Act 1861(w) which states the following:

Arrangements for Certain Services

1. (w)(1) The Term " arrangements" is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharge the liability of such individual or any other person to pay for the services.

15. None of the following can be applicable for the LPN providing services under this Agreement, if the LPN was:
    a. Denied Medicare or Medicaid Enrollment
    b. Revolved Medicare or Medicaid billing privileges
    c. Excluded or terminated from any federal health care program
    d. Debarred from participating in any government program

16. **TERM OF AGREEMENT.** The term of the Agreement shall commence on the date written above, and shall continue in full force and effect for a period of one year (the "Initial Term"). Upon expiration of the Initial Term, this Agreement shall be automatically renewal, unless thirty (30) days advanced written notice of termination is given by either party to the other. Either party may, at any time during the term of this Agreement, terminate this Agreement upon fifteen (15) days prior written notice based on the other party's breach of this Agreement.

Independent Contractor's signature below indicates the Independent Contractor has read, understood, is satisfied with and agrees to abide by all conditions of this AGREEMENT.

High Standard Health Services, Inc.,
a Florida corporation.

Signed and Sealed the date first written above

_____ _____

Administrator/Alternate Administrator Licensed Practical Nurse

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.,'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. _____

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 ❑ Mailed ❑ Fax ❑ 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. _____

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 ❑ Mailed ❑ Fax ❑ 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:

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 ☐ Hand Hygiene ☐ Bag Technique			
	Initial	**Annual**	**Annual**	**Annual**
Competency Evaluation for HHA (initially and annually) ☐ Hand Hygiene ☐ 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)				

High Standard
HEALTH SERVICES

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)		

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: _____

High Standard
HEALTH SERVICES

LICENSED PRACTICAL NURSE
JOB DESCRIPTION

JOB SUMMARY

The Licensed Practical Nurse provides nursing care assigned by and under the direction of a Registered Nurse who provides on-site supervision as needed, based upon the severity of patients medical condition and the nurse's training and experience.

DUTIES AND RESPONSIBILITIES

1. Prepares and record clinical notes for the clinical records.

2. Reports any changes in the patient's condition to the registered nurse with the reports documented in the clinical records.

3. Provides care to the patient including administration of treatments and medications.

4. Follows any other duties assigned by the registered nurse.

5. Participates in the nursing process by sharing the following:
   a. Planning of patient's care.
   b. Implementing the patient's care plan.
   c. Evaluating the care plan.
   d. Maintaining patient's clinical record by preparing the skilled nursing notes.
   e. Records all pertinent observation and treatments.

6. Notify the Director of Nursing and/or Registered Nurse designee about unusual symptoms and/or changes in condition of patients. Documentation of this change or changes must be noted in the patient's clinical record.

7. Provides for the emotional and physical comfort and safety of the patient.

8. Assist the patient in learning appropriate self-care techniques as order by the patient's physician.

9. Complies with infection prevention and control and assessing and managing pain.

10. Participates in case conferences, meetings, in-service and continuing education.

11. Prepares equipment and materials for treatment.

12. Observing aseptic techniques as needed.

13. Observes confidentiality and safeguards all patient related information.

14. Attends staff meetings and patient care conference as scheduled.

15. Updates personnel file in a timely manner.

16. Respect the patient's and/or cargiver's home at all time.

17. Report any abuse/neglect and/or fraud to the Administrator and/or Director of Nursing.

QUALIFICATIONS

- Completed a practical nursing program.
- Must be licensed in the State of Florida.
- Furnishes services under the supervision of a qualified registered nurse
- Prefers at least one (1) year experience, preferable in community health or home health.

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

REPORTS TO

Director of Nursing/Nursing Supervisor

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

Applicant's Signature _____ Date _____

Print Name _____

High Standard HEALTH SERVICES

LICENSED PRACTICAL NURSE
PERFORMANCE EVALUATION

Name: _____ Date: _____

☐ PROBATIONARY ☐ ANNUAL

PERFORMANCE RESPONSIBILITIES:	BELOW	MEETS	EXCEEDS
Prepares and record clinical notes for the clinical records.			
Reports any changes in the patient's condition to the registered nurse with the reports documented in the clinical records.			
Provides care to the patient including administration of treatments and medications.			
Follows any other duties assigned by the registered nurse.			
Participation in the nursing process by sharing in: planning patient's care, implementing the patient care plan, evaluating the care plan, maintaining patient medical record by preparing clinical notes, and records all pertinent observations and treatments.			
Notify an appropriate person about unusual symptoms and/or changes in condition of patients. Documentation of this change or changes must be noted in the patient's clinical record.			
Provides for the emotional and physical comfort and safety of the patient.			
Assist the patient in learning appropriate self-care techniques as order by the patient's physician.			
Participates in case conferences, meetings, in-service and continuing education.			
Prepares equipment and materials for treatment.			
Observing aseptic techniques as needed.			
Assists the patient in learning appropriate self-care techniques.			
Observes confidentiality and safeguards all patient related information			
Attends staff meetings and patient care conference as scheduled.			
Updates personnel file in a timely manner.			

Comments: _____

_____

_____

Licensed Practical Nurse's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Print Name/Title: _____

High Standard HEALTH SERVICES

COMPETENCY SKILLS/ EVALUATION CHECKLIST SKILLED NURSE

Nurse Name: _____ Title: ❑ RN ❑ LPN Date: _____

Type of Evaluation: ❑ Initial ❑ At Least Every 3 Years ❑ Other (specify) _____

Self Assessment Key: 1 - Proficient 2 - Needs to observe 3 - Never Performed

Method Keys: O = Observed V = Verbal N/A - Not Applicable

COMPETENCY STANDARD	SELF ASSESSMENT			STANDARD MET		METHOD		N/A	Competency Validation Date by supervisor
	1	2	3	YES	NO	O	V		
Clinical Process									
Suctioning									
▸ Nasal									
▸ Oral									
▸ Tracheal									
Urinary catheters									
▸ Foley insertion - Male									
▸ Foley insertion - Female									
▸ Suprapubic - insertion									
▸ Suprapubic - removal									
Enteral Feeding									
▸ Bolus/Intermittent Feed									
▸ Continuous Drip Method									
▸ Removal/insertion PEG Tubes									
Equipment									
▸ IV pumps									
▸ Enteral pumps									

COMPETENCY STANDARD	SELF ASSESSMENT			STANDARD MET		METHOD		N/A	Competency Validation Date by supervisor
	1	2	3	YES	NO	O	V		
▸ Oxygen concentrator									
▸ Oxygen tank									
▸ Nebulizer									
▸ Pulse Oximetry									
Tracheostomy									
▸ Assessment of stoma site									
▸ Care of Stoma Site									
▸ Tracheal suctioning									
▸ Trach tie change									
▸ Apnea alarm intervention									
▸ Loose lead alarm intervention									
Central Lines									
▸ Dressing change									
▸ Heparinization of catheter as per agency protocols/ physician orders									
▸ Injection cap change									
▸ Blood withdrawal									
▸ Medication administration									
▸ Complications and emergency care									
PICC Line									
▸ Assessment of site and dressing change									
▸ Heparinization of catheter									
▸ Blood withdrawal									

COMPETENCY STANDARD	SELF ASSESSMENT			STANDARD MET		METHOD		N/A	Competency Validation Date by supervisor
	1	2	3	YES	NO	O	V		
▸ Complications and emergency care (migration)									
▸ Medication administration									
Diabetes									
▸ Insulin administration									
▸ Foot & skin care									
▸ S/S of Complications									
▸ Instruct patient/care giver in medications, administration and rotation of site									
Irrigation									
▸ Bladder									
▸ Colostomy									
Venipunctures									
▸ Uses appropriate technique									
▸ Observes infection control procedure									
▸ Uses proper equipment/tubes									
▸ Specimens clearly marked									
▸ Calls lab for pick-up									
Wound Care									
▸ Review orders/procedure									
▸ Wash hands before & after contact									
▸ Assembles supples/equipment on clean/sterile surface									
▸ Uses appropriate PPE									

COMPETENCY STANDARD	SELF ASSESSMENT			STANDARD MET		METHOD		N/A	Competency Validation Date by supervisor
	1	2	3	YES	NO	O	V		
▸ Irrigation/cleaning solution marked with initials/ date									
▸ Proper storage of supplies									
▸ Proper disposal of medical waste									
▸ Wound size documented on admission & at least weekly									
▸ Documents patient/care giver instructions; level of comprehension									
Nursing Process									
Plan of Care (POC)									
♦ Reviews POC prior of providing care									
♦ Provides services according to POC.									
♦ Conducts assessment/ reassessment on each visit									
♦ Coordinates care with clinical manager, physician, caregivers and other team members									
♦ Assessing and managing pain.									
Documentation									
♦ Writing is legible, neat									
♦ Provides/documents specific instructions									
♦ Patient education									
♦ Assesses and documents patient's response to treatment									

COMPETENCY STANDARD	SELF ASSESSMENT			STANDARD MET		METHOD		N/A	Competency Validation Date by supervisor
	1	2	3	YES	NO	O	V		
♦ Completes and signs notes, time sheets, etc., in a timely manner.									

Based on this assessment, Nurse is competent to perform all duties: ❑ Yes ❑ No

Requires additional training/experience in the following areas: _____

_____

_____

_____

Documentation of experience/training is filed in individuals' personnel record.

_____
Nurse's Signature/Title

_____
Supervisor's Signature/Title

_____
Print Name

_____
RN License Number

High Standard HEALTH SERVICES

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

High Standard HEALTH SERVICES

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

High Standard HEALTH SERVICES

GLUCOMETER COMPETENCY EVALUATION

Name: _____ ☐ RN ☐ LPN

Type of Evaluation: ☐ Initial ☐ Annual Date Competency Evaluated: _____

Method Keys: O = Observation, D = Demonstration, V = Verbally

PERFORMANCE CRITERIA	DEEMED COMPETENT		METHOD USED		
	Yes	No	O	D	V
Washes hands; dons gloves.					
Turns on glucose meter.					
Prepares meter by validating the proper calibration with strips to be used; checks expiration dates.					
Prepares the finger to be lanced.					
Selects finger; cleanses with alcohol pad.					
Pricks the patient's finger lateral to the fingertip using lancet type device obtaining a large hanging drop of blood.					
Applies blood to strip area.					
For meters with a "wipe system":					
- Times the blood contact with the strip					
- Wipes off blood with a firm stroke using					
- Cotton ball at appropriate time					
- Inserts strip into meter for final result/result					
For meters with a "no wipe system", allows blood to remain on the strip until results appear on meter.					
Covers lanced finger with gauze/tissue until bleeding subsides.					
Disposes of lancet in puncture resistant container.					
Removes glove; washes hands.					
Documents in clinical record as appropriate.					
Additional Comments:					

Staff's Signature/Title: _____ Date: _____

Evaluator's Signature/Title: _____ Date: _____

High Standard HEALTH SERVICES

GLUCOSE METER COMPETENCY TEST

Nurse's Name: _____ ☐ RN ☐ LPN Date: _____

Mark "T" for True and "F" for False for the following Statements:

1. ☐ T ☐ F Glucose control solutions do not have to be dated when first opened.

2. ☐ T ☐ F The test strips should be dated upon opening.

3. ☐ T ☐ F If the meter result does not seem to coincide with the clinical symptoms, repeat the test.

4. ☐ T ☐ F Quality control is not required when the glucose monitors is not used for patient testing.

5. ☐ T ☐ F Quality control test must be done when new test strip bottle is open, if meter falls, if patient's condition contradicts the results or as per manufacturer's guidelines.

Answer the following questions or fill in the blanks:

6. Blood glucose test are performed as ordered by the physician. The results are reported to the physician per specific patient parameters or if less than _____ mg/dl or greater than _____ mg/dl.

   A. < 50 and > 400 mg/dl
   B. < 60 and > 350 mg/dl
   C. < 60 and > 400 mg/dl
   D. < 70 and > 400 mg/dl
   E. None of above

7. Proper sequence of procedure is:

   A. Identify patient, calibrate meter, insert strip, apply blood.
   B. Identify patient, perform hand washing technique, don gloves, validate proper calibration, insert strip, perform finger stick, apply blood, dispose lancet in sharp container, remove gloves, wash hands.
   C. Identify patient, don gloves, validate proper calibration, insert strip, perform finger stick, apply blood, dispose lancet in sharp container, remove gloves, wash hands.

D. Insert strip, apply blood, dispose lancet in sharp container, remove gloves.

8. What are the proper steps that you should follow to perform quality control test?
   A. Check the expiration date on vial of Control Solution
   B. Check the expiration date on the test strips
   C. Press the power button to turn on the meter and check the battery status to ensure adequate power
   D. Select the test strip lot number from the list displayed of the meter
   E. All of the above

9. Quality Control must be performed:
   A. Monthly
   B. As per Manufacturer's Guidelines
   C. Daily
   D. At least weekly
   E. B and D

10. If you get an abnormal results from the glucose meter, you will _____.
   A. Treat patient and repeat the test
   B. Repeat the test
   C. Notify the physician
   D. None of above

Signature: _____ Date: _____

Score: _____ Pass ☐ Fail ☐ Reviewed by: _____

High Standard HEALTH SERVICES

COAG-SENSE MONITORING SYSTEM (PT/INR)
COMPETENCY EVALUATION

Name: _____ ☐ RN ☐ LPN

Type of Evaluation: ☐ Initial ☐ Annual Date Competency Evaluated: _____

Method Keys: O = Observation, D = Demonstration, V = Verbally

PERFORMANCE CRITERIA	DEEMED COMPETENT		METHOD USED		
	Yes	No	O	D	V
Washes hands; dons gloves.					
Turns on meter.					
Take a test strip out of the container. Close the container tightly.					
Prepares meter by validating the proper code number on the test strips container matches with the code chip; checks expiration dates.					
Slide the test strip into the test strip.					
Have patient wash hands with soap and warm water. Dry completely.					
Selects finger; clean the finger with alcohol pad using one side for the first cleaning. Use the second side for the final wipe.					
Dry the fingertip with gauze to remove any excess alcohol.					
Perform testing by removing the cap from the single use lancet. Place it against the fingertip skin. Holding the body of the lancet, push down firmly against the finger to lance the surface of the skin.					
Collect the drop of blood, hold the sample transfer tube between your thumb and forefinger below the bulb, being sure not to cover the air hole in blub. DO NOT SQUEEZE THE BLUB.					

PERFORMANCE CRITERIA	DEEMED COMPETENT		METHOD USED		
	Yes	No	O	D	V
Once the sample is collected, immediately put it into the sample well on the test strip where you see the flashing green light. Gently touch the tip down onto th sample well.					
Slowly squeeze the blub until the blood leaves the tube careful not to introduce air bubbles into the sample. Keep pressure on blub while you pull your hand away to avoid back suction of sample.					
Discard the sample transfer tube in a biohazard waste container.					
When the sample is detected, the meter display "Testing Please Wait".					
When testing is complete, the meter beeps once. The results (INR / PT) are shown on the screen.					
Record the results.					
Remove the test strips. Throw it away in a biohazard collection container.					
Turn of meter.					
Clean the outside of the meter - use a clean damp non-abrasive cloth.					
Remove glove; washes hands or hand sanitize.					
Additional Comments:					

Based on this assessment, Nurse is competent to perform all duties: ❑ Yes ❑ No

Requires additional training/experience in the following areas: _____

_____

_____

_____

Staff's Signature/Title: _____ Date: _____

Evaluator's Signature/Title: _____ Date: _____

COAG-SENSE PT/INR TEST/ ANTICOAGULATION

Nurse Name: _____ ☐ RN ☐ LPN Date: _____

❑ Initial ❑ Annual ❑ Other (specify) _____

Score: _____ Pass: ❑ Fail: ❑

Check "T" (True) or "F" (False)

☐ T ☐ F 1. Blood samples must be applies to the test strip immediately after collection on the blood begins to clot, causing unreliable results.

☐ T ☐ F 2. After removing the test strip from the container, it is important to close the cap tightly.

☐ T ☐ F 3. The test strips are designed for multi-use only.

☐ T ☐ F 4. Control testing confirms the performance of both the meter and the test strips and should be completed for each new lot of test strips.

☐ T ☐ F 5. Immediately after collecting the patient sample, place the tip of the sample transfer tube at a 45° angle into the sample well on the test strip where you see the flashing green lights.

☐ T ☐ F 6. INR is a reporting format that stands for International Normalized Result.

☐ T ☐ F 7. When testing is complete, the meter beeps twice.

☐ T ☐ F 8. Quality control ensures that you are performing the test correctly and that your PT/INR monitor and test strips are working properly together as a system.

☐ T ☐ F 9. The most recent patient result appears first when reviewing memory.

☐ T ☐ F 10. The Coag-Sense monitoring system stores up to 100 results with time and date in its memory.

Choose the one correct answer for each of the following questions.

11. What is used to clean the exterior of the Coag-Sense PT/INR Monitoring System?

A. Antibacterial wipe
B. Clean damp non-abrasive cloth

C. 70% isopropyl alcohol
D. Both B and C are correct

12. Which of the following are common goal INR ranges?
A. 2 - 3
B. 1 - 2
C. 4 - 5
D. Both a and b are correct

13. Which of the following can be used to revise high INR's and bleeding with warfarin?
A. Small (1 - 2 mg) doses of oral vitamin K
B. Transfusions of packed cells
C. Protamine sulfate
D. A and b are both possible options

14. If a patient misses a dose of warfarin, what should be he or she instructed to do?
A. Notify the healthcare provider
B. Take an extra dose the next day
C. Skip the missed dose and continue with the normal dosing regimen
D. Both A and C are correct

15. How does warfarin work to inhibit clot formation?
A. It actually "thins" the blood
B. It antagonizes vitamin K which is needed to form clots
C. It antagonizes vitamin E which is needed to form clots
D. It works with Vital K to inhibit clot formation

Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Print Name: _____

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: _____

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: ☐ 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				
☐ W-4 (Direct) ☐ W-9 (Contract)				
Medical Information Binder/Folder				
Physical Examination	Expires			
PPD/Chest X-Ray	Expires			
Hepatitis Declination Form				
Influenza Vaccination Form (Annually)	Expires			

High Standard
HEALTH SERVICES

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: High Standard Health Services, Inc.
Address of Health Care Provider: 10689 N. Kendall Drive, Suite 310, Miami, Florida 33176

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 *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

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				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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*)	City or Town	State	ZIP Code
10689 N. Kendall Drive, Suite 310	Miami	FL	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
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

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

Refer to the instructions for more information about acceptable receipts.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

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

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

Purpose of Form

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

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

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

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

HSHS-045

High Standard
HEALTH SERVICES

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

Test Date: _____

Date Read: _____

Test Results: _____

CHEST X -RAY

Test Date: _____

Date Read: _____

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

High Standard
HEALTH SERVICES

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

High Standard HEALTH SERVICES

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:

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	☐ Yes	☐ Yes	☐ Yes
Date Printed:			
CPR Card (Back of the card most 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			