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 THE BACK

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 _____

INDEPENDENT CONTRACTOR AGREEMENT

This INDEPENDENT CONTRACTOR AGREEMENT ("Agreement"), is made this _____ day of _____, 20_____ between ***High Standard Health Services, Inc.***., a Florida Corporation (hereinafter referred as "the Agency") and _____ an independent contractor registered to practice ☐ PHYSICAL THERAPY; ☐ PHYSICAL THERAPY ASSISTANT; ☐ OCCUPATIONAL THERAPY; ☐ OCCUPATIONAL THERAPY ASSISTANT; ☐ SPEECH LANGUAGE PATHOLOGIST; ☐ SPEECH LANGUAGE PATHOLOGIST ASSISTANT; in the State of Florida (hereinafter referred as "Contractor").

WITNESSETH

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

WHEREAS, Agency requires appropriately licensed Contractor to visit patients in their place of residence to perform Home Health Services;

WHEREAS, Contractor is appropriately licensed in the State of Florida and agrees to be engaged by the Agency, as an independent contractor to provide Home Health Services to the Agency's patients;

WHEREAS, Contractor shall provide services to those patients that have been accepted for care only by the Agency; and

NOW, THEREFORE, Agency and Contractor agrees:

I. GENERAL PROVISIONS

The purpose of this Agreement is to provide therapy services in patient's place of residence receiving care from the Agency. The Therapy services will be delivered in accordance with the orders of the patient's attending physician and under the established applicable policies of the Agency and may not be altered in type, scope or duration by the Contractor, without the approval of the Agency's staff and patient's attending physician. The supervision of services will be provided by the physician in charge of the patient's medical care and by the appropriate supervisor of the Agency.

II. SERVICES/COMPENSATION

Contractor agrees to provide Therapy Services. Agency will pay Contractor for Home Health Care Services rendered pursuant to this Agreement at the rate of $ _____ per visit. The services performed by the Contractor shall be schedule by the Agency in accordance with the policies and procedures of the Agency. 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 Contractor. No payment will be made for visits where care is refused by the patient.

The services performed by the Contractor will be controlled, coordinated and evaluated by the Agency. Supervision of Contractor will be the responsibility of the Agency or a professional designee. Performance Evaluation of the services provided by Contractor will be conducted as per Agency policy.

III. CONTRACTOR AGREES

1. To provide ☐ Physical Therapy, ☐ Physical Therapy Assistant, ☐ Occupational Therapy, ☐ Occupational Therapy Assistant, ☐ Speech Language Pathologist, ☐ Speech Language Pathologist Assistant Services to the Agency's patients in the Counties of Miami Dade and Monroe Area.

2. To 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.

3. To provide the Agency with a weekly itinerary of services provided, itemizing patient visits and signed by each patient (or an appropriated member of the patient's household), for payment.

4. To participate in interdisciplinary patient care planning, in the development of plan of care, case conferences, utilization review, and discharge planning with other Agency personnel for the planning and evaluation of patient care.

5. To conduct the initial assessment/evaluation within 48 hours (therapy case only) or after the initial visit by the Registered Nurse within 5 days from the initial referral date. (Only applicable for qualified Therapist)

6. To visits the patients within the scheduling parameters given by the Agency. If unable to visit patient on the schedule visit, Contractor need to provide adequate notice to the Agency.

7. To participate in meetings and in-services training sessions of the Agency.

8. 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.

9. To abide the specific job description and all the Agency policies and procedures including personnel qualifications that are applicable to the Contractor.

10. To maintain confidentiality and patient's rights and privacy of all information obtains verbally or writing by patient/caregiver with anyone outside the agency.

- The duties and responsibilities of the Contractor are those in the job description and selected policies of the Agency. The conditions of participation in policies of the Agency have been provided to thereupon signing of this Agreement. The Contractor shall perform his/her work in accordance with the currently approved methods and practice of his/her profession and according to the Code of Ethics of his/her professional association.

- Contractor shall be an independent contractor and not an employee of the Agency under this Agreement and shall maintain a policy of liability insurance in the minimum amount of $1,000,000 to $3,000,000 to cover any claims arising out of the performance of his/her services under this Agreement and shall indemnify, save harmless and defend the Agency for any such claims arising from an act or omission of the Contractor or his/her agents. Contractor assumes the liability in the event of a Worker's Compensation or Malpractice liability claim.

- The Therapist is not entitle to coverage under the Agency's worker's compensation policy, and waives all benefits under the terms of this policy.

DECLINATION OF WORKER'S COMPENSATION INSURANCE. Therapist 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 therapist.

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

- Contractor is responsible to pay for his/her own federal withholding taxes, self employment taxes, liability insurance, worker compensation and any other related expenses on account of amounts paid to him/her by the Agency.

- Contractor shall NOT have any claim under this Agreement, or otherwise, against the Agency for vacation pay, sick leave, retirement benefits, Social Security taxes, Workers' Compensation Taxes, disability or unemployment insurance benefits or employee benefits of any kind.

- **SOCIAL SECURITY ACT 1861(w)** . Contractor 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.

- None of the following can be applicable for the therapist providing services under this Agreement, if the Contractor 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

IV. RESPONSIBILITIES OF THE AGENCY:

1. To provide all records information relevant to the patient for purposes of services being provided by the Contractor.

2. To provide appropriate report forms.

3. To determine in cooperation with the physician and the Contractor the duration of the therapy of each patient.

4. Develop, review and revise the Plan of Care for all the Agency's patients.

5. Conduct orientation to the Contractor to review:
    - Clinical, orientation, personnel, general policy and procedure manual
    - Documentation procedures and requirement
    - Infection Control, and Safety /Risk Management

6. Initiate requests for the services of Contractor in a timely fashion.,

7. Maintain clinical records of patients.

8. To provide scheduling of all daily visits, initial evaluations and supervision by the Director of Nursing or professional designee.

- The Agency will comply with the Civil Rights Act of 1964 (Title VI) to the end that no person in the United States shall, on grounds of race, color, or national origin, be excluded from participation to be denied the benefits of, or be otherwise subjected to discrimination.

- The Agency shall review the Contractor's qualifications and performance ninety (90) days after the initial employment and annually thereafter, in written form and on an informal basis during the contract term.

- Send to the Contractor the completion of each calendar year, a Form 1099 or other appropriate Internal Revenue Services form indicating annual income paid to the Contractor; such form shall also show no Federal or State of Florida withholding or FICA taxes due to the non-employees status of the Contractor.

V. **TERM.** This Agreement shall be in effect from _____ until _____ and, unless terminated by the Agency or the Contractor, shall automatically renew itself for additional one (1) year periods. The Agency and the Contractor are each entitled to terminate this Agreement by affording thirty (30) days written notice to the other party.

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

Signed and Sealed the date first written above

_____	_____
Administrator/Alternate Administrator	Contractor
_____	_____
Print Name/Title	Print Name/Title

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: _____

REGISTERED PHYSICAL THERAPIST (RPT)
JOB DESCRIPTION

JOB SUMMARY

Professional member of patient's treatment team who evaluates, assesses, and delivers services according to a written plan of care approved by a physician. Provides supervision for all services rendered by Physical Therapist Assistants ("PTA"). Supervises certified nursing assistant/home health aide (CNA/HHA) when appropriate. The registered physical therapist ("RPT") shall be accessible at all times by two way communication, which enable the physical therapist to be readily available for consultation during the delivery of care.

DUTIES AND RESPONSIBILITIES

1. Provides physical therapy services as prescribed by a physician which can be safely provided in the home and assisting the physician in evaluating patients by applying diagnostic and prognostic muscle, nerve, joint and functional abilities test.

2. Discusses evaluation with physician to help establish a plan of treatment to assist patient to meet maximum rehabilitation potential.

3. Carry out prescribed treatments; and/or supervise physical therapist assistant in carrying out physical therapy program.

4. Observes and records activities and finding in the clinical record and report to the physician of the patient's reaction to treatment and any changes in the patient's condition or when there are deviations from the Plan of Care.

5. Instructs the patient, patient's family and/or care giver in care and use of physical therapy devices.

6. Instructs other health team personnel including, when appropriate, CNA/HHA and/or care givers in certain phases of physical therapy with which they may work with the patient.

7. Instructs the patient's family and/or care giver on the patient's total physical therapy program.

8. Maintains appropriate documentation of all services provided to the patient.

9. Participates the agency's meeting, case conferences and in-service.

10. Understands and adheres to established polices and procedures.

11. Prepares clinical and progress notes.

12. Helps develop the plan of care and revise as necessary.

13. Updates personnel file in a timely manner.

14. Assists the physician in evaluating level of function and at least every 30 days the qualified therapist functionally reassess the patient for on-going therapy services.

QUALIFICATIONS

1. Must be licensed in the State of Florida.

2. Must be a graduate of approval school.

3. Must have at least one (1) years of experience in physical therapy.

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

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

PHYSICAL THERAPIST
PERFORMANCE EVALUATION

Name: _____ Date: _____

☐ PROBATIONARY ☐ ANNUAL

PERFORMANCE DUTIES AND RESPONSIBILITIES:	BELOW	MEETS	EXCEEDS
Provides physical therapy services as prescribed by a physician which can be safely provided in the home and assisting the physician in evaluating patients by applying diagnostic and prognostic muscle, nerve, joint and functional abilities test.			
Discuss evaluation with physician to help establish plan of care to assists patient to meet maximum rehabilitation potential.			
Carry out prescribed treatments; and/or supervise PTA in carrying out physical therapy program.			
Observes and records activities and finding in the clinical record and report to the physician of the patient's reaction to treatment and any changes in the patient's condition or when there are deviations from the Plan of Care.			
Instruct patient, patient's family and/or care giver in care and use of physical therapy devices.			
Instruct other team members on proper techniques and body mechanics for assisting patient with treatment plan, including home health aide when appropriate.			
Instruct the patient's family and/or care giver on the patient's total physical therapy program.			
Maintain appropriate documentation of all services provided to the patient.			
Participate in case conferences, team meetings, staff meetings, and in-service programs.			
Understands and adheres to established policies and procedures.			
Prepares clinical and progress notes			
Helps develop the plan of care and revise as necessary.			
Updates personnel file in a timely manner.			

COMMENTS: _____

_____

_____

Therapist's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Print Name/Title: _____

High Standard HEALTH SERVICES

COMPETENCY SKILLS/ EVALUATION CHECKLIST PHYSICAL THERAPY

Therapist Name: _____ Title: ❑ PT ❑ PTA Date: _____

Type of Evaluation: ❑ Initial ❑ At least every 3 years ❑ Other (specify) _____

Self Assessment Key: 1 - Proficient 2 - Needs to be 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		
SKILLS									
Evaluation & Treatment of:									
1. ROM									
2. Strength									
3. Balance									
4. Coordination									
5. Functional Mobility									
a. Bed Mobility									
b. Transfer									
c. W/C Mobility									
d. Gait									
6. Sensation									
7. Muscle Tone									
8. Edema									
9. Endurance									
10. Positioning									
11. Home/environmental Safety									

COMPETENCY STANDARD	SELF ASSESSMENT			Standard Met		Method		N/A	Competency Validation Date by supervisor
	1	2	3	YES	NO	O	V		
12. Pt/CG Teaching/HEP									
13. Body mechanics									
Assistive Device									
1. Gait Devices									
a. Walker/Rolling Walker									
b. Crutches									
c. Quad Cane									
d. Straight Cane									
e. Wheelchair									
f. Hoyer Lift									
g. Other:									
2. Exercise Aids									
a. Overhead Pulley									
b. Free Weights									
c. Theraband									
d. Other:									
3. Modalities									
a. Ultrasound									
b. TENS									
c. Hot Pack									
d. Cold Pack									
e. Electro therapy									
f. Therapeutic Massage									
4. Patient Monitors									

COMPETENCY STANDARD	SELF ASSESSMENT			Standard Met		Method		N/A	Competency Validation Date by supervisor
	1	2	3	YES	NO	O	V		
a. Vital Signs/BP									
b. Pulse Oximetry									
5. Splints									
a. AFO									
b. Back Brace									
c. Cervical Collar									
d. Knee Immobilizer									
6. Documentation									
Patient assessment documented									
Treatment provided/patient response documented									
Documentation of specific instruction to patient/caregiver									
Notes are clear, legible, signed & dated									
Assessing and Managing Pain									
Other:									

Based on this assessment, Therapist 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.

_____ Therapist's Signature/Title

_____ Supervisor's Signature/Title

_____ Print Name

_____ RPT 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

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.*

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

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			