

ON CALL HEALTHCARE PROFESSIONALS LLC

1900 ROUTE 70 SUITE 9 MANCHESTER, NJ 08759

Phone 732-657-4400

Fax 732-657-4411

**PLEASE SEND BACK OR HAVE AVAILABLE TO COPY
THE FOLLOWING WITH YOUR APPLICATION**

DRIVERS LICENSE
SOCIAL SECURITY CARD
CURRENT PPD OR X-RAY RESULTS
2 STEP PPD
TITERS (RUBELLA, MUMPS, MEASLES) ACTUAL LAB RESULTS
CURRENT PHYSICAL (WITHIN THE LAST 18 MONTHS)
PROOF OF CAR INSURANCE
CERTIFICATION OR LICENSE (WHICHEVER APPLIES)

THANK YOU AND WELCOME TO ON CALL

ON CALL HEALTHCARE PROFESSIONALS LLC

1900 ROUTE 70 SUITE 9 MANCHESTER, NJ 08759

Phone 732-657-4400

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DATE _____

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

CELL PHONE _____ HOME PHONE _____

SOCIAL SECURITY # _____

PLEASE CIRCLE LPN C.N.A. RN CHHA CMA

LICENSE # _____ EXP. DATE _____

LICENSE-ISSUING AUTHORITY OR BOARD _____

HAVE YOU EVER BEEN ACCUSED OF OR CONVICTED OF ABUSE OR NEGLIGENCE OF A PATIENT yes/no
DATE / BOARD ACTION _____

HAVE YOU EVER BEEN CONVICTED OF A MOTOR VEHICLE CRIME yes/no
DATE / RESULTS _____

PLEASE LIST PREVIOUS EMPLOYER FIRST--- NAMES AND ADDRESSES OF ALL INSTITUTIONS, PATIENTS AND AGENCIES WORKED FOR WITHIN THE ONE YEAR PERIOD PRECEDING THE DATE OF THE APPLICATION. PLEASE STATE REASON FOR LEAVING AND SUPERVISORS NAME THAT WOULD HAVE DIRECT KNOWLEDGE OF WORK PERFORMANCE.

ONLY LIST UP TO 5 PREVIOUS EMPLOYERS IF MORE THAN 5 IN THE PAST YEAR

1.) _____
NAME

ADDRESS & PH. # _____

SUPERVISOR AND REASON FOR LEAVING _____

2.) _____
NAME

ADDRESS & PH. # _____

SUPERVISOR AND REASON FOR LEAVING _____

3.) _____
NAME

ADDRESS & PH.# _____

SUPERVISOR AND REASON FOR LEAVING _____

4.) _____
NAME

ADDRESS & PH.# _____

SUPERVISOR AND REASON FOR LEAVING _____

5.) _____
NAME

ADDRESS & PH.# _____

SUPERVISOR AND REASON FOR LEAVING _____

EMERGENCY CONTACT PERSON: _____
PH. # _____

NAME ADDRESS AND INSURANCE POLICY OF MALPRACTICE INSURANCE CARRIER IF
APPLICABLE _____

I hereby authorize On Call Health Professionals to request and receive any and all information from past employers, not limited to those on this application.

Signature _____ Date ____/____/____

Education

School	Location (mailing address)	Years Completed	Major	Degree or Diploma
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High School

College or Business/Trade School

Military

Have you even been in the Armed Forces?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date entered
Are you now a member of the National Guard?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Discharge date
Specialty			

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1. Have you ever been convicted of, or entered a plea of guilty, no contest, or had a withheld judgment to a felony?

B. If yes please explain:

2. Have you had any accidents during the past three years? How Many?
3. Have you had any moving violations during the past three years? How many?

PLEASE NOTE: It is important that you complete all parts of the application. If your application is incomplete or does not clearly show the experience and/ or training required, your application may not be accepted. If you have no information to enter in this section, please write N/A.



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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **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



Employer Completes Next Page





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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

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

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

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

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	
C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.				
Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)		
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.				
Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative		

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be **UNEXPIRED**

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

LIST A 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 Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2019	
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)				3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code				4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>	
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2019, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here				7	
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.)					
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)				9 First date of employment	
				10 Employer identification number (EIN)	

HEALTHCARE INSTITUTION APPLICANT REFERENCE FORM

Pursuant to the Health Care Professional Responsibility and Reporting Enhancement Act (HCPREA) (P.L.2005,083, effective 2005) Which enables health care entities to exchange certain information regarding health care professionals(2) and in the interest of verifying such information, this form seeks information regarding the health care professional named below. Upon inquiry from a health care entity about a current or formerly employed health care professional health care entities must provide the following information about that health care professional (see N.J.S.A. 26:2H-12.7C): (1) job performance as it relates to patient care based upon job performance evaluations (2) eligibility for re employment at the health care entity; (3) reason for separation for a formerly employed health care professional and (4) copies of any notifications and supporting documentation sent to the New Jersey Division of Consumer Affairs(DCA), the medical practitioner review panel, a professional or occupational licensing board of the DCA within seven years preceding the date of this inquiry (N.J.S.A. 26:2H-12.2a and 12.2b)

Instructions: This reference form was designed so that employers would gain the protections of the State of New Jersey Health Care Professional Responsibility and Reporting Enhancement Act (HCPREA)
We will gather information about your employment within the past seven years.

TO BE COMPLETED BY APPLICANT

Please print full name: _____

Other name employed under: _____

I provided care to clients/patients/residents? ☐ yes ☐ No

CERTIFICATION AND WAIVER

I certify that all information I will provide is true, complete, and correct. Any information provided found to be false, incomplete or misrepresented in any respect, will be sufficient cause to cancel further consideration of this application, or immediately terminate me from the employer's service, whenever it is discovered.

I authorize and request that my former/current employer, listed on this form, complete the form where indicated and release any additional information about my job performance that they may have upon receiving a further inquiry. My signature indicates my approval for this process and for the release of any such information requested during the reference. I waive all claims, any right of action, cause of action or other means of redress related to both the completion of this form by my former/current employer and any further disclosure of information about me and I release all prior employers from whom such information is obtained from any and all liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or any attempts to comply, with this authorization.

I understand that the prospective employer does not unlawfully discriminate in employment and that no question will be used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by applicable local, state, or federal law. Finally to the extent that I have signed with my prior employer any document by which the prior employer promised not to disclose information requested on this form, I waive all rights to enforce such a promise and release my prior employer from any such non-disclosure obligation. I certify that I have read, fully understand, and accept all terms of this statement.

APPLICANT _____ DATE _____

The HCPREA defines "health care entity" as health care facilities licensed pursuant to N.J.S.A. 26:2H-a, state and county psychiatric hospitals and developmental centers, HMO's, carriers offering managed care plans, staffing registries and home care service agencies. (2) The HCPREA defines "health care professionals" as individuals licensed or authorized to practice a health care profession regulated by the DCA or other professional and occupational licensing boards including but not limited to physicians, podiatrists; nurses; pharmacists, physical, occupational and respiratory therapists; psychologists; psychoanalysts; social workers, audiologists and speech-language pathologists; optometrists; ophthalmic dispensers and technicians; dentists, orthotists and prosthetists; marriage and family therapists; veterinarians and chiropractors; and acupuncturists. Health care professionals also include home health aides certified by the Board of Nursing and nurse aides and personal care assistants certified by the Department of Health and Senior Services.

ON CALL HEALTHCARE PROFESSIONALS LLC

1900 ROUTE 70 SUITE 9 MANCHESTER, NJ 08759

Phone 732-657-4400

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Dear Personnel:

The following applicant has applied for a position with On Call Health Professionals. You have been listed as one of their former employers or personal references. Would you please take the time and assist us in obtaining a reference and/or give applicant's dates of employment and job performance. All information received will be kept confidential. Thank you for your time.

Start Date _____ End Date _____ Position Held _____

Is employee eligible for rehire? _____ Comments _____

EMPLOYEE EVALUATION

<u>ATTENDANCE</u>	Excellent	Good	Fair	Poor
<u>PUNCTUALITY</u>	Excellent	Good	Fair	Poor
<u>RELIABILITY</u>	Excellent	Good	Fair	Poor
<u>PERFORMANCE</u>	Excellent	Good	Fair	Poor

Signature _____ Title _____ Date _____

TO BE COMPLETED BY APPLICANT

Applicant's Name: _____

Employer or Personal Reference Name: _____

(please circle one)

Address _____ Ph# _____ Fax# _____

I hereby authorize you to disclose this information to On Call Health Professionals

Applicant Signature _____ Date _____

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Start Date _____ End Date _____ Position Held _____

Is employee eligible for rehire? _____ Comments _____

EMPLOYEE EVALUATION

<u>ATTENDANCE</u>	Excellent	Good	Fair	Poor
<u>PUNCTUALITY</u>	Excellent	Good	Fair	Poor
<u>RELIABILITY</u>	Excellent	Good	Fair	Poor
<u>PERFORMANCE</u>	Excellent	Good	Fair	Poor

Signature _____ Title _____ Date _____

TO BE COMPLETED BY APPLICANT

Applicant's Name: _____

Employer or Personal Reference Name: _____

(please circle one)

Address _____ Ph# _____ Fax# _____

I hereby authorize you to disclose this information to On Call Health Professionals

Applicant Signature _____ Date _____

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HANDBOOK ACKNOWLEDGEMENT

Employment at will-

Employment with On Call Health Professionals LLC and its affiliated companies is "at will" and for an indefinite period. Employees may be separated from the Company at any time, for any reason or no reason at all, with or without cause or notice.

Additionally, On Call Health Professionals employees are not guaranteed work assignments, shifts or any specific number of hours on a weekly basis. Although many employees may work full time hours for an extended period of time during their tenure with On Call Health Professionals, assignment availability will be solely determined by the needs of the client, which are subject to change with or without advance notice.

Acknowledgement of Temporary Employment-

I understand that I am accepting a temporary position with On Call Health Professionals LLC. I further understand that it is my responsibility to contact On Call Health Professionals at the completion of any and all assignment(s). I understand that if I do not contact On Call Health Professionals at that time, I will be considered to have voluntarily separated my employment and that this may have an effect on any benefits for which I am otherwise eligible.

Company Policy and Procedure Acknowledgement-

The purpose of this handbook is to describe the company's current personnel policies and is to provide general guidance only. The company reserves the right to change these policies at any time and without notice. THIS HANDBOOK IS NOT AN EMPLOYMENT CONTRACT. NOR DOES THIS HANDBOOK GUARANTEE ANY FIXED TERMS OR CONDITIONS OF YOUR EMPLOYMENT.

This is to acknowledge that I have received and reviewed a copy of the On Call Health Professionals Employee Handbook, and I hereby agree to follow all of the policies and procedures outlined in the Handbook, including all changes to such policies and procedures as may occur after the date hereof. If at any time I have any questions about On Call Health Professionals policy and procedures, I will promptly ask my staffing or office manager at the office 732 657-4400.

Date _____

Employee Signature

Please Print Name

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COMPANY POLICY AND PROCEDURES

1). A No Call No Show Will Be Considered a Voluntary Quit

a.) This agency is On Call 24/7. If you cannot make a shift YOU ARE REQUIRED TO CALL, DO NOT TEXT IN A LATE OR CALL OUT, YOU MUST CALL this agency regarding said shift as soon as you know you are unable to work or going to be late. Any Employee who does not show for work and does not have "Documentation" from an official state law enforcement, government agency, medical doctor or hospital excusing you from work will be deemed a voluntary quit.

b) Call outs or canceled shifts should be called in to On Call Health Professionals as soon as you know you are unable to fulfill your commitment. A *call out* is considered to be any shift canceled *within* 24 hours of the start of your shift. A *canceled* shift is a shift canceled 25 hours or more prior to the start of your shift. More than three *call outs or cancellations* in any 30 day period without "Documentation" will result in a verbal and written warning. Anyone receiving two verbal and written warnings in one six month period will be terminated. A copy of all warnings will be kept in your Personnel file and may be used in future unemployment disputes.

2). Lateness

a) Being late is getting to a shift more than 15 minutes after the start of said shift. All shifts are 7am-3pm 3pm-11pm 11pm-7am 4pm-8am 7pm-7am 7am-7pm. Employees must notify this agency as soon as you are going to be more than 10 minutes passed the start of your shift. Chronic lateness is considered to be three lates in any 30 day period without documentation. A verbal warning will be issued for any employee who is late 3 times in any 30 day period. If lateness persists, (three lates in any other 30 day period) within six months of your first warning you will be terminated.

3). Status Change-Phone Number Address, Certification or License

Employees are required to update On Call Health Professionals as to any phone number, address change or changes concerning their Licenses or certifications as soon as they occur. Any employee under investigation by any state or local agency will be suspended until a decision is made and found to be in your favor.

4). Confirmation of Shifts

- a) It is the sole responsibility of all employee's to call this agency on a daily basis 4 hours prior to the time a shift is booked. You are responsible for confirming, booking and canceling shifts. This is a part time temporary agency and all shifts are subject to change or be canceled at any time.

5). Insurance

- a) All employees are required to carry automobile Insurance. This policy will be your primary insurance covering you and your passengers during working hours. There will be no coverage offered for employees during their lunch or dinner breaks. Your insurance will be the only coverage during this time.

6). No Lift Policy

- a) This agency has a no lift policy. This means if you have a resident/client who needs to be moved or lifted in any way you must use the appropriate hoist or two person transfer method. On Call Health Professionals will not be liable for anyone sustaining injuries that do not follow these procedures.

7). Time slip Responsibility

- a) It is the responsibility of the employee to have a time slip signed by the appropriate supervisor for each and every shift worked. All Time slips are to be faxed into or brought into ON Call Health Professionals PRIOR TO NOON ON MONDAY FOR THAT WORK WEEK. Or you will not be paid until the following pay date. You will not be paid for any shift worked without a signed time slip.

I hereby acknowledge that I have received, reviewed and understand the Company Policy and Procedures given to me at this time.

EMPLOYEE SIGNATURE

DATE

PRINT EMPLOYEE NAME

**PLEASE READ AND INITIAL ALL OF THE FOLLOWING 7 PAGES AND
SIGN THE LAST PAGE**

CERTIFIED HOME HEALTH AID PERFORMANCE CHECKLIST
EVERYONE IS REQUIRED TO KNOW

UNIVERSAL PRECAUTIONS

1.) **HAND WASHING** – TURN ON WARM WATER FAUCET, WET HANDS, AND LOWER ARMS UNDER RUNNING WATER WITH HANDS HELD LOWER THAN ELBOWS. USE SOAP TO RUB ALL SURFACES OF HANDS. WORK SOAP INTO FOAMY LATHER WHILE RUBBING HANDS TOGETHER USING CIRCULAR MOTIONS. USE CARE BETWEEN FINGERS, CREASES, AND BREAKS IN SKIN, AND UNDER NAILS. SPEND AT LEAST 15-30 SECONDS CLEANING EACH HAND. RINSE HANDS WITH WARM RUNNING WATER, WITH WATER WASHING DOWN HANDS AND OVER FINGERTIPS. DRY HANDS WITH TOWEL, USED TOWEL TO TURN OFF FAUCET, AND DISCARD TOWEL IN RECEPTACLE.

2.) **CARING FOR A CLIENT IN ISOLATION** – WASH HANDS. PICK UP GOWN BY COLLAR AND ALLOW IT TO UNFOLD. PUT ARMS THROUGH SLEEVES AND PULL GOWN UP OVER SHOULDERS. FASTENED NECKTIES AND WAIST TIES, MAKING SURE GOWN LAPPED OVER ITSELF AT THE BACK. PUT ON DISPOSABLE GLOVES BY PULLING CUFF OF EACH GLOVE OVER EDGE OF GOWN SLEEVE, AND INTERLACED FINGERS AS NEEDED TO ADJUST FIT OF GLOVES. DONNED MASK BY POSITIONING OVER NOSE AND MOUTH. BEND NOSE BAR OVER BRIDGE OF NOSE, AND FASTEN IT IN PLACE WITH ELASTIC OR STRINGS. PUT ON GOGGLES AFTER MASK IS IN PLACE.

REMOVAL OF ALL BARRIERS: REMOVE GOGGLES FIRST WITHOUT TOUCHING FACE OR HAIR AT THE ENTRANCE TO THE CLIENT'S ROOM. UNTIE GOWN AT WAIST ONLY. REMOVE GLOVES BY GRASPING OUTSIDE CUFF OF ONE GLOVE AND PULLING GLOVE INSIDE OUT OVER HAND. HOLD REMOVED GLOVE IN SECOND HAND, AND PULL SECOND GLOVE OFF INSIDE OUT OVER FIRST. REMOVE GOWN BY UNTYING GOWN AT NECK AND ALLOWING IT TO FALL FORWARD. SLIDE HANDS THROUGH SLEEVES AND REMOVE THEM WITHOUT TOUCHING OUTSIDE OF GOWN. HOLD GOWN AT INSIDE SHOULDER SEAMS AWAY FROM BODY, TURNED INSIDE OUT AND FOLDED WITH CONTAMINATED SIDE TO THE INSIDE. DISCARD IN PROPER RECEPTACLE. REMOVE MASK BY PULLING ELASTIC OR UNTYING STRINGS WITHOUT TOUCHING OUTSIDE SURFACE OF MASK. DISCARD AND WASH HANDS.

SAFETY PRECAUTIONS

THIS AGENCY HAS A NO LIFT POLICY YOU MUST USE TWO PEOPLE AT ALL TIMES

3.) **USING A MECHANICAL LIFT:** OBTAIN A FUNCTIONING LIFT AND MOVE IT INTO THE CLIENT'S ROOM. PLACE THE BED IN ITS LOWEST POSITION AND PLACE THE ON OR TWO PIECE SLING UNDER THE CLIENT. MAKE SURE THE SLING SUPPORTS THE CLIENT'S SHOULDERS AND BUTTOCKS. HAVE THE CLIENT CROSS ARMS ACROSS OWN CHEST. SECURELY CONNECT THE SLING HOOKS THE LIFT. RAISE THE LIFT TO ELEVATE THE CLIENT ENOUGH TO CLEAR THE BED. MOVE THE LIFT UNTO IT ALIGNS WITH THE CHAIR, LOCK THE WHEELS RELEASE THE PRESSURE VALVE AND LOWER THE CLIENT SLOWLY INTO THE CHAIR. REMOVE THE SLING FROM THE LIFT AND STORE IT IN A CORNER OUT OF TRAFFIC. KEEP THE SLING UNDER THE CLIENT AND POSITION THE CLIENT INTO PROPER BODY ALIGNMENT.

4.) **SIT TO STAND LIFT (SARA LIFT):** APPROACH RESIDENT AND MAKE THEM AWARE OF YOUR INTENTIONS. MANEUVER THE LIFT IN FRONT OF THE RESIDENT AND PLACE THEIR FEET ON THE FOOTREST AND STRAP AROUND THEIR LEGS. SECURE THE SLING AROUND THEIR WAIST AND STRAPS UNDER THE ARMS. HOOK STRAPS ONTO THE ARMS OF THE LIFT. TELL RESIDENT TO HOLD BARS AND PRESS THE UP BUTTON AND THE RESIDENT WILL BE PULLED INTO A STANDING POSITION.

5.) **TRANSFERRING AN IMMOBILE CLIENT FROM BED TO WHEELCHAIR:** OBTAIN AN ASSISTANT BEFORE TRANSFERRING THE RESIDENT. PLACE THE CHAIR PARALLEL TO THE BED BEFORE TRANSFERRING THE RESIDENT. PULL THE BED OUT FROM THE WALL, IF NECESSARY. ONE AID IS TO GO BEHIND THE RESIDENTS SHOULDERS AND UPPER BODY FROM THE OTHER SIDE OF THE BED. IN UNISON AND USING GOOD BODY MECHANICS, AIDS WILL LIFT THE RESIDENTS SHOULDERS AND LEGS. LOWER THE RESIDENT INTO THE CHAIR AND POSITION IN GOOD BODY ALIGNMENT USING PILLOWS AND OTHER DEVICES AS NEEDED.

6.) **HELPING RESIDENT OUT OF BED:** WITHOUT A TRANSFER BELT
PLACE THE BED IN THE LOWEST POSITION AND RAISE THE HEAD OF THE BED.
PLACE THE CHAIR AT A 45 DEGREE ANGLE TO THE BED. PLAN FOR RESIDENT TO GET OUT OF BED ON RESIDENTS STRONG SIDE. SUPPORT THE RESIDENT IN A SITTING POSITION ON THE SIDE OF THE BED WITH FEET DANGLING. IF RESIDENT IS ABLE, HAVE THE RESIDENT PLACE HANDS ON THE AIDS SHOULDERS ON THE MATTRESS ON EITHER SIDE OF THE BODY. PLACE HANDS UNDER RESIDENTS ARMS. PLACE KNEES IN FRONT OF THE RESIDENTS KNEES AND HELP RESIDENT TO RISE TO A STANDING POSITION. PIVOT WITH THE RESIDENT TOWARD THE CHAIR, BEING CAREFUL NOT TO DISLODGE EQUIPMENT OR LINES. USE GOOD BODY MECHANISMS, LOWER THE RESIDENT INTO THE CHAIR SLOWLY AND REPOSITION THE RESIDENT IN PROPER BODY ALIGNMENT. MAKE RESIDENT AS COMFORTABLE AS POSSIBLE.

WITH A TRANSFER BELT: PLACE TRANSFER/ GAIT BELT AROUND RESIDENTS WAIST. STAND IN FRONT OF THE RESIDENT, GRASP THE BELT ON BOTH SIDES OF RESIDENT TOWARD THE BACK. ASSESS WHETHER THE RESIDENT HAS STRENGTH TO STAND. WHEN THE RESIDENT IS READY, HELP TO A STANDING POSITION BY ROLLING BODY AND ARMS UPWARD, PULLING THE RESIDENT WITH THE TRANSFER BELT. PIVOT THE RESIDENT

TOWARD THE CHAIR AND LOWER SLOWLY INTO IT. HAVE THE RESIDENT REACH FOR THE ARM RESTS, IF AVAILABLE, WHILE LOWERING INTO THE CHAIR.

DAILY PERSONAL CARE

7.) HELPING THE RESIDENT WITH A TUB BATH OR SHOWER:

ASSES THE CLIENT'S CAPACITY FOR SELF-CARE. ASSES THE TOLERANCE FOR ACTIVITY, COGNITIVE STATE, AND MUSCULOSKELETAL FUNCTION. MAKE SURE THE BATHROOM HAS BEEN PREPARED AND THE TUB OR SHOWER CLEAN. PLACE MAT ON FLOOR BY TUB OR SHOWER. ADJUST THE ROOM TEMPERATURE SO THE RESIDENT IS NOT CHILLED DURING THE BATH. PUT ON CLEAN GLOVES. ASSES THE RESIDENTS ABILITY TO ACCESS THE BATHROOM. KEEP THE CLIENT COVERED WITH A BATH BLANKET WHILE PREPARING THE WATER. PROVIDE PRIVACY FOR THE RESIDENT. TEST THE WATER TEMPERATURE BEFORE THE RESIDENT GOES INTO TUB OR SHOWER. BATHTUBS SHOULD BE FILLED NO MORE THAN $\frac{1}{2}$ WAY, AND AT 105 DEGREES FAHRENHEIT. PROVIDE ASSISTANCE FOR THE RESIDENT WHILE RESIDENT ENTERS TUB OR SHOWER. ASSESS WHETHER THE RESIDENT COULD SAFELY BATHE WITHOUT ASSISTANCE. IF RESIDENT CAN REMAIN UNATTENDED, SHOW RESIDENT HOW TO USE THE CALL SIGNAL AND SAFETY BARS. PLACE ALL BATH SUPPLIES WITHIN EASY REACH. CHECK EVERY 10 MIN. TO SEE IF RESIDENT NEEDS ASSISTANCE, IF LEFT ALONE. IF NOT ABLE TO BATHE INDEPENDENTLY REMAIN WITH RESIDENT AT ALL TIMES. ASSIST AS NEEDED WITH BATHING. WASH ANY AREAS THAT THE RESIDENT IS UNABLE TO REACH. WATCH CLOSELY FOR SIGNS OF DIZZINESS OR WEAKNESS WHILE CLIENT IS IN THE TUB OR SHOWER AND IMMEDIATELY ON EXITING. HELP RESIDENT OUT AND ASSIST WITH DRYING. CONTINUE TO ASSIST WITH DRESSING AND GROOMING.

8.) PERFORMING FOOT AND NAIL CARE: WASH HANDS AND DONNE GLOVES IF NECESSARY. FILL A BASIN WITH WARM WATER. TEST THE TEMPERATURE WITH BATH THERMOMETER OR BY INSERTING ELBOW. PLACE A WATERPROOF PAD UNDER THE BASIN. PLACE RESIDENTS FOOT OR HAND IN THE BASIN. LET SOAK. RINSE AND REMOVE FROM THE BASIN. PLACE ON TOWEL. DRY GENTLY. WHILE OTHER FOOT OR HAND IS SOAKING PROVIDE NAIL CARE FOR THE FIRST HAND OR FOOT. CAREFULLY CLEAN UNDER NAILS WITH COTTON TIPPED APPLICATOR. USE ORANGE STICK TO REMOVE DEBRIS. PUSH THE CUTICLE BACK WITH THE ORANGE STICK BEING CAREFUL TO AVOID INJURY TO SKIN UNDER THE NAIL RIM. BEGIN WITH THE LARGE TOE OR THUMB, CLIP THE NAILS STRAIGHT ACROSS. CLIP SMALL SECTIONS AT A TIME, STARTING WITH ONE EDGE AND WORK ACROSS. FILE AND SHAPE EACH NAIL WITH AN EMERY BOARD. AFTER COMPLETING THE MANICURE OR PEDICURE APPLY LOTION AND POWDER. REPEAT PROCEDURE WITH OTHER HAND OR FOOT. HELP CLIENT TO A COMFORTABLE POSITION, REMOVE ALL EQUIPMENT WASH HANDS AND DOCUMENT CARE.

9.) SHAMPOOING RESIDENT IN BED: PLACE WATERPROOF PADS UNDER THE RESIDENTS HEAD AND SHOULDERS. REMOVE PINS, CLIPS, OR BARRETTES. PLACE THE BED IN ITS FLAT POSITION. PLACE A SHAMPOO BOARD OR INFLATED BASIN UNDER THE RESIDENTS HEAD. DRAPE TOWEL OVER RESIDENTS SHOULDERS. UNCOVER THE RESIDENTS UPPER BODY BY FOLDING THE LINENS DOWN TO WAIST LEVEL. PLACE A BATH BLANKET OVER THE RESIDENTS CHEST. PLACE A WASHCLOTH OVER RESIDENTS EYES. SHAMPOO UNDER RESIDENTS HEAD. USE A WATER PITCHER TO POOR WATER OVER THE HAIR UNTIL IT IS THOROUGHLY WET. ENSURING THAT THE WATER IS COMFORTABLY WARM. APPLY SMALL AMOUNT OF SHAMPOO. WORKING FROM HAIRLINE TO NECK LINE. RINSE WITH WARM WATER. APPLY A SMALL AMOUNT OF CONDITIONER IF NEEDED. MAKE A TURBAN BY WRAPPING TOWEL AROUND RESIDENTS HEAD. PAT OR TOWEL DRY UNTIL THE HAIR IS FREE OF EXCESS MOISTURE. CHANGE THE RESIDENTS GOWN AND LINEN IF THEY ARE WET. DRY AND STYLE RESIDENTS HAIR. HELP RESIDENT INTO A COMFORTABLE POSITION AND REMOVE ALL EQUIPMENT FROM ROOM.

Code of Conduct

To function effectively, every organization must develop policies and procedures to ensure that co-worker's and the Company's rights are respected. Generally, no conduct by an employee that is disruptive, unproductive, immoral, unethical or illegal will be tolerated.

The following is list of some examples of, but not inclusive of the rules in which we must follow. Violation or occurrence of the following will lead to disciplinary action, which based on the circumstances of each individual case, could result in a corrective action up to and including termination. The Company will consider an employee's job performance, prior violation of our work rules, and other relevant circumstances in determining whether to counsel, provide a warning, suspend or terminate an employee. The supervisor and the Company's management will decide which corrective action is appropriate, which may include termination of the employee.

- A. Insubordination
- B. Unauthorized use, possession or distribution of intoxicants or drugs on our premises or attempting to perform their work duties while under the influence of intoxicants, drugs or alcohol.
- C. Falsifying reports or records, including time sheets, attendance records or bills.
- D. Sleeping on the job
- E. Fighting on the job or the threat of bodily harm to co-workers or patients.
- F. Destruction, damage or misuse to Company property or equipment or that of any other co-worker or patient.
- G. Unauthorized use, possession or taking of any Company or other person's property
- H. Continued/excessive absence or tardiness, abandoning your job, leaving the job without permission, unreported absence
- I. Insufficient productivity or unacceptable work quality
- J. Violation of safety or operating rules
- K. Carrying or possessing weapons of any kind on the Company's property or while engaged in any assignment.
- L. Gambling on Company property or while engaged in any assignment
- M. Interrupting, disrupting or jeopardizing the Company's personnel, patient or services
- N. Dishonesty
- O. Smoking in "No Smoking" areas
- P. Signing in or out for another employee or asking another employee to falsify your attendance record
- Q. Not abiding by our Sexual Harassment policy
- R. Failure to provide requested information to assure the Company's compliance with your Personnel file or the completion of a patient file in a timely manner

THIS HANDBOOK DOES NOT CONTAIN REFERENCES TO ALL COMPANY POLICY AND PROCEDURES. EMPLOYEES ARE ASKED TO SEE THEIR SUPERVISOR REGARDING ANY ISSUE THAT MAY ARISE AND IS NOT REFERRED TO IN THIS HANDBOOK. AS PREVIOUSLY STATED, THIS HANDBOOK DOES NOT REPRESENT OR GUARANTEE EMPLOYMENT, NOR DOES THIS HANDBOOK SERVE AS A CONTRACT OF EMPLOYMENT AND IS TO BE USED ONLY AS A REFERENCE TO CERTAIN COMPANY POLICY AND PROCEDURES.

HIPPA Privacy Rule Compliance Training

Privacy is one of our most important rights. Our customers trust us with their personal information and expect that we will keep it private and confidential. A breakdown in confidentiality can embarrass and hurt both our customer and the agency.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) ensures that customers have the right to control who will see their protected identifiable health information. Only the customer and individuals that the customer authorizes have access to their information. There are civil and criminal penalties for violating HIPPA.

Key Concepts You Should Know:

Protected Health Information

1. Name
2. Address
3. Social Security Number
4. Employer
5. Relatives Names
6. Date of Birth
7. Phone/Fax #
8. E-Mail Address
9. Medical Record #
10. Member Account #
11. Certificate #
12. Photographs
13. Codes
14. Fingerprints
15. ANYTHING ELSE that may identify the individual

Keeping confidential information private is not new to long term care. Our Medical ethics has always emphasized the importance of confidentiality. Keeping personal information private is central in providing quality care. If our customers do not trust us they may not communicate important medical information and changes in their condition may go undetected.

Who has the right to access information?

Foremost, the customer and his /her representative always has the right to access their own information (with very few exceptions)

Family and Friends can be informed of the customer's health care, if the customer has asked for them to have access. This does not require a written authorization. The customer can always be asked if it is acceptable to share their information with their family. Health care workers can access customer's protected health information, if they have a "need to Know" This means that the information is necessary to provide care. Must follow the simple "need to know" rule. If you need to see customer information to perform your job, as doctors nurses, pharmacists, can's, and billing clerks do, you are allowed to do so.

However even doctors and nurses don't have the right to look at all the information about every resident. In addition to these rights, our customers can request and amendment, or change to the information that is contained in their medical record. If customers think the record is inaccurate, they can submit proposed amendments for review.

All customers have a right to ask where their personal information was release. Maintaining accurate details regarding the release of such information is critical to quality care.

If you overhear or see something you shouldn't:

Sometimes you will overhear information. Sometimes you will see something discarded in the trash. Even that is private. Keep all information to yourself.

As healthcare providers involved with long term and private care, we have an important responsibility to stay informed in order to provide quality health care while respecting and protection our customer's privacy.

ON CALL HEALTH PROFESSIONALS

I hereby acknowledge that I have reviewed and understand the
HIPPA April 2003 Privacy Act and reviewed the Safety
Precautions, Universal Precautions, Personal Care and
Conduct Instructions as part of my employee orientation
packet.

DATE _____

EMPLOYEE NAME-PLEASE PRINT

EMPLOYEE SIGNATURE

On Call HealthCare Professionals LLC

1900 Route 70 Suite 9 Manchester, NJ 08759

Phone 732-657-4400

Fax 732-657-4411

I agree to the terms below as an applicant of On Call HealthCare Professionals LLC.

This agreement is made and entered into by all applicants and employees for the one hundred eighty (180) day period following the end of employment or following the last shift worked with On Call HealthCare Professionals LLC.

Because On Call HealthCare Professionals has made a substantial investment in recruiting and orientating said employees, no employee shall seek employment from On Call HealthCare Professionals LLC contracted partners. Whether it be, (BUT NOT LIMITED TO) Long Term Care Facilities, Assisted Livings Facilities, Hospice Companies, or Private Care cases for a period of one hundred eighty (180) days from the employees last day of work or shift worked for On Call HealthCare Professionals LLC.

If in fact the employee does seek employment or gain employment with one of On Call HealthCare Professionals LLC contracted partners within the 180 days following their last day of employment from On Call HealthCare Professionals LLC, said employee will be responsible for the buyout fee.

The fees are as follows:

Companions/Certified Nurse Aides/Certified Home Health Aides/Certified Medication Aides: \$1,500.00.

Licensed Practical Nurse: \$3,000.00

Registered Nurse: \$5,000.00

Buyout Fee is payable to On Call HealthCare Professionals LLC and due in full immediately.

I agree to these terms as an applicant / employee of On Call HealthCare Professionals LLC.

Applicant / Employee Signature

Date

Witness

Date

ON CALL HEALTHCARE PROFESSIONALS LLC

1900 ROUTE 70 SUITE 9 MANCHESTER, NJ 08759

Phone 732-657-4400

Fax 732-657-4411

SEXUAL HARRASSMENT POLICY

Sexual harassment can occur in a variety of circumstances, including but not limited to the following:

- A. The victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.
- B. The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, a co worker, or a non employee.
- C. The victim does not have to be the person harassed but could be anyone affected by the offensive conduct.
- D. Unlawful sexual harassment may occur without economic injury to or discharge of the victim.
- E. The harasser's conduct must be unwelcome.

What constitutes sexual harassment can vary depending on the situation and people involved. It might include behaviors like unwelcome sexual advances, requests for sexual favors, direct or indirect threats or bribes for sexual activity, sexual innuendos and comments, sexually suggestive jokes, unwelcome touching or brushing against a person, pervasive displays of materials with sexually illicit or graphic content, and attempted or completed sexual assault.

Under no circumstances will this behavior be tolerated or accepted. Any employee accused of sexual harassment will be suspended pending an investigation and terminated immediately if the allegations are found to be true. All findings will then be reported to the proper board or licensing body for further action.

Sexual harassment is a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964. Very generally, "sexual harassment" describes unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature. Title VII is a federal law that prohibits discrimination in employment on the basis of sex, race, color, national origin, and religion.

INITIALS _____ DATE _____

ON CALL HEALTHCARE PROFESSIONALS LLC

1900 ROUTE 70 SUITE 9 MANCHESTER, NJ 08759

Phone 732-657-4400

Fax 732-657-4411

CODE OF CONDUCT

To function effectively, every organization must develop policies and procedures to ensure that co worker's and the company's rights are respected. Generally, no conduct by an employee that is disruptive, unproductive, immoral, unethical or illegal will be tolerated.

The following list are some examples of, but not inclusive of the rules in which we must follow. Violation or occurrence of the following will lead to disciplinary action, which based on the circumstances of each individual case, could result in a corrective action up to and including termination. The company will consider an employee's job performance, prior violation of our work rules, and other relevant circumstances in determining whether to counsel, providing a warning, suspend or terminate an employee. The supervisor and the company's management will decide which corrective action is appropriate, which may include termination of the employee.

- A. Insubordination
- B. Unauthorized use, possession, or distribution of intoxicants or drugs on our premises or our partnered premises or attempting to perform their work duties while under the influence of intoxicants, drugs or alcohol.
- C. Falsifying reports or records, including time sheets, attendance records or bills
- D. Sleeping on the job
- E. Fighting on the job or the threat of bodily harm to co workers or patients
- F. Continued excessive absence or tardiness, abandoning your job, leaving the job without permission, unreported absence
- G. Unauthorized use, possession or taking of any Company or other persons property
- H. Continued excessive absence or tardiness, abandoning your job, leaving the job without permission, unreported absence
- I. Insufficient productivity or unacceptable work quality
- J. Violation of safety or operating rules
- K. Carrying or possessing weapons of any kind on the company's property or while engaged in any assignment.
- L. Gambling on company property or while engaged in any assignment
- M. Interrupting, disrupting or jeopardizing the company's personnel, patient or services
- N. Dishonesty
- O. Smoking in non designated areas
- P. Signing in or out for another employee or asking another employee to falsify your attendance record
- Q. Not abiding by our sexual Harassment policy
- R. Failure to provide requested information to assure the company's compliance with your personnel file or the completion of a patient file in a timely manner

Physical Examination Form

Employee/Student Name: (Last) _____ (First) _____

As a condition for employment as a Health Care employee/student, you must successfully pass an examination to determine that you're in good health and free of tuberculosis. In addition, your physician must provide the results of your 2 step TB skin test or chest x-ray, as well as the date on which it was preformed and read.

TO BE COMPLETED BY PHYSICIAN

Date of Examination: ____/____/____ Allergies: _____ MMR Date: ____/____/____

Height: _____ Weight: _____ Respiration: _____ B/P _____ Temperature: _____ Pulse: _____

TB Test #1 Date Done: _____
Date Read: _____
Result: _____ MM

TB Test #2 Date Done: _____
Date Read: _____
Result: _____ MM

If positive, chest x-ray Date Done: _____ Result: _____ Date TB prophylaxis initiated: _____

SYSTEM	YES	NO	If abnormal, comments:
Skin			
Eyes			
Ears			
Nose			
Throat/Dental			
Cardiovascular			
Respiratory			
Gastro Intestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Other			

ANY LIMITATIONS OF PHYSICAL ABILITY: EX. The ability to lift 50 lb, bending/squatting ability to lift 5lb overhead.

I hereby certify that I have examined the above applicant and that the above is a complete and accurate record of my examination. I hereby state that this employee is in good physical and mental health, which is required to perform the essential functions of a home health care employee.

Print Name: _____

Lic No: _____

Signature: _____

Address: _____

Telephone: _____

QUESTION AND

NAME: _____

All employees/volunteers who tested positive or did not receive PPD tests must complete this form annually along with bringing in a negative X-ray report within the past 5 years.

EMPLOYEE SECTION:

1. Have you been exposed to anyone with TB?
2. Do you cough frequently?
3. Do you cough up blood or blood - tinged sputum?
4. Do you ever have chest pain?
5. Have you experienced an unexpected weight loss?
6. Are you excessively fatigued for no apparent reason?
7. Do you have frequent fevers?
8. Do you have general malaise?
9. Do you have night sweats?
10. Do you have back pain unrelated to an injury?
11. Do you have blood in your urine?

(Click Yes or No)

[illegible]

Signature: _____

Date: _____

AN REVERSE:

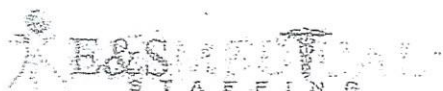
Does this staff member/volunteer require a physician referral?

15/11 15/11

Comments: _____

Signature of RN _____ Date: _____

Date: _____



Questions? Let us know!
 Phone: 845-565-8608 Fax: 845-562-8863
 Email: Eric@esmedicalstaffing.com

Certified Nursing - Assistant Proficiency Skills Checklist

Please check the appropriate boxes to describe your experience level with each skill listed below.

Date _____ Name (Print) _____

Signature _____

Key To Competency Levels

- 0 — No Experience
- 1 — Minimal experience, need review and supervision, have performed at least once
- 2 — Comfortable performing with resource available
- 3 — Competent to perform independently and safely
- 4 — Expert, able to act as resource to others

	0	1	2	3	4
Patient Rights					
Communicates and obtains information while respecting the rights and privacy and confidentiality of information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)					
Involves the patient and family and respects their role in determining the nature of care to be provided, including Advance Directives.					
Complies with nursing staff responsibility included in the hospital policy related to Organ Donation.					
Meets patient and families needs regarding communication, including interpreter services.					
Provides accurate information to patient and families in a timely manner.					
Vital Signs and Weights					
Obtaining and Recording:					
BP, including Orthostatic					
Pulse, Radial					
Temperature, Oral					
Temperature, Rectal					
Temperature, Axillary					
Temperature, Tympanic					
Respirations					
Weight, Pounds and Kilograms					
Recognizing Cardiac Arrest					
Activating Code Team					
Bringing Emergency Equipment to Room					
Providing Appropriate Code Support					
Use of Electronic VS equipment:					
Automatic BP machine (Dynamap)					
Electronic Thermometer					
Applying Oximeter					
Scale Use:					
Standing					
Chair					
Bed					
GI / GU					
Report Abnormal Findings					
Bowel Function					
Bladder Function					

	0	1	2	3	4
Administering Enemas:					
Tap Water					
Fleets					
Return Flow					
Placing and Removing Bed Pan					
Clamping Catheter					
Emptying Foley Bag					
Placing Condom Catheter					
Emptying and Replacing Ostomy Bag (Established Ostomy)					
Nutrition					
Estimating Intake					
Setting up for Meals					
Feeding Patients					
Aspiration Precautions					
Nourishments					
Counting Calories					
Fluid Restriction					
NPO					
Specimens					
Collecting Stool					
Collecting Sputum					
Collecting Urine:					
Clean Catch					
24 Hour					
Labeling Specimens and Preparing for Transport					
Hygiene/Skin					
Risk Factors for Skin Breakdown					
Observing Pressure Points for Redness or Breakdown					
Bathing /Daisy Hygiene:					
Bathing (Shower /Tub /Arjo)					
Oral Care, Including Patients who are NPO, Comatose, Patients with					
Pen Care					
Foot Care for Patients with Impaired Circulation or Sensation					
Incontinence Care					
Shaving and Precautions					
Reducing Pressure and Friction					
Use of Pressure and Friction Reduction Devices:					
Special Beds /Mattresses					
Heels and Elbow Protection					
Foot Cradles					
Use of Shower Chair					
Use of Bath /Shower Boat					
Infection Control					
Proper use of Specific Barrier Methods:					
Gloves					
Gown					
Mask /Goggles					
Reverse Isolation					
Body Substance Isolation					
TB Precautions					
MRSA Precautions					
Hand Washing					
Infectious /Hazardous Waste Disposal					
Supply /Equipment Disposal					
Use of Disposable Thermometer					
Use of CPR Mask/Bag					

Confidential

Safety and Activity	0	1	2	3	4
Determining Patient ID					
Identifying Safety Hazards					
Determining Need for Additional Help					
Assessing Safety and ADL Needs					
Recognizing Abuse: Substance, Physical, Emotional, etc.					
Maintaining Clean, Orderly Work Area					
Disposing of Sharps					
Handling Hazardous Materials					
Proper Body Mechanics					
ROM Exercises					
Transfer ^g to Bed, WC, Commode, etc					
Turning and Positioning					
Patient Safety Module					
Reporting Broken Equipment					
Responding to Safety Hazards					
Use of Hoyer Lift (Dextra /Maxi)					
Bed Operation					
Use of Wheel Locks					
Use of Alarms: Bed, Patient, Unit					
Use of Call Light					
Documenting Use of Restraints					
Application of Restraints:					
Belt Including Seat Belt					
Wrist /Ankle					
Vest					
Use of Transfer Belt					
Use of Gait Belt for Ambulation					
Use of Seizure Pads					
Care Routines					
New Admissions and Transfers:					
Inventory and Disposition of Belongings, Use of Checklist					
Room Orientation, Call Bell					
Basic Comfort Measures					
Post-op Patients:					
Transferring into Bed					
Call Bell					
Assist with Turns					
ROM Exercises					
Maintaining O2 Therapy:					
Replacing Mask or Nasal Cannula if Needed					
Notifying Nurse of Problems					
Basic Comfort Measures					
Preparation For and Transfer to SNF:					
Early Bath					
Preparing Belongings					
Preparing for and Explaining Routines to Patient					
Post Mortem Care					
Use of Incentive Spirometer					
Removing /Replacing:					
Antiemetic Stockings					
Sequential Stockings					
Communication					
Using Appropriate Abbreviations					
Identifying Unusual Patient Incidents that Require Reporting					

	0	1	2	3	4
Communicating to RN:					
Changes in Patient Condition					
Patient Needs, Complaints and Concerns					
Unusual Incidents					
Recording and Reporting:					
Vital Signs					
Bathing /Hygiene					
Turning and Repositioning					
Ambulation and Activity					
Diet intake, Calorie Count					
Bowel Movements					
I & O:					
Shift Volumes and Totals					
Marking and /or Measuring Amount of Urine, Gastric Fluid, NG Drainage, Emesis, Diarrhea					
Reinforcing RN Teaching With Patient					
Selecting and Using Forms Appropriately					
Using Alternate Communication Tools /Devices					
Unit Activity					
Identifying Unusual Incidents on the Unit that Require Reporting					
Locating and Using Appropriate Reference Materials: Hospital, Patient Care and					
Charging for Patient Care Items					
Completing Risk Management Reports as Needed					
Obtaining Needed Supplies and Equipment					
Reporting and Following up on Faulty Equipment and Supplies					
Using Telephone System					

Experience Areas, Record Years/ Months of Previous Experience. (Check all that apply.)					
<input type="checkbox"/> Acute	Years:	Months:	<input type="checkbox"/> Long Term Care	Years:	Months:
<input type="checkbox"/> Ambulatory Care	Years:	Months:	<input type="checkbox"/> Other	Years:	Months: