LPN

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 **Fax 732-657-4411**

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

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 hear by 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____/____/_____

ON CALL HEALTHCARE PROFESSIONALS LLC

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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.

Education				
School	Location (mailing address)	Years Completed	Major	Degree or Diploma
High School				
College or Business/Trade School				

Military			
Have you even been in the Armed Forces?	☐ Yes	☐ No	Date entered
Are you now a member of the National Guard?	☐ Yes	☐ No	Discharge date
Specialty			

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

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 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				
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

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)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	B. Date of Rehire *(if applicable)* 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

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

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 ☐ Single ☐ Married ☐ 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. ▶ ☐	

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.) ▶ **Date** ▶

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 (HCPRREA) (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 cate entities must provide the following information about that health care professional (see N.J.S.A...526:2H-12.7C): (l)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 (HCPRREA)
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 HCPRREA 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 HCPRREA 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 **Fax 732-657-4411**

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

ATTENDANCE	Excellent	Good	Fair	Poor
PUNCTUALITY	Excellent	Good	Fair	Poor
RELIABILITY	Excellent	Good	Fair	Poor
PERFORMANCE	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

ATTENDANCE	Excellent	Good	Fair	Poor
PUNCTUALITY	Excellent	Good	Fair	Poor
RELIABILITY	Excellent	Good	Fair	Poor
PERFORMANCE	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_____

ON CALL HEALTHCARE PROFESSIONALS LLC

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Phone 732-657-4400 **Fax 732-657-4411**

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 herby 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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Phone 732-657-4400 **Fax 732-657-4411**

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 hoyer 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 ½ 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 CON TAIN 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 hob, 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 herby 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: _____

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TB QUESTIONNAIRE

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:

(Check Yes or No)

		Yes	No
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?		

Signature: _____ Date: _____

RN REVIEW:

Does this staff member/volunteer require a physician referral? ☐ Yes ☐ No

Comments: _____

Signature of RN _____ Date: _____

Continuous Care
LICENSED PRACTICAL NURSE
Job Description

PURPOSE:
This Hospice LPN is pivotal in identifying the physical, psychological, social and spiritual needs of the patient and family. He/she, under the direction of the RN, Case Manager, initiates the appropriate interventions in support of the patient and family. The LPN also follows a comprehensive and responsive plan of care. Works under the supervision of a Registered Nurse.

REPORTS TO: Registered Nurse

QUALIFICATIONS:
- Currently licensed to practice nursing in the state of New Jersey
- Excellent Communication Skills
- Access to reliable transportation
- Understanding of Hospice philosophy and needs of terminally ill
- At least one year of clinical experience

RESPONSIBILITIES *(including, but not limited to):*

- Ensure and document care and interventions provided as well as appropriate use of medication, durable medical equipment and supplies.
- Provides accurate documentation with visit itineraries to the office. Documentation must be completed according to hospice, state and federal guidelines/standards. If documentation is not prepared and turned in according to these guidelines. I understand that my compensation for this work will be withheld until I have completed the required documentation.
- Follows RN care plan appropriately. Reports any changes in the patient's status to the RN case manager.
- Reports necessary information to the Clinical Director/Team Leader/RN case manager and other members of the IDT.
- Responds to issues as clinically appropriate.
- Works in conjunction with RN case manager.

- Customer Service
  - Promotes a customer service oriented approach to care & customer relationships.
  - Adheres to Grace Best Practices.
  - Participates in customer conflict resolution.

I hereby agree to fulfill this position with my best efforts, having read and understood the foregoing job description.

_____ Date: ___/___/___

Signature of License Practical Nurse

Date Created: June 2013

grace
Healthcare Services

Raritan Plaza III
105 Fieldcrest Ave - Ste 402
Edison, NJ 08837-3622
Phone: 866-447-0246
Fax: 732-395-4233
www.gracehcs.com

Contracted Staff Completed In-Service Sheet

Print Name: _____ **Year:** _____

- Hospice Philosophy _____
- Pain Management / Scope of Practice _____
- HIPAA _____
- Infection Control _____
- Bloodborne Pathogens _____
- Fire Safety _____
- Tuberculosis Awareness _____
- Elder Abuse & Neglect _____
- Safety Orientation _____
- Other (RN | LPN only - Pain Management Overview) _____
- Other Alzheimers Disease _____
- Other Behavior Management _____

Agency Name: On Call Health Care Professionals

Authorized Representative: _____

CHHA/LPN Signature: _____

Note: 12 hours of in-service is mandatory annually

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Competency Checklist – Skilled Nursing

LPN Name: _____ DOH: ____/ ____/ 20____

Registered/Licensed Nurse Self Assessment Skills Competency

Agency name:

The following skills competency checklist is designed to provide Grace Healthcare with an overview of the areas in which you are competent (you are able to verbalize and/or perform the skill correctly without coaching) and those where you may need additional education. **It is the responsibility of the orientee to complete the self-assessment portion of the checklist and review the form with your mentors. The mentor must initial the form when the competencies have been reviewed. The completed checklist is to be given to your supervisor to be included in your personnel file.**

SKILLS COMPETENCIES	Self assessment key: 1. No experiences 2. May require some supervision/assistance 3. Competent			COMPETENCY ACHIEVED DATE AND INITIALS	
				Skill Verbalized	Skill Demonstrated
SKILLS	1	2	3		
INFECTION CONTROL					
Standard Precautions					
Aseptic Technique/Hand Washing					
Glucometers					
Caring for Patients in Isolation/signage					
Linen Handling					
Nurse Bag Protocol					
Collecting and disposing of body wastes					
Cleaning equipment between patients					
REPORTING MEDICAL / HEALTHCARE ERRORS					
Incident Reports					
Patient Complaints					
Adverse Drug Reactions					
MISCELLANEOUS					
Restraint Application / Necessary Documentation					
Intermittent Catheter Program					
Care and use of leg bags / bedside drainage bags					

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Competency Checklist – Skilled Nursing

LPN Name: _____ DOH: ____/____/ 20___

SKILLS COMPETENCIES	Self assessment key: 1. No experiences 2. May require some supervision/assistance 3. Competent			COMPETENCY ACHIEVED DATE AND INITIALS	
				Skill Verbalized	Skill Demonstrated
SKILLS	1	2	3		
Supra-pubic catheter care					
External catheters					
Dysphasia Precautions					
Care of Colostomy / Ileostomy					
Wound Care					
Drainage Tubes					
Respiratory Therapy					
O_2 Mask					
O_2 Cannula					
Non-rebreathing masks					
Oximeter					
Wall and portable suction.					
Incentive spirometry					
Portable O_2 tanks					
Ventilator Care					
Tracheostomy Care					
IV Therapy					
Peripheral Lines					
PICC Lines					
Central Lines					
Implanted Pumps					
TPN					

Mentors please sign below if you participated in the Orientation program.

Name: _____ Initials: _____

Name: _____ Initials: _____

Name: _____ Initials: _____

Vitas of NJ

Human Trafficking for Agencies

Program	66, 65, 67	Start Time	
Team		Stop Time	
Date	5/9/2018	Place	

EMPLOYEES ATTENDING:

	Employees Attending & Discipline	Employees Signature	Time

Vitas

Abuse and Neglect for Agencies

Program	66, 65, 67	Start Time	
Team		Stop Time	
Date	5/11/2018	Place	

EMPLOYEES ATTENDING:

	Employees Attending & Discipline	Employees Signature	Time

Vitas

Child and Elder Abuse for Agencies

Program	66, 65, 67	Start Time	
Team		Stop Time	
Date	5/11/2018	Place	

EMPLOYEES ATTENDING:

	Employees Attending & Discipline	Employees Signature	Time

VITAS® Healthcare

Agency Staff Record – Job Qualifications & Hospice Orientation

Agency Name:	On Call HealthCare Professionals	Agency Employee Discipline	X

Agency Employee legal name and address:

First Name	Middle Name	Last Name	DOB	Address	City	State	Zip
X							

Agency Manager – please check the following indicating that valid document(s) received and training of Agency employee completed prior to VITAS patient assignment:

Qualifications verified:

All Staff	☐ Background check	☐ Initial competency evaluation
	☐ Annual competency evaluation	☐ Infection Control Training
	☐ Certificate of completion of state required training (such as Alzheimer's training)	
	☐ Applicable health clearances (such as TB…)	
Nurse / Therapist	☐ Current Professional license and verification of good standing	
	☐ Current CPR card (VIPU nurse)	
	☐ Discipline specific Self Assessment Checklist (CT program)	
Home Health Aide	☐ Certificate or diploma demonstrating classroom and practical home health aide training under instruction of a licensed RN with a combined total of at least 75 hours	
	☐ Current CPR card (VIPU)	
	☐ Evidence of rolling annual 12 hours continuing education	

List additional staff certifications or specialty skills:

Overview of Hospice and VITAS

	☐ VITAS Values	☐ Service / Levels of Care

Practice

	☐ Communication	☐ Pain and Symptom Management
	☐ Care at the Time of Death	☐ Patient and Family Education: WINK
	☐ CPR Policy	☐ Restraint and Seclusion training (VIPU direct care staff)

Documentation

	☐ VITAS Standards	☐ Start & End time
	☐ Hospice Plan of Care	☐ Procedures for Documentation

Work Rules

	☐ Name Badge	☐ Scope of Practice
	☐ Dress Code, Grooming & Appearance	☐ No Sleeping On Duty
	☐ No Smoking	☐ On-Duty Meal & Rest Periods (Continuous Care

Compliance Program

	☐ Compliance Defined	☐ Risk Areas	☐ Code of Conduct
	☐ Protecting Patient Privacy	☐ Communication/Compliance Hotline	

I verify that I have provided valid documentation and received training regarding the above information. I authorize VITAS to utilize this information to verify that I am not excluded from Federal health care programs.

Agency Employee Signature	Printed Name	Date
X	X	X

I verify that this employee has provided valid documentation and has received training regarding the above information and is competent to provide care to VITAS patients and families.

Agency Manager Signature	Printed Name	Date

VITAS Manager: Add name of qualified staff to *Agency Staff log* or place unqualified staff name on 'do not use' section of list and submit this completed form to business manager for retention in agency contract file; refer to **VMS Agency Staff** as needed

Caring Hospice Services

CARING HOSPICE SERVICES

CONFIDENTIALITY OF INFORMATION

Personal information about any patient, family, staff, contractor or board member must be regarded as confidential. Information on patient medical records, telephone conversations, family histories, disease or illness must never be communicated to anyone other than the professional and paraprofessional personnel who require such information to treat the patient/family. Information regarding types of cases or internal problems must not be discussed with individuals outside of Caring Hospice, personnel or other organizations, the news media, or the general public, except by those individuals who are directed to communicate such information at the appropriate times. Breach of this policy of confidentiality may lead to disciplinary action, including dismissal.

I, _____, certify that I understand the policy of Caring Hospice Services regarding Confidentiality of information and I agree to comply with this policy.

SIGNATURE _____ DATE _____

7-17-19

SERENITY
Hospice Care

General Orientation

I have received a review and/or copy of:

Title	Signature
Mission Statement	
Philosophy	
Vision	
Objectives	
Services	
Privacy Practices	
Job Description	
Pain Management	

_____

PRINT NAME

TITLE_____ DATE_____

SERENITY
Hospice Care

AGENCY EMPLOYEE REQUIREMENTS

Employee Name: _____

Title: _____ DOB: _____

Annual Staff Education	2015	2016	2017	2018
Infection Control				
Bloodborne Pathogens and Tuberculosis				
Universal Precautions				
Patient Rights				
Restraints and/or Seclusion				
HIPPA				
Fire Safety				
Hazardous Materials				
Body Mechanics				
Pain				
Annual Education; Employee Orientation				

Employee Health Records	Date	Results
MMR		
PPD		
Physical		

Copy of License Attached?: _____

NEW JERSEY STATE POLICE, STATE BUREAU OF IDENTIFICATION (SBI)

NAME CHECK ONLY
REQUEST FOR CRIMINAL HISTORY RECORD INFORMATION FOR A NONCRIMINAL JUSTICE PURPOSE

(TYPE OR PRINT ALL INFORMATION)

A. COMPLETE NAME AND ADDRESS OF REQUESTER

This will be used as a mailing label - Type/Print legibly

ADDITIONAL DATA (Optional)

B. SUBJECT OF THE REQUEST

NAME (Including Maiden Name)

(Last Name) (Maiden Name) (First Name) (Middle)

SBI NUMBER (If Known)

ADDRESS

(Number) (Street) (City) (State)

FBI NUMBER (If Known)

DOB	SEX	RACE	SOCIAL SECURITY NUMBER (If furnished)
(Month) (Day) (Year)			

C. AUTHORITY AND PURPOSE OF THE REQUEST

(Check appropriate box to indicate the type of request and supply all other required information.)

☐ Noncriminal justice purpose by a governmental entity of this State, the federal government, or any other state for any official governmental purpose, including but not limited to employment, licensing, and the procurement of services pursuant to N.J.A.C. 13:59-1.2(a)(1).
(Authorization By Subject Of Request And Privacy Act Notification; Certification of Requester are required.)

☐ Noncriminal justice purpose by a person or non-governmental entity of this State, or any other State, for purposes of determining a person's qualifications for employment, volunteer work, or other performance of services pursuant to N.J.A.C. 13:59-1.2(a)(2).
(Authorization By Subject Of Request And Privacy Act Notification; Certification of Requester are required.)

☐ Noncriminal justice purpose by a private detective licensed by the Division of State Police pursuant to N.J.A.C. 13:59-1.2(a)(4) and N.J.S.A. 45:19-8 et.seq., for purposes of obtaining information in furtherance of the performance of their statutorily authorized functions, as specifically enumerated by N.J.S.A. 45:19-9(A) 1 to 9.
(Certification Of Requester is required. However, section D (3) and (4) DO NOT apply.)

(OVER)