

CONDITIONS OF EMPLOYMENT

Welcome to Health Force, and industry leader in home care and supplemental staffing. Adherence to our work policies and procedures will help you achieve a successful career with Health Force. Please note the following:

We will do our best to find suitable job assignments which will take full advantage of your qualifications and experience. Health Force hires their employees on a per-diem (as needed) basis, therefore, we cannot guarantee employment. It is the responsibility of you, the employee, to call the office weekly with your availability.

If your work performance falls below Health Force standards, you will be subject to discipline and possibly termination. Unacceptable work performance includes excessive cancellation and tardiness as well as "no shows". (Remember that you must contact the Health Force office as soon as you are aware of a change in your availability).

You are not permitted to accept or hold money or other valuable property for any client.

Unless a signed transportation release is on file in our office, you are not permitted to drive patients in their cars, family member's cars, or your own car. You may, however, accompany the patient in a vehicle as long as you assume the role of a passenger.

Health Force office staff will be glad to answer any questions you have about your employment with Health Force.

Health Force provides a weekly newsletter that is issued with your employee checks or direct deposit stubs as the means of communication between the office staff and field employee. It is a valuable communication tool to keep the employee current regarding Health Force events as well as any important policy changes. The weekly newsletter is considered to be required reading, therefore it is considered an expectation and the employee's responsibility to read the newsletter on a weekly basis.

An employee handbook will be provided for you the day of your orientation with full details of this form and additional policies and procedures.

I understand that my employment may be terminated by Health Force at any time, without liability to me for wages except as have been earned by me at the date of such termination.

Indicate below by your signature and the date that you fully understand and intend to adhere to all Health Force policies/procedures listed on this form.

Employee Signature

Date

Health Force Representative

Date

HEALTH FORCE REQUEST FOR TIME OFF POLICY

I understand that if I am assigned to a case and work regular hours on this case, I must submit, in writing (form provided), two (2) weeks advance notice that I need time off. It is also my responsibility to submit in writing, two (2) weeks advance notice, if I choose to be removed from a case. I understand that failure to follow this policy could result in disciplinary action including termination.

Employee Signature

Date

HEALTH FORCE CONFIDENTIALITY AGREEMENT

Staff and physicians alike share the responsibility - the responsibility of safeguarding information regarding our patients.

In addition, Health Force (or the “Company”) has adopted certain policies regarding the confidentiality of information relating to the operation of Health Force.

Finally, an employee has a legal duty to his/her employer not to disclose confidential business information to anyone outside th Company.

In order to ensure that you recognize this responsibility for safeguard information regarding our patients, and regarding the Company, and agree to assume it is in your position with Health Force, we ask that you read carefully and sign the following statement:

I, _____, having accepted a position with Health Force, hereby acknowledge that I am fully aware of the confidential nature of my position. I also acknowledge my obligation to Health Force and its patients to safeguard all information regarding patients and their affairs which I receive and with which I am entrusted. I understand I am to release such information only on the authorization of both the patient and my supervisor.

I further acknowledge that Health Force prohibits the discussion of salaries, bonuses or any other form of compensation of any employee in the Company.

I further acknowledge that Health Force prohibits the discussion of Company business and future direction of the Company (including discussions at community meetings), whether professional or social.

I further acknowledge that Health Force prohibits the discussion of Company policies or procedures, including giving out copies, with anyone not employed by Health Force. If it becomes necessary to give out copies of Company policies or procedures, I acknowledge that I must receive approval from the Director of Clinical Services or the Administrator before the information is released.

I further acknowledge that Health Force prohibits discussion of Company business with any member of the press, whether local, national, or international. I agree to refer any inquiries from the press the Administrator.

I further acknowledge that upon the expiration or termination of my employment with Health Force, I will never reveal any of such confidential information.

Employee Signature

Date







March 15, 2010

I attest that Health Force has provided updated contact information for Interpreter Services for the Hearing-impaired, Discrimination for the Limited English Proficient Clients, non-Discrimination Policy, Equal Employment Opportunity and No retaliation Policy.

Employee _____



DEPARTMENT OF CHILDREN & FAMILIES

ATTENTION	AVISO	ATANSYON
<p>INTERPRETER SERVICES FOR THE HEARING-IMPAIRED</p> <p>IF YOU ARE DEAF OR HARD OF HEARING, YOU ARE ENTITLED TO INTERPRETER SERVICES AT NO COST TO YOU.</p> <div style="text-align: center;">  </div> <p>PLEASE INFORM STAFF OF THE SERVICES NEEDED.</p>	<p>SERVICIOS DE INTERPRETE PARA PERSONAS CON SORDERA O PROBLEMAS AUDITORIOS</p> <p>SI USTED ES SORDO O NO OYE BIEN USTED TIENE DERECHOS A SERVICIOS DE INTREPRETE GRATIS</p> <div style="text-align: center;">  </div> <p>POR FAVOR DE INFORMAR AL PERSONAL SI NECESITA ESTE SERVICIO</p>	<p>INTEPWETE POU MOUN KI BEBE OUBYEN MOUN KI MAL POU TANDE</p> <p>SI OU PA PALE ANGLE, SI OU BEBE (SOUD) SI OU MAL POU TANDE, SI JE OU PA BON, OU KA JWEN MOUM POU EDE-W TRADWI EPI INTEPWETE POU OU GRATIS.</p> <div style="text-align: center;">  </div> <p>TANPRI MANDE POU YO EDE-W</p>
<p>IN ADDITION, SERVICES MAY BE ACCESSED THROUGH FLORIDA RELAY by dialing 7-1-1 or calling toll free:</p> <div style="text-align: center;">  </div> <p>1-800-955-8770 (Voice) 1-800-955-8771 (TTY) 1-877-955-8773 (Spanish) 1-877-955-8707 (French Creole)</p>	<p>ADEMAS, PUEDE USAR LOS SERVICIOS DE RELEVO LLAMANDO AL 7-1-1 o los siguientes números gratis:</p> <div style="text-align: center;">  </div> <p>1-800-955-8770 (Ingles) 1-800-955-8771 (TTY) 1-877-955-8773 (Español) 1-877-955-8707 (Creole Frances)</p>	<p>Ou Kapab joyn lot sèvis Ou Kap rele nimerwo 7-1-1 (nan tout eta-Laflorid la)</p> <p>Oubyen rele telefòn gratis sa yo:</p> <div style="text-align: center;">  </div> <p>1-800-955-8770 (Vwo) 1-800-955-8771 (TTY) 1-877-955-8773 (Spanol) 1-877-955-8707 (Francals oubyen Creole)</p>
<p>Any person who believes that he/she has been discriminated or retaliated against in violation of Section 504 of the Rehabilitation Act of 1973 and/or the Americans with Disabilities Act of 1990 may file a complaint by writing or calling:</p> <p>Department of Children & Families Office of Civil Rights 1317 Winewood Blvd., Building 1, Room 110 Tallahassee, Florida 32399-0700 (850) 487-1901 TTY (850) 922-9220</p>	<p>Cualquier persona que crea que él/ella ha sido discriminado en violación de la Sección 504 del Acta de Rehabilitación del 1973 y/o de la Ley de Americanos con Discapacidades del 1990 pueden archivar una queja escribiendo o llamando:</p> <p>Department of Children & Families Office of Civil Rights 1317 Winewood Blvd., Building 1, Room 110 Tallahassee, Florida 32399-0700 (850) 487-1901 TTY (850) 922-9220</p>	<p>Nenpòt moun, ki santi ke li te viktim diskriminasyon oubyen entimide nan Seksyon 504 Lwa 1973 sou Reyabilitasyon an (Rehabilitation Act of 1973) oubyen Lwa 1990 sou Americans with Disabilities Act of 1990. Pou-ou enregistre yon plent kontakte:</p> <p>Department of Children and Families Office of Civil Rights 1317 Winewood Blvd., Building 1, Room 110 Tallahassee, Florida 32399-0700 (850) 487-1901 TTY (850) 922-9220</p>

United States Department of Justice (USDJ)
Civil Rights Division
Office of the Assistant Attorney General
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20531
(202) 514-4609 (voice) (202) 514-0711 (TDD)
(202) 307-2839 (Fax)

United States Department of Health and Human Services (HHS)
Attention: Office for Civil Rights
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909
(404) 662-7881 or TDD (404) 331-2867



DEPARTMENT OF CHILDREN & FAMILIES

NON-DISCRIMINATION POLICY	POLITICA DE NO DISCRIMINACION	RÈGLEMAN KONT DISKRIMINASYON
<p>No person shall, on the basis of race, color, religion, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to unlawful discrimination under any program or activity receiving or benefiting from federal financial assistance administered by the department and its providers. Any applicant or participant who believes he or she has been denied services may file a complaint with the United States Department of Health and Human Services, Office of Civil Rights or the Department of Children and Families, Office of Civil Rights within 180 days of the alleged violation.</p>	<p>Ninguna persona será, por su raza, su color, su religión, origen nacional, el sexo, la edad, ni la incapacidad será excluida a participar en, ser negado los beneficios de, o ser sujeto a la discriminación ilegal bajo cualquier programa o actividad recibiendo o beneficiándose de la ayuda financiera federal administrada por el departamento y sus proveedores. Cualquier solicitante o participante que cree que él o ella han sido negados dichos servicios pueden archivar una queja o reclamo con el Ministerio de Sanidad y Seguridad Social de los Estados Unidos, la Oficina de Derechos Civiles o el Departamento de Niños y Familias, la Oficina de Derechos Civiles dentro de 180 días de la infracción pretendida.</p>	<p>Okenn moun pa dwe, poutèt baz, kouè, relijyon, nasyonallite, sèks, laj, ouswa andikape, èskil ou refize benefis si ou viktim diskriminasyon nan kelkeswa pwogram oswa aktivite ki resewva benefis ekonomik nan Depatman Federal ak sipote-l yo. Nenpòt aplikasyon oswa patisipant ki santi ke yo te refize-sèvis ka pote plint. Pou pote plent pou vyolasyon Règleman sa a. Kontakte Sekretè Depatman Sante ak Sèvis Himen nan adres sa : United States Department of Health and Human Services (HHS), oubyen Depatman Timoun ak Fanmi, Office of Civil Rights (Biwo Sivil) nan yon delè de 180 jou apati dat zak diskriminasyon-an fèt-la.</p>
<p>EQUAL EMPLOYMENT OPPORTUNITY POLICY</p> <p>The Department of Children and Families assures to each applicant or employee an equal employment opportunity without regard to a person's age, race, color, sex, religion, national origin, political opinions or affiliations, marital status or disability, except when such requirement constitutes a bona fide occupational qualification necessary to perform the tasks associated with the position. Such equal employment opportunity will be attained using both objective and subjective recruitment, examination, appointment, training, promotion, demotion, compensation, retention, discipline, separation, or other employment practice.</p>	<p>POLITICA de OPORTUNIDAD DE EMPLEO IGUALITARIA</p> <p>El Departamento de Niños y Familias asegura a cada solicitante o el empleado una oportunidad de empleo igualitaria sin consideración a la edad de una persona, la raza, el color, el sexo, la religión, origen nacional, opiniones o afiliaciones políticas, el estado civil o la incapacidad, menos cuando tal requisito constituye un requisito profesional auténtico necesario para realizar las tareas asociadas con la posición. Tal oportunidad de empleo igualitaria será alcanzada utilizar ambas contratación objetiva y subjetiva, el examen, la cita, la instrucción, la promoción, la degradación, la compensación, la retención, la disciplina, la separación, u otra práctica del empleo.</p>	<p>RÈGLEMAN EGALITE NAN TRAVAY</p> <p>Depatman Timoun ak Fanmi bay chak aplikasyon oswa anplwaye menn chans pou travay san gade sou kesyon laj, ras, kouè, sèks, relijyon, nasyonallite, opinyon politik, si you moun marye ou andikape; e septe si pozisyon-an ta mande yon kalifikasyon espesyal nesèse pou fè travay la. Prinsip travay sa ka realize sou divès objektif e sibjektif, randevou, fòmasyon, pwomosyon, rekòmandasyon, konpansasyon, revokasyon, disiplin, separasyon, ak tout lòt regle travay.</p>
<p>Any applicant or employee who believes that he or she has been discriminated against may file a complaint with the Florida Commission on Human Relations (FCHR) or with the Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700, within 365 days of the alleged violation. Complaints can also be filed with the United States Equal Employment Opportunity Commission (EEOC), within 300 days of the alleged violation.</p>	<p>Cualquier solicitante o el empleado que cree que él o ella han sido discriminados puede archivar en contra un reclamo con la Comisión de Florida de Relaciones Humanas (FCHR) o con el Departamento de Niños y Familias, la Oficina de Derechos Civiles, 1317 Winewood Bl., Tallahassee, Florida 32399-0700, dentro de 365 días de la infracción pretendida. Reclamos también pueden ser archivados con la Comisión de Oportunidad de Empleo Igualitaria de Estados Unidos (EEOCC), dentro de 300 días de la infracción pretendida.</p>	<p>Nenpòt moun, aplikasyon oswa anplwaye ki santi ke li te viktim diskriminasyon. Si ou vie pote plent nan Komisyon Laflorid sou Relasyon Imen 2009 Apalachee Parkway suite 100, Oakland Building Tallahassee, Florida 323001. Telefòn (850) 488-7082. Oubien kontakte Depatman Timoun ak Fanmi, Office of Civil Rights (Biwo Dwo Sivil) nan 1317 Winewood Boulevard, Building 1, Room 110, Tallahassee, Florida 32399-0700. Telefòn (850) 487-1901. Ou dwe pote plent nan yon delè kip pa depase 365 jou apati dat zak diskriminasyon-an fèt-la. Ou ka pote plent tou nan biwo komisyon Etazini pou Egalite nan Travay (U.S. Equal Employment Opportunity Commission). Ou dwe pote plent nan yon delè kipa depase 300 jou apati dat zak diskriminasyon-an fèt-la.</p>
<p>NONRETALIATION POLICY</p> <p>No person shall be retaliated against, harassed, intimidated, threatened, coerced or discriminated against for making a charge, testifying, assisting or participating in any manner in an investigation, proceeding, or hearing for opposing alleged unlawful discriminatory practices prohibited by state and federal laws.</p>	<p>POLITICA de NO RETALIACION</p> <p>Ninguna persona será vengada en contra, acosado, intimidado, amenazado, obligado ni discriminado en contra para hacer una carga, testificar, ayudar ni tomando parte en cualquier manera en una investigación, continuar, ni oyendo para oponer las prácticas discriminatorias, ilegales y pretendidas prohibidas por estado y leyes federales.</p>	<p>REGLEMAN KONT VANJANS</p> <p>Okenn moun pa dwe sibi vanjans, atake, entimidè, menase, oswa diskrimine, paske li te pote plent, temwaye, ou bien patisipe yon jan Kèlkonk nan rechèch ki ap fèt pou anpeche pratik diskriminasyon ki kont la lwa e ki entedi nan Eta Laflorid e Federal.</p>
<p>In accordance with Federal law and U.S. Dept. of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. (Not all prohibited bases apply to all programs.)</p> <p>To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD), USDA is an equal opportunity provider and employer.</p>	<p>De acuerdo a lo establecido por las leyes Federales y el Dep. de Agricultura de los EE.UU. (USDA, siglas en Ingles), se prohíbe a este organismo la discriminación por raza, color, origen nacional, sexo, edad, religión, creencias políticas, o impedimentos de las personas. (No toda las bases de prohibición se aplican a todos los programas.)</p> <p>Para presentar una queja sobre discriminación, escriba a USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410, o llame al (202) 720-5964 (voz y TDD). USDA es un proveedor y empleador que ofrece oportunidad igual a todos.</p>	<p>Depatman Agrikilti ameriken (USDA) entèdi ankenn diskriminasyon baze sou ras moun, kouè, peyi orijin, sèks, relijyon, laj, opinyon politik, andikap, pwogram li yo ak nan aktivite li yo. (Tout baz yo pa aplike pou tout pwogram yo.)</p> <p>Pou pote plent pou diskriminasyon, ekri USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410, USA,</p> <p>oswa rele (202) 720-5964 (telefòn ak vwa epi ak sèvis pou moun sòd). USDA ofri tout moun mennm sèvis la ak mennm opòtinite travay.</p>

United States Department of Justice (USDOJ)
 Civil Rights Division
 Office of the Assistant Attorney General
 950 Pennsylvania Avenue, N.W.
 Washington, D.C. 20531
 (202) 514-4609 (voice) (202) 514-0711 (TDD)
 (202) 307-2839 (Fax)

United States Department of Health and Human Services (HHS)
 Attention: Office for Civil Rights
 Atlanta Federal Center, Suite 3B70
 61 Forsyth Street, S.W.
 Atlanta, Georgia 30303-8909
 (404) 562-7881 or TDD (404) 331-2867

HEALTH FORCE EMPLOYEE BADGE POLICY

Health Force policy states, in recognition of State of Florida regulations, that any employee entering the home of a client or nursing facility for our agency is required to have on them a visible, unexpired ID badge issued by our Human Resource Staff.

If at anytime you misplace your badge, please take the time to stop in the office and have another made for you, you must be wearing it on the outside of your clothes at all times. This is a requirement for your continued employment at Health Force.

I HAVE READ AND UNDERSTAND THE POLICY AND HAVE RECEIVED MY ID BADGE TODAY:

EMPLOYEE SIGNATURE

DATE

Review of Health Force Policy
Please Read and Initial

1. Dress Code and ID Badge
 1. Scrubs
2. Shoes must have enclosed toes, Nonskid soles are encouraged
3. Clean, pressed lab coat may be worn.
4. Jewelry is to be worn sparingly
5. Fingernails are to be clean and short
6. Employee is to wear appropriate identifying name tags issued by Health Force.

Office and On Call Hours (only call 239-275-4747 For on Call)

Health Force office hours are 8:30 AM to 5:30 PM Monday through Friday, Health Force phones are turned over to our ON CALL person who is a Health Force employee after hours to answer any emergency that may arise. ON CALL is for EMERGENCY ONLY SERVICE, which include call offs, and medical emergencies. Anything else can be address during office hours. Please be courteous to the On Call Coordinator, do not leave non emergency messages on the phone in the middle of the night... THIS IS NOT A ANSWERING SERVICE.....

CALL OFFS

PLEASE give adequate time to fill your visit or shift. Health Force policy is 4 hours, unless it is an emergency. CALL THE OFFICE NOT THE PATIENT..

PAPERWORK/PAYROLL

ALL paperwork is due on by Tuesday 9AM anything received after 9 AM will be processed for payroll the following week there is no excuse (use the drop box on nights and weekends.)

FAXING notes: Any employee that faxes their notes is responsible to follow up with a phone call to the office to guarantee we receive the notes. Also original notes are due in the office by the end of that week.

All paperwork requires patient or caregiver signature.. Also make sure all notes have patient labels. Labels are available in the office.

Scheduling

All employees are required to show up 10 minutes prior to their shift to receive patient report. Please be courteous to your co-workers. Employees are only paid for the hours they were scheduled. If you need to stay late or are going to be late please notify the office or on call coordinator.

Personal Phone Use

All phones should be kept on vibrate .. No personal phone calls or texting during your shift. Limit phone use for emergencies only..

Name _____ Date _____

EMPLOYMENT REFERENCE REQUEST

HEALTH FORCE HOME HEALTH
5276 SUMMERLIN COMMONS WAY, #702
FORT MYERS, FLORIDA 33901

MAIN # (239)275-4747

FAX # (239)275-4210

Applicant's Name: _____

Address: _____

I hereby authorize the company named below to release information requested on this reference request.

Applicant's Signature

Date

To Whom It May Concern:

The above named applicant has indicated that he/she was previously or is currently employed by your company. Your prompt reply to the evaluation below would be greatly appreciated and will be held in the strictest of confidence...

Company Name: _____

Telephone #: _____ Fax #: _____

Attention: _____

To Be Completed by Reference Company Representative:

Dates of Employment: From _____ To _____

Position: _____ Would you rehire: ()Yes ()No

Duties/Responsibilities: _____

Reason for Leaving: _____

Any other comments related to this applicant's capabilities: _____

Name of person completing reference: _____

Title: _____

Date: _____

**** (Please fax back to (239)275-4210) ****

EMPLOYMENT REFERENCE REQUEST

HEALTH FORCE HOME HEALTH
5276 SUMMERLIN COMMONS WAY, #702
FORT MYERS, FLORIDA 33901

MAIN # (239)275-4747 FAX # (239)275-4210

Applicant's Name: _____

Address: _____

I hereby authorize the company named below to release information requested on this reference request.

Applicant's Signature

Date

To Whom It May Concern:

The above named applicant has indicated that he/she was previously or is currently employed by your company. Your prompt reply to the evaluation below would be greatly appreciated and will be held in the strictest of confidence...

Company Name: _____

Telephone #: _____ Fax #: _____

Attention: _____

To Be Completed by Reference Company Representative:

Dates of Employment: From _____ To _____

Position: _____ Would you rehire: ()Yes ()No

Duties/Responsibilities: _____

Reason for Leaving: _____

Any other comments related to this applicant's capabilities: _____

Name of person completing reference: _____

Title: _____

Date: _____

** (Please fax back to (239)275-4210) **

HEALTH FORCE

**EMPLOYEE EMERGENCY CONTACT
INFORMATION**

Employee: _____

Contact Name: _____

Relationship: _____

Address: _____

Contact Home Phone: _____

Contact Work Phone: _____

Health Force
5276 Summerlin Commons Way, #702
Fort Myers, Florida 33907

HEALTH FORCE DISASTER POLICY

Living and working in Southwest Florida exposes all of us to certain weather related hazards, in particular, tropical storms and hurricanes. We all need to be aware of these possible threats to health and safety to ourselves and our families and plan for emergencies.

As employees of a health care agency, we also need to keep in mind the safety and well being of our patients. As part of that responsibility we need to plan for emergencies that would affect our patients who are at greatest risk due to age and infirmity.

Some of our patients will leave the area in the event of a hurricane, but others either choose to remain or are unable to leave. Many of our patients are isolated and have no family in the area. For these clients, we will need to provide care or see that they will be as safe as possible during the hurricane and afterwards.

In order to provide this care we need a commitment from you to be available to provide patient care during future times of disaster. Some people have family commitments (small children or others that need to be evacuated or cared for) and therefore will be unable to work during these times. Because of this, we will need all available staff for our patients as well as for emergency calls that will come in. In an effort to plan ahead for possible disasters, we need to know who will be available.

In the event of a hurricane or natural disaster:

I will not be available for work.

I will make every effort to be available for work.

Signature

Date

Phone Number

Health Force

JOB DESCRIPTION

PHYSICAL THERAPIST

JOB SUMMARY:

Provides Physical Therapy services to patients as directed by the plan of treatment and in line with the philosophy, objectives and policies of the agency.

QUALIFICATIONS:

Licensed as a Physical Therapist by the State of Florida, has graduated from a PT curriculum approved by the American Physical Therapy Association or the Council of Medical Education and Hospitals of the AMA and a minimum of one year experience as a Physical Therapist.

RESPONSABILITIES:

- Assists the physician in evaluating patient's level of function, establishing treatment plan and goals.
- Performs initial evaluations within 48 hours of referral and re-evaluations every 30 days, as appropriate coordinating plan of care with the physician as needed.
- Prepares clinical and progress notes and required summaries, as appropriate.
- Revises the plan of treatment and contacts the physician for change in plan of care.
- Advises and consults with patient's family and other health care staff.
- Coordinates care with agency DON and other staff as appropriate.
- Observes, records and reports any changes in the patient's condition and updates the agency on changes in the patients status or schedule changes.
- Supervises the Physical Therapy Assistant including but not limited to, informing the PTA of new patients, scheduling supervisory visits and co-signing PTA documentation.
- Instructs patient and/or family in use of equipment safe patient management and home therapy programs as needed.
- Provides staff in-services when required.
- Participates in chart reviews, case conferences peer review and QA/PI activities when required.
- Communicates effectively with patient, caregivers and families as well as agency staff.
- Provides quality and appropriate care and reports issues or concerns to the DON /Administrator.
- Assures that all tasks are performs in a timely manner.
- Performs other duties as assigned.

Health Force

JOB DESCRIPTION
PHYSICAL THERAPIST
PAGE 2 OF 2

OTHER QUALIFICATIONS:

Able to effectively perform and prioritize multiple functions or tasks.
Able to stand, bend, stoop, kneel, lift and reach freely.
Able to read and interpret instructions related to patient care.
Has transportation to travel to assignments.
Has current driver's license and car insurance.
Maintains annual TB test, CPR certification and other required documents and submits them to HR.

Acknowledgement:

***I have reviewed my job description and agree to perform all duties mentioned to the best of my ability; I understand that my job duties may change as the needs of the agency change. I further agree to notify my immediate supervisor if I am unable to complete any of my job duties in a timely manner.**

Employee's Signature

Date

Form W-4 (2010)

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. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children. 	G _____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H _____
	For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are 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.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; border: 1px solid black; padding: 5px; display: inline-block;">2010</div>
1 Type or print 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, but legally separated, or spouse is a nonresident alien, check the "Single" box.
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 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2010, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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 (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1 Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions 1 \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$11,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,400 \text{ if head of household} \\ \$5,700 \text{ if single or married filing separately} \end{array} \right\}$ 2 \$ _____
- 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919) 4 \$ _____
- 5 Add lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.) 5 \$ _____
- 6 Enter an estimate of your 2010 nonwage income (such as dividends or interest) 6 \$ _____
- 7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 Divide the amount on line 7 by \$3,650 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3." 2 _____
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 _____

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 Subtract line 5 from line 4 6 _____
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$7,000 -	0	\$0 - \$6,000 -	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
7,001 - 10,000 -	1	6,001 - 12,000 -	1	65,001 - 120,000	910	35,001 - 90,000	910
10,001 - 16,000 -	2	12,001 - 19,000 -	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
16,001 - 22,000 -	3	19,001 - 26,000 -	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 27,000 -	4	26,001 - 35,000 -	4	330,001 and over	1,280	370,001 and over	1,280
27,001 - 35,000 -	5	35,001 - 50,000 -	5				
35,001 - 44,000 -	6	50,001 - 65,000 -	6				
44,001 - 50,000 -	7	65,001 - 80,000 -	7				
50,001 - 55,000 -	8	80,001 - 90,000 -	8				
55,001 - 65,000 -	9	90,001 -120,000 -	9				
65,001 - 72,000 -	10	120,001 and over	10				
72,001 - 85,000 -	11						
85,001 -105,000 -	12						
105,001 -115,000 -	13						
115,001 -130,000 -	14						
130,001 - and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

HEALTH FORCE
AUTO INSURANCE/DRIVER'S LICENSE POLICY

I _____, understand that it is a
(PRINT)
policy of Health Force to carry valid Driver's License and
valid/current auto insurance when I am traveling back and forth
to work for Health Force.

Please Check Appropriate Box Below:

_____ I drive myself back and forth to work and keep my
Driver's License and Auto Insurance valid and current.

_____ I rely on public transportation and/or family/friends to
drive me back and forth to work.

Employee Signature: _____

Company Representative: _____

Date: _____

HEALTH FORCE

Security and Confidentiality Agreement

As an employee of Health Force (hereinafter "the provider"), and as a condition of my employment, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA policies, which were provided to me.
2. I will treat all information received in the course of my employment with the provider, which relates to the patients of the provider, as confidential and privileged information.
3. I will not access patient information unless I have a need to know this information in order to perform my job.
4. I will not disclose information regarding the provider's patients to any person or entity, other than as necessary to perform my job, and as permitted under the provider's HIPAA policies.
5. I will not log on to any of the provider's computer systems that currently exist or may exist in the future using a password other than my own.
6. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my name tag.
7. I will not allow anyone, including other employees, to use my password to log on to the computer.
8. I will log off of the computer as soon as I have finished using it.
9. I will not use e-mail to transmit patient information unless I am instructed to do so by the privacy officer.
10. I will not take patient information from the premises of the provider in paper or electronic form without first receiving permission from the privacy officer.
11. Upon cessation of my employment with the provider, I agree to continue to maintain the confidentiality of any information I learned while an employee and agree to turn over the keys, access cards, or any other device that would provide access to the provider or its information.

I understand that violation of this agreement could result in disciplinary actions.

Name (Print)

Date

Name(signature)

Witness



3651 Evans Avenue

Suite 106

Fort Myers, FL 33901-8323

PHONE: (239) 275-4747

**CERTIFICATE OF AGREEMENT
DRUG – FREE POLICY**

I understand that as a condition of my employment and thereafter, if my performance indicates it is necessary, I will submit to a drug test. I also understand that failure to comply with a drug testing request or a positive result may lead to termination of employment.

I give consent for the release of test, inspection, and investigation results to appropriate Health Force and client officials for evaluation. All information derived from this test will be classified as confidential and released only to those individuals with a need to know.

I voluntarily release Health Force and its clients from liability for any claims or damages of any nature, which I may incur in taking such tests, or as a result of such inspections or investigations, or any matters arising out of their administration and consideration of their results.

(Employee Name, Print)

(Employee Signature)

(Date)

For your information, I have utilized the following drugs/medications within the last 30 days: _____



AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may be used by all employees to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an application for a health care provider license, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

- Criminal offenses found in section 435.04, F.S
- a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
 - b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
 - c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
 - d) Section 782.04, relating to murder.
 - e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
 - f) Section 782.071, relating to vehicular homicide.
 - g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.
 - h) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
 - i) Section 784.011, relating to assault, if the victim of the offense was a minor.
 - j) Section 784.03, relating to battery, if the victim of the offense was a minor.
 - k) Section 787.01, relating to kidnapping.
 - l) Section 787.02, relating to false imprisonment.
 - m) Section 787.025, relating to luring or enticing a child.

- (n) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (o) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (p) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (q) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (r) Section 794.011, relating to sexual battery.
- (s) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (t) Section 794.05, relating to unlawful sexual activity with certain minors.
- (u) Chapter 796, relating to prostitution.
- (v) Section 798.02, relating to lewd and lascivious behavior.
- (w) Chapter 800, relating to lewdness and indecent exposure.
- (x) Section 806.01, relating to arson.
- (y) Section 810.02, relating to burglary.
- (z) Section 810.14, relating to voyeurism, if the offense is a felony.
- (aa) Section 810.145, relating to video voyeurism, if the offense is a felony.
- (bb) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
- (cc) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
- (dd) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
- (ee) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- (ff) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
- (gg) Section 826.04, relating to incest.
- (hh) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
- (ii) Section 827.04, relating to contributing to the delinquency or dependency of a child.
- (jj) Former s. 827.05, relating to negligent treatment of children.
- (kk) Section 827.071, relating to sexual performance by a child.
- (ll) Section 843.01, relating to resisting arrest with violence.
- (mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- (nn) Section 843.12, relating to aiding in an escape.
- (oo) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
- (pp) Chapter 847, relating to obscene literature.
- (qq) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.
- (rr) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
- (ss) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
- (tt) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- (uu) Section 944.40, relating to escape.
- (vv) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
- (ww) Section 944.47, relating to introduction of contraband into a correctional facility.
- (xx) Section 985.701, relating to sexual misconduct in juvenile justice programs.
- (yy) Section 985.711, relating to contraband introduced into detention facilities.
- (3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S

- (a) Any authorizing statutes, if the offense was a felony.

- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (g) Section 817.234, relating to false and fraudulent insurance claims.
- (h) Section 817.505, relating to patient brokering.
- (i) Section 817.568, relating to criminal use of personal identification information.
- (j) Section 817.60, relating to obtaining a credit card through fraudulent means.

- (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (l) Section 831.01, relating to forgery.
- (m) Section 831.02, relating to uttering forged instruments.
- (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (p) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screened conducted by: _____ Date of Prior Screening: _____

- Agency for Health Care Administration
- Department of Health
- Agency for Persons with Disabilities
- Department of Children and Family Services
- Department of Financial Services

Affidavit

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature

Title

Date

**Health Force
HEPATITIS B FORM**

Employee Name: _____ **Date:** _____

Hepatitis B

Vaccination Status: _____ **Able** _____ **Not able to receive vaccine**

Vaccination Dates: _____ **Initial Dose** _____ **Has previously received series**
 _____ **30 Days** _____ **Antibody testing reveals immunity**
 _____ **6 Months** _____ **Medical reasons prevent taking
vaccination**

Antibody test results – prevaccine (optional): _____

Antibody test results – postvaccine (optional): _____

Time interval since last injection: _____

Reason for nonparticipation/discontinuation: _____

Yes:	No:	N/A	
_____	_____	_____	Vaccine Declined
_____	_____	_____	Declination form on file
_____	_____	_____	Exposure incident Date: _____ Time: _____
_____	_____	_____	A copy of the exposure report on file
_____	_____	_____	A copy of after exposure professional opinion report
_____	_____	_____	A copy of employee's request for access to these records
_____	_____	_____	Date medical records given to the employee: _____ (Employees that worked for the agency less than 1 year may receive their records at time of separation from the agency. This exempts the agency from keeping records for 30+ years)
			Date of employee's separation from agency: _____
			Employee Signature: _____

**HEALTH FORCE
HEPATITIS B VACCINE DECLINATION STATEMENT
MANDATORY**

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, however, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I decide to be vaccinated with Hepatitis B vaccine, I will forward a copy of my vaccination record to Health Force.

Employee Signature: _____

Date: _____

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address <i>(Street Name and Number)</i>		Apt. #	Date of Birth <i>(month/day/year)</i>
City	State	Zip Code	Social Security #

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):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date <i>(month/day/year)</i>
----------------------	------------------------------

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address <i>(Street Name and Number, City, State, Zip Code)</i>	
Date <i>(month/day/year)</i>	

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address <i>(Street Name and Number, City, State, Zip Code)</i>		Date <i>(month/day/year)</i>

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name <i>(if applicable)</i>	B. Date of Rehire <i>(month/day/year)</i> <i>(if applicable)</i>	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.		
Document Title: _____	Document #: _____	Expiration Date <i>(if any)</i> : _____
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		Date <i>(month/day/year)</i>

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

Documents that Establish Both
Identity and Employment
Authorization

LIST B

Documents that Establish
Identity

LIST C

Documents that Establish
Employment Authorization

	OR	AND
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. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	4. Voter's registration card	
	5. U.S. Military card or draft record	5. Native American tribal document
	6. Military dependent's ID card	6. U.S. Citizen ID Card (Form I-197)
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
9. Driver's license issued by a Canadian government authority	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
For persons under age 18 who are unable to present a document listed above:	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		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

MEDICAL QUESTIONNAIRE

(To be completed after an offer of employment is extended.)

Name of employer HEALTH FORCE HOME HEALTH

Name of employee _____

Employee's Social Security no. _____ Height _____ Weight _____

1. Do you now have, or have you ever had, any of the following?

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (convulsions, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	Surgical or spontaneous fusion of a major weight-bearing joint (frozen joint)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (medication? <input type="checkbox"/> Yes <input type="checkbox"/> No)	<input type="checkbox"/>	<input type="checkbox"/>	Hyperinsulinism
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac (heart) disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Menisectomy (inflammation of cartilage of certain joints—e.g., knee)	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Amputation of foot, leg, arm or hand	<input type="checkbox"/>	<input type="checkbox"/>	Herniated intervertebral disk
<input type="checkbox"/>	<input type="checkbox"/>	Total loss of sight of one or both eyes, or a partial loss of corrected vision of more than 75% bilaterally	<input type="checkbox"/>	<input type="checkbox"/>	Surgical removal of an intervertebral disk, or spinal fusion
<input type="checkbox"/>	<input type="checkbox"/>	Polio (poliomyelitis)	<input type="checkbox"/>	<input type="checkbox"/>	Total deafness
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	One or more back or neck injuries or a disease process of the back or neck, substantiated by a doctor's opinion and resulting in disability over a total of 120 or more days
<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis			
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	Obesity (30% overweight)
<input type="checkbox"/>	<input type="checkbox"/>	Patellectomy (surgically removed kneecap)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Ruptured cruciate ligament (knee ligament)			_____
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia			_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic osteomyelitis (infection in bone)			

2. Have you previously received workers' compensation for an on-the-job injury? Yes No *If yes, please write why, when and where.**

3. Have you ever received a disability rating or had one assigned to you by an insurance company or state/federal agency? Yes No
If yes, state percentage: _____%.

4. Have you ever injured or sprained your back? Yes No *If yes, did you have surgery?* Yes No *If yes, please give details.**

5. Have you ever injured or sprained your neck? Yes No *If yes, did you have surgery?* Yes No *If yes, please give details.**

6. Have you ever injured or sprained a knee? Yes No *If yes, did you have surgery?* Yes No *If yes, please give details.**

7. Have you ever had any other type of surgery not mentioned above? Yes No *If yes, please give details.**

8. Do you have arthritis? Yes No *If yes, what parts of the body are affected?** _____
Are you on medication for arthritis? Yes No

The information on this form shall not be used to discriminate against a qualified individual with a disability because of the existence of the disability in regard to the following: job application procedures; hiring, advancement or discharge of the employee; employee compensation; job training; and other terms, conditions and privileges of employment.

Under penalty of perjury, I declare that I have read the foregoing and that the facts alleged are true to the best of my knowledge and belief.

Employee's signature _____ Date _____

Employer's signature _____ Position _____ Date _____