LVN Application

Florence Home Health Care

EMPLOYEE HANDBOOK

WELCOME

This Employee's Handbook provides you with general information about Florence Home Health Care policies and procedures that affect you as an employee. You should be able to find the answer to most of your questions within the following pages. If you do have any unanswered questions after reading this handbook, feel free to address them to your immediate supervisor.

Florence Home Health Care reserves the right to change or revise the policies and/ or procedures described herein without notice, whenever the company determines that such action is warranted.

1. Purpose of the Handbook

Every business, in order to operate at its maximum level of efficiency, must be operated by a clearly defined set of policies and procedures. Each policy and procedure was written in compliance with the Equal Employment Opportunity guidelines, the Immigration Reform and Control Act of 1986, and the employee guidelines of the State of California, Department of Industrial Relations.

Whenever people are required to work together for any purpose, guidelines is implemented to govern their personal conduct. Therefore, the company considers employee compliance with established company policies and procedures to be an important responsibility. Florence Home Health Care policies and procedures, are a necessary part of managing its business so that employees can be treated fairly, and work safely and effectively. These policies and procedures apply to all employees.

2. Office Hours and Employee protocol

Florence Home Health Care regular office hours are from 8:00 am to 5:00 pm Monday through Friday.

Work Hours

The hours of work at Florence Home Health Care vary to accommodate business demands. The standard workweek is five (5) days, eight (8) hours per day, for a total of (40) forty hours per week. The Home Health Agency provides home health care (24) twenty-four hours a day, seven (7) days a week in accordance with physician's needs. An on-call RN is provided (24) twenty-four hours a day, seven(7) days a week. All RNs are required to participate in on-call coverage.

The agency's office is closed in the observance of the following holidays. Florence Home Health Care's holidays – (New Year's Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day).

Attendance and Tardiness

The smooth and efficient running of any company depends on its employees, compliance with its attendance and tardiness policies. All employees are expected to report to work when assigned and to report on time.

When an employee is unable to report to work on time or is going to be absent from work for whatever reason, it is the employee's responsibility to notify his/her immediate supervisor no later than two (2) hours before they are to report to work. Leaving a message with a co-worker is not considered proper notification. Failure to notify your Supervisor of your absence from work or tardiness may be cause for termination.

Lunch and Rest Breaks

Each supervisor is responsible of assigning lunch and break schedules for his or her subordinates. Supervisors must take into consideration the special function and staffing needs of the Agency.

For reason of health and safety, and because it is a good business practice, employees are discouraged from eating at their desks. Employees are encouraged to utilize dining facilities or designated rest areas for lunches and/ or rest breaks. Lunch breaks are for (30) thirty minutes unless otherwise authorized.

Personal calls and Mail

Personal telephone calls during regular work hours are not permitted. Emergency telephone calls placed to an employee will be communicated through the department supervisor as soon as possible after it is received in the office.

Under no circumstances is an employee permitted to charge long distance personal telephone calls to company telephones unless previously cleared by your Supervisor. Abuse of this company policy may be grounds for immediate termination.

Because of the large volume of company mail that is processed every day, employees may not have personal mail addressed or delivered to Florence Home Health Care.

Visitors

Employees are not permitted to invite family members, guests, and/or visitors into Florence Home Health Care office work areas during normal working hours unless previously authorized by your Supervisor.

Employees may make arrangements for meeting friends and family during lunch or after regular working hours in the lobby of the office or elsewhere.

3. Dress Code

In the interest of employee safety and welfare, the company requires all employees to observe the following dress code:

a. Shoes are to be worn that are consistent with the office environment (i.e. no sneakers or sandals).
b. Slacks and shirts are acceptable for men.
c. Dresses or pantsuits are appropriate for women. No halter-tops, shorts or immodest attire is acceptable.
d. Your Supervisor will set the Dress Code for employees who work after hours and on weekends.

Employees who are inappropriately dressed will be sent home and directed to return to work in the proper attire. Such employees will not be compensated for the time away from work.

4. Code of Ethics

a. We will strive to provide quality services to our patients and the community with the highest professional ethical standards.
b. We will not discriminate on the basis of age, sex, race, creed, color, national origin, or handicap.
c. We will match the skills and abilities of our employees to the specific needs of our patients. Staff will not be assigned to care for their own family members.
d. We will recognize and respect the patient's right to privacy and will prevent unauthorized disclosure of medical and financial information.
e. We will not knowingly misrepresent our service or our employees.
f. We will take all precautions possible to ensure the safety of our employees and patients.
g. We will actively involve ourselves with community agencies to help implement and improve the standards of patient care and control of health care costs.
h. We will assist in planning and securing services to meet total patient needs in cooperation with community agencies.
i. For the protection of our employees, patients and ourselves, we carry professional liability, and worker's compensation insurance.
j. We will only bill the payer source when all requirements are met and services are provided.

5. Disciplinary Process

An established disciplinary process enables each employee to understand and correct deficient performance and/or unacceptable behavior or conduct. This process may vary based upon the severity of the action. The following steps are guidelines for implementing this process:

a. Verbal Warning
b. Written Warning
c. Suspension/ Probation
d. Termination

The following is a list of examples that may lead to immediate termination:

a. Insubordination
b. Drug and/ or alcohol use
c. Patient abandonment

d. Non-submission of patient medical records
e. Fraudulent activity
f. Abuse, misuse and/ or unauthorized removal of company owned property or equipment
g. Stealing
h. Abusive behavior that poses danger to one's self or others

6. Paychecks, Wage Advances, and Garnishment

Paychecks

Paychecks will be issued on the fifteenth (15th) and the last day of the month after the two (2) weeks services provided. Paycheck stubs will reflect all taxes, voluntary deductions, gross and net wages, and year-to-date accrued earnings.

Florence Home Health Care will insure that employee salary information will remain confidential.

Debts and Court Action

The company is required by law to recognize certain court order, such as wage garnishments and wage assignments. When the company receives a notice of a pending garnishment and wage assignment the department supervisor will discuss it with the employee in an effort to settle the matter without involving the company. Employees are encouraged to avoid financial transactions that result in wage garnishments or assignments.

Salary Advances and Loans

The company does not provide any salary advances nor extend credit to any of its employees.

Final Paychecks

Employees who are terminated will receive their final paycheck within (72) seventy-two hours from their last day of work.

The final paycheck for employees who resign will be provided 72 hours from their last day of work.

The employee must return all agency property such as keys, and equipment to their respective Supervisor prior to the issuance of their final paycheck.

7. Employment Categories

The following employment categories have been established:

Probationary Employees: Florence Home Health Care Employees on a trial basis for a period of (90) ninety calendar days for the purpose of assessing their ability to perform assigned tasks. Such employment may be terminated at any time for any reason during the 90- day period.

Regular Employees: Employees who successfully complete their probationary period are called "regular" employees. Such employees are hired for an indefinite and unspecified duration of time. Accordingly, their employment is at mutual consent of the employee and Florence Home Health Care, and can be terminated at will by the employee or the company.

8. Overtime

The law requires employers to compensate non-managerial/ salaried employees for all hours worked in excess forty hours per week at the rate of one and one half (1 & 1/5) times their regular hourly rate.

Although non-managerial/ salaried employees workday is eight (8) hours, if you are requested to and do work beyond your regular workday, you will be compensated accordingly.

If an employee is absent during the workweek, the minimum week of forty hours must first be satisfied before overtime compensation will be paid.

All overtime must be pre-approved by the immediate supervisor.

9. Holiday Benefits

All regular full-time employees who have completed their probationary period are eligible for holiday benefits, provided the employee works on the last scheduled workday after the holiday. Employees who work on a holiday will be paid one and one-half times their regular hourly rate.

The following days are observed as holidays at Florence Home Health Care:

New Year's Day-	January 1
Memorial Day-	Last Monday of May
Independence Day-	July 4
Labor Day-	First Monday of September
Thanksgiving Day-	Fourth Thursday of November
Christmas Day-	December 25

In the event a holiday falls on a day when an employee is on a "leave of absence" such employee will not be eligible for holiday benefits for a holiday that is observed during the period of the leave of absence.

10. Vacation Benefits and Scheduling

Vacation Benefits

The company provides one (1) week of paid vacation benefit to employees after a probationary period of ninety days (90) and have worked consistently for six (6) months at the rate of forty hours (40) per week.

For example: Hire date: 01/01/2007
Probationary date: 04/01/2007

Vacation benefits start after a probationary period 04/01/2007 and for a maximum of (2) two weeks in a year.

Vacation payments

Vacation checks are issued automatically, employees will receive payment of their vacation benefits with the regular paycheck that is issued following the date their vacation time begins.

Scheduling and accrual

Vacation must be scheduled and approved by the company (30) days in advance.

An employee will be paid for all unused vacation benefits upon termination of employment.

11. Paid Sick Leave

After one (1) year of full-time employment you will be eligible to receive up to (5) five days of paid sick leave per year. Paid sick leave benefits do not accumulate from year to year.

Paid sick leave begins on the fourth consecutive day of illness from the job and is paid only for scheduled workdays.

Failure to notify your supervisor of your absence prior to your scheduled time to report to work will disqualify you for paid sick leave benefits. The company may, at its sole discretion, require a certificate of illness from a licensed physician before making any sick leave payments.

An employee will not be paid for accumulated sick leave upon termination of employment.

12. Leave of Absence, Personal and Medical Leave

There are two (2) types of unpaid leaves of absence available for eligible employees. They are: Personal Leave and Medical Leave.

For Occupational medical leave refer to ARTICLE XI, "Safety and workers Compensation."

Leave of Absence Guidelines

All approved leaves of absence are provided on an unpaid basis including leaves due to jury duty.

Returning From Leave of Absence

When an employee is granted an approved Leave of Absence, an effort will be made to hold the employee's position open for the period of the approved leave. However, there will be times when positions cannot be held open, and therefore it is not possible to guarantee reinstatement. Hence, if an employee's former position is unavailable when the employee in a comparable position for which the employee is qualified will be made. If such a position is not available, the employee will be offered the next available position for which the employee is qualified. An employee, who refuses to accept the available position offered, will be considered to have voluntarily terminated employment, effective the day of such refusal.

Effect upon Vacation and Sick Leave Benefits

The period that an employee is on leave of absence is not considered time worked for purposes of determining eligibility for the amount of vacation and sick leave benefits. When an employee returns from an approved leave of absence, the eligibility and accrual dates for such benefits will be adjusted accordingly to reflect the period of leave.

Holiday Benefits

If a paid holiday falls during the period an employee is on an approved leave of absence, the employee will not be eligible for the holiday pay.

Failure to Return Promptly

If an employee fails, for any reason, to return to work promptly upon the expiration of an approved leave of absence and has not obtained an extension from the company prior to such expiration date, the employee will be considered to have voluntarily resigned.

Resignation While on Leave

If an employee accepts other employment or fails to return to work on the next regularly scheduled workday following the expiration of the approved leave of absence, the employee will be considered to have voluntarily resigned.

Personal Leave of Absence

Regular full time employees who have been continuously employed by the company for at least one (1) year may request for a personal leave of absence without pay for a reasonable period of time up to thirty (30) days. The leave may be extended for a reasonable period of time of up to (30) thirty days due to special circumstances, as determined on an individual basis by the company. Requests for leaves of absence will be considered on the basis of the employee's length of service, performance, responsibility level, the reason for the request, whether other individuals are already out on leave, and the expected impact of the leave on the employer.

Requests for personal leave must be submitted in writing to the company and must be approved in writing by the employee's department Supervisor and/or Administrator before the leave begins.

Request for extension of leave of absence must be submitted in writing and approved in writing by the company before the extended period of a leave begins.

It is the employee's responsibility to report to work at the end of the approved leave of absence. An employee who fails to report to work on the day after the leave of absence expires will be considered to have voluntarily resigned.

Medical Leaves

Employees, who are temporarily unable to perform their usual and customary work due to personal illness or injury, including a pregnancy-related disability, will be granted a medical leave of absence.

Medical leaves will be granted on the basis of a physician's written statement submitted to the company, that an employee is no longer able to work due to a medical condition or disability.

An employee who plans to take a medical leave must provide the company reasonable notice of the date the leave will commence, the estimated duration of the leave, and the date on which it is expected that the employee will be able to return to work.

When an unplanned medical situation or emergency occurs that does not allow an employee to provide advance notification of the situation within three (3) working days of an absence. If an employee is absent more than three (3) working days without notifying the employer, the employee will be considered to have voluntarily resigned.

The maximum length of leave that will be granted for any medical disability is one (1) month. Employees returning to work after any disability must have a written release from a physician verifying that they are able to return to work and safety perform their duties.

13. Safety and Worker Compensation

Every employee is responsible for on the job safety. To achieve our goal of providing a completely safe work place, everyone must be safety conscious.

Worker Compensation

In cases of an accident on the job involving a personal injury, regardless of how serious, please notify your immediate supervisor. Failure to report accidents can result in a violation of legal requirements, and can lead to problems and/ or delays in processing insurance claims.

When an employee return from disability leave, the eligibility and accrual dates for vacation benefits such benefits will not be adjusted forward to reflect the period of the leave unless the leave exceeds (90) ninety days.

If a paid holiday falls during the period an employee is on a disability leave, the employee will not be eligible for the holiday pay.

If an employee fails for any reason to return to work promptly upon the expiration of a disability leave, the employee will be considered to have voluntarily resigned.

14. Other Benefits

Employees may use sick leave to compensate for bereavement of immediate family members. (Immediate Family: Employee's spouse, child, mother, father, sister, brother, grandparents)

Employee's are allowed time off to Vote without pay. Arrangements must be made in advance with supervisor.

Employees will not be compensated for Jury Duty. Employees serving on Jury Duty will be given a Personal Leave of Absence.

15. Employment References and Re-employment

The company will not issue any employee references, however; upon written request from an employee, the company will furnish its letter containing the employee's job title and the inclusive period of employment.

To be eligible for re-employment, an employee must have voluntarily resigned from the company and have given at least two (2) week's notice prior to leaving.

16. Title VI and VII of the Civil Rights Act Non-Discrimination Policy

It is the policy of to admit and treat all patients without regard to race, age, color, handicap, religion, medical condition, marital status or sex. The same requirements for admission are applied to all, and patients are assigned without regard to race, age, color, handicap, religion, national origin, medical condition, marital status or sex. There is no distinction in eligibility for, or in the manner of, providing any patient service provided by or by others in or outside of the agency.

All facilities of the agency are available without distinction, and rules of courtesy are uniformly applied to all regardless of race, age, color, handicap, religion, national origin, medical condition, marital status or sex. All persons and organizations having occasion either to refer patients for admission or to recommend must do so without regard to the patient's race, age, color, handicap, religion, national origin, medical condition, marital status or sex.

Florence Home Health Care is an Equal Opportunity Employer and manages employment and employee relation practices without regard to race, age, color, handicap, religion, national origin, medical condition, marital status or sex.

Florence Home Health Care shall adhere to applicable state-directed mandates. Florence Home Health Care is an equal employment opportunity employer and will not discriminate against any employee or applicant for employment in an unlawful manner.

17. Compliance with immigration reform Act of 1986

The Immigration reform and Control Act of 1986 makes it illegal for you to knowingly hire or employ an unauthorized alien. An unauthorized alien is a person who has entered the United States after January 1, 1982 and has failed to obtain temporary or permanent status to remain in this country.

The Act does not require you to verify employment eligibility of an existing employee continuing in his or her job with the agency, however; all new employees must furnish documentary proof of identity and employment eligibility within three (3) days of being hired or in the alternative, to submit to a completed 1-9 Form, "Employee Information and Verification."

18. Conflict of Interest

Florence Home Health Care Governing Board will be responsible for in ensuring that any existing or potential conflict of interest is identified and appropriately addressed.

The identification of any situation that presents a conflict or a potential conflict between the private interest of any Florence Home Health Care personnel and their official Florence Home Health Care responsibilities and duties shall constitute a conflict-of-interest and shall be disclosed to the Governing Board for review and appropriate action.

All associates should conduct business affairs in such a manner and with such integrity that no conflict of interest, real or implied, could be construed.

Business decisions are made on the basis of furthering the best interests of the company. Associates are not allowed to accept expensive gifts, unusual hospitality or gratuities, since acceptance might affect the independent judgment required for making sound decisions.

Associates and their families may not have financial interests in competing or supplying companies that could affect performance of their duties and responsibilities as employees of the company, or influence business decision.

Confronted with a situation in which a conflict of interest might exist, associates should discuss the matter with their immediate supervisor.

Associates who have knowledge of a potential conflict of interest situation and who do not report it can be held liable for that knowledge. Conflicts of interest may be cause for termination.

Florence Home Health Care

New Employee Checklist

Employee Name	Date of Hire
Social Security #	Position

☐ New Employee Checklist

☐ Application ☐ Contract

☐ Drivers License Expiration ___/___/___ ___/___/___ ___/___/___

☐ Social Security Card or other Eligibility to work in the U.S.A.

☐ Auto Insurance Expiration ___/___/___ ___/___/___ ___/___/___

☐ W-4 Form ☐ W-9 Form

☐ I-9 Form [kept in separate Binder]

☐ CPR Certification Expiration ___/___/___ ___/___/___ ___/___/___

☐ References [at least two (2)]

☐ Resume

☐ Change of Address Form

Florence Home Health Care

APPLICATION FOR EMPLOYMENT

EQUAL OPPORTUNITY EMPLOYER

PERSONAL INFORMATION

Date _____

Name (Last Name First)			Social Security No.	
Present Address	City		State	Zip Code
Permanent Address	City		State	Zip Code
Phone No.	Pager / Cellular No.		Referred By	

EMPLOYMENT DESIRED

Position	DATE YOU CAN START	Salary Desired
ARE YOU EMPLOYED NOW? Yes _____ No _____	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? Yes _____ No _____	ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.A.? Yes _____ No _____
EVER APPLIED TO THIS COMPANY BEFORE? Yes _____ No _____	Where?	When?

EDUCATION HISTORY

	Name and Location of School	*Yrs Attended*	*Diploma*	*Subjects Studied*
High School				
College				
Trade, Business or Correspondence School				

GENERAL INFORMATION

Subjects of Special Study or Research Work
Special Training
Special Skills

U.S. Military Service	Rank

FORMER EMPLOYERS

LIST BELOW LAST FOUR EMPLOYERS, BEGIN WITH MOST RECENT EMPLOYER FIRST.

Date, Month and Year	*Name and Address*	*Salary*	*Position*	*Reason for Leaving*
From				
To				
From				
To				
From				
To				
From				
To				

REFERENCES

GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

Name	*Address*	*Phone No.*	*Business*	*Yrs Known*

HAVE YOU EVER BEEN CONVICTED OF, PLEAD GUILTY / NO CONTEST TO A CRIME?	Yes _____	No _____
IF YES, EXPLAIN.		

(A CONVICTION RECORD WILL NOT NECESSARILY EXCLUDE YOU FROM CONSIDERATION. THIS INFORMATION WILL BE USED ONLY FOR JOB-RELATED PURPOSES AND ONLY TO THE EXTENT PERMITTED BY LAW.)

AUTHORIZATION

"I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES AND EMPLOYERS LISTED ABOVE TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THEY MAY HAVE, PERSONAL OR OTHERWISE, AND RELEASE THE COMPANY FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM UTILIZATION OF SUCH INFORMATION.

I ALSO UNDERSTAND AND AGREE THAT NO REPRESENTATIVE OF THE COMPANY HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING, UNLESS IT IS IN WRITING AND SIGNED BY AN AUTHORIZED COMPANY REPRESENTATIVE.

THIS WAIVER DOES NOT PERMIT THE RELEASE OR USE OF DISABILITY-RELATED OR MEDICAL INFORMATION IN A MANNER PROHIBITED BY THE AMERICANS WITH DISABILITIES ACT (ADA) AND OTHER RELEVANT FEDERAL AND STATE LAWS."

Date _____ Signature _____

DO NOT WRITE BELOW THIS LINE

Interviewed By _____ Date _____

Remarks

Hired	For Dept.	Position	Will Report	Salary / Wages

Approved: 1. _____ 2. _____ 3. _____

Employment Manager Department Head General Manager

Florence Home Health Care

Reference Request

Dear Human Resources Department,

One of your previous/current employees has applied at *Florence Home Health Care*. We ask that you verify and complete this form at your earliest convenience and return it to our office. Thank you for your time.

Very truly yours,

The Human Resources Department

I authorize my previous/current employer to furnish *Florence Home Health Care* with the information requested on this form and I further authorize *Florence Home Health Care* to provide this information to any individual or organization to which I may be assigned.

_____ _____

Applicant Signature Date

Applicant please complete the following information below:

Name of Applicant: _____

Social Security Number: _____

Previous Employer Name: _____

Address: _____

Position Held: _____

Dates Employed From: _____ To: _____

Reason for separation: _____

Previous/current employer please complete:

Dates of Employment From: _____ To: _____

Position held at your Company: _____

Eligible for Rehire: Yes ☐ No ☐

Comments: _____

_____

_____ _____

Employer Signature/Title Date

Florence Home Health Care

Reference Request

Dear Human Resources Department,

One of your previous/current employees has applied at *Florence Home Health Care*. We ask that you verify and complete this form at your earliest convenience and return it to our office. Thank you for your time.

Very truly yours,

The Human Resources Department

I authorize my previous/current employer to furnish *Florence Home Health Care* with the information requested on this form and I further authorize *Florence Home Health Care* to provide this information to any individual or organization to which I may be assigned.

_____ _____

Applicant Signature Date

Applicant please complete the following information below

Name of Applicant: _____

Social Security Number: _____

Previous Employer Name: _____

Address: _____

Position Held: _____

Dates Employed From: _____ To: _____

Reason for separation: _____

Previous/current employer please complete:

Dates of Employment From: _____ To: _____

Position held at your Company: _____

Eligible for Rehire: Yes ☐ No ☐

Comments: _____

_____

_____ _____

Employer Signature/Title Date

Florence Home Health Care

LICENSURE VERIFICATION RECORD

Employee/Contractor Name: _____

Date: _____

License Number: _____

Expiration Date: _____

OFFICE USE ONLY

_____ **RN**	_____ **LVN**	_____ **CHHA**
(916) 322-3350	**(916) 263-7800**	**(916) 327-2445**
_____ **PT**	_____ **OT**	_____ **ST**
(916) 263-2550	**(301) 990-7979**	**(916) 263-2666**
_____ **MD**	_____ **LCSW**	
(916) 263-2382	**(916) 445-4933**	

License/Certificate is ☐ Clear/Active ☐ Inactive

Spoke to/or	Confirmation Number	
Verified by	Title	Date

Employee Licensure Checklist

☐ Professional License Expiration ___/___/___ ___/___/___ ___/___/___

☐ Licensure Verification Date Verified ___/___/___ ___/___/___ ___/___/___

Other Certifications –

☐ I.V.

☐ Psychiatric

☐ Ventilator

☐ Other: _____

_____

_____

Orientation Checklist

- ☐ Administrative Orientation CheckList
- ☐ Orientation to Forms [Clinical Staff]
- ☐ Infection Control CheckList
- ☐ Safety Policy and Procedures Acknowledgement
- ☐ Abuse Reporting Statement
- ☐ Confidentiality Statement
- ☐ Employee Handbook Acknowledgement
- ☐ Grievance Procedure
- ☐ Pre-Employment Exam
- ☐ Skills CheckList [Clinical Staff]
- ☐ Submission of Clinical Notes Agreement
- ☐ Other: _____

Florence Home Health Care

ADMINISTRATIVE ORIENTATION CHECKLIST

Human Resources/Personnel Orientation Checklist	Orientee's Initials	Date Discussed
Administrative		
1. History of the Company		
2. Organizational Structure		
3. Employee Handbook		
4. Tour of the Agency		
5. Introduction to Office Staff		
6. Administrative/Clinical P&Ps		
7. Corporate Compliance		
Health and Safety		
1. Code of Safe Practices		
2. Universal Precautions		
3. Body Mechanics		
4. Safety Management		
5. Emergency and Disaster Preparedness		
6. Emergency in a Patient's Home		
7. Safety Program		
8. Seat Belts		
9. Abuse/Restraint		
General		
1. Home Health Concepts		
2. Patient Rights		
3. DNR		
Medicare Requirements		
1. Skilled Services		
2. Homebound Status		
3. Intermittent Care		

Orientee's Printed Name/Title _____

Orientee's Signature/Title _____

Orientor's Printed Name/Title _____

Orientor's Signature _____

Florence Home Health Care

ORIENTATION TO FORMS CHECKLIST

FORMS	ORIENTEE'S INITIALS	DATE DISCUSSED
1. Patient Assessment Package (review all forms)		
2. Medication Profile		
3. Physician Orders		
4. 485/ Plan of Care		
5. All Consent Forms		
6. 30-Day Progress Note		
7. Clinical Note		
8. Discharge Summary		
9. Discharge Instructions		
10. OASIS form		
11. Team Conference		
12. Wound Sheet		
13. Evaluation/60-Day Summary		
14. Instruction Calendar		
15. Safety Evaluation		
16. Patient Visit Records		
17. Flow Sheet		
18. Communication Note		
19. Adverse Drug Reaction		
20. Medication Error		
21. Accident/Incident Report		
22. Infection Control Report		

☐ **Submission of Paperwork**
☐ **Review of frequencies and how to write**
☐ **Writing goals**

Orientee's Printed Name/Title _____

Orientee's Signature/Title _____

Orientor's Printed Name/Title _____

Orientor's Signature _____

Florence Home Health Care

INFECTION CONTROL ORIENTATION CHECKLIST

Infection Control	Orientee's Initials	Date Discussed
1. Attend Lecture		
2. Video on Tuberculosis		
3. Video on Universal Precautions		
4. Demonstrated Hand Washing		
5. Sharps Container Inventory Form		
6. Review PPE		
7. Receive PPE		
8. Post Test		

Orientee's Signature/Title _____

Orientee's Printed Name _____

Orientor's Signature/Title _____

Orientor's Printed Name _____

Florence Home Health Care

ABUSE REPORTING STATEMENT

California Welfare and Institutions Code, Section 15632, and the California Penal Code, Section 11166, requires that any custodian, health practitioner (both medical and non-medical) or an employee of any agency who has knowledge of or observes a child or dependent adult in his or her professional capacity or within the scope of his or her employment, or who reasonably suspects that there has been a victim of abuse, shall report such suspected instances to a child protective agency or an adult protective agency or local law enforcement agency immediately, or as soon as practically possible, by telephone and to prepare and send a written report thereof with 36 hours of receiving the information concerning the incident.

Any custodian, health practitioner (both medical and non-medical) or an employee of an agency who has knowledge of, or who reasonable suspects that mental suffering has been inflicted on a child or dependent adult or its emotional well-being is endangered in any way, may report such suspected instances of abuse to a protective agency. Infliction or willful and unjustifiable mental suffering must be reported.

"Care custodian" means an administrator, teacher, or an employee of any of the following public or private facilities: health facility, clinic, home health agency, educational institution including foster homes and group homes, community care facility, adult/child day care facility, legal guardian or conservator, or any person who provides goods or services necessary to avoid physical harm or mental suffering and who performs such duties.

Child Protective Agency means a police or sheriff's department, a county probation department, or county welfare department.

The undersigned now has knowledge of the provisions of section 15630 of the California Welfare Code; and section 11166 of the California Penal Code; and will comply with its provisions.

I acknowledge that I have read, understand and will comply with the above information, and its content.

_____ _____

Employee Signature Date

Florence Home Health Care

CONFIDENTIALITY STATEMENT

I have been formally instructed in maintaining the confidentiality of medical records, personnel files and agency proprietary information, and I understand the medical information regarding the patient may not be discussed with anyone, either inside or outside the agency except as needed to provide care for the patient. I understand that no medical records are to be removed from the agency unless a "Release of Information" has been completed and signed by the patient. It is my understanding that such discussion of release of information is cause for dismissal. I have been instructed during a formal orientation regarding the policies and procedures of *Florence Home Health Care* regarding confidentiality.

_____ _____

Employee Signature Date

Florence Home Health Care

SAFETY POLICY AND PROCEDURE ACKNOWLEDGEMENT

I, the undersigned, have read and understand the safety policies and procedures provided to me by *Florence Home Health Care*. I understand that these guidelines are provided to me for the safety of myself and my co-workers; and that it is my responsibility to review and comply with these policies and procedures.

Employee's Signature & Title: _____

Employee's Printed Name: _____

Date: _____

Florence Home Health Care

HANDBOOK ACKNOWLEDGEMENT FORM

This is to acknowledge that I have received a copy of the Employee Handbook and understand that it contains important information on general personnel policies and on my privileges and obligations as an employee. I agree that I will read and comply with the material in the Handbook, which describes the general personnel policies governing my employment. If I do not understand any of these provisions, I agree to contact *Florence Home Health Care* for clarification.

I further understand that *Florence Home Health Care* may change, supplement or rescind any policies, benefits, or practices described in the Handbook from time to time at its sole and absolute discretion, with or without prior notice with the exception of the employment at-will provisions.

No statement(s) in the Handbook or in other statement(s) of Company policy, including statements made during performance appraisals, are to be construed either as an expressed or implied promise of continuing employment, unless expressly agreed and confirmed in writing by both the Company and the employee. I understand and agree, that other than the Administrator of *Florence Home Health Care*, no manager, supervisor or representative of *Florence Home Health Care*, has authority to enter into any agreement, expressed or implied, for employment for any period of time, or to make any agreement for employment other than at-will; only the Administrator has the authority to make any such agreement and then only in writing signed by the Administrator.

Further, I understand that employment with *Florence Home Health Care* is not for a specified term and is at the mutual consent of the employee and *Florence Home Health Care*. Accordingly, either the employee or *Florence Home Health Care* can terminate the employment relationship at-will, with or without cause, at any time.

_____ _____

Employee Signature Date

_____

Employee's Printed Name

Florence Home Health Care

EMPLOYEE GRIEVANCE PROCEDURE

It is the desire of *Florence Home Health Care* to maintain employee satisfaction at all times. In order to minimize the possibility of misunderstanding, an employee is requested to discuss any problem or grievance with the employee's immediate supervisor as soon as possible after it arises. If the employee does not promptly receive a satisfactory response from the immediate supervisor and/or the employee wishes to appeal the matter, such as disciplinary penalties or working conditions, the employee can formalize his/her complaint by following the grievance procedure outlined below:

Step One: Complete a Grievance Report Form and submit it to your supervisor.

Step Two: Discuss the grievance with your supervisor.

Step Three: If the problem cannot be alleviated at the supervisory level, it should be discussed with the Administrator or Director of Patient Care Services.

The supervisor should document on the Grievance Report Form the action taken to resolve the employee's grievance. A copy of the completed Grievance Report Form should be returned to the Administrator/Director of Patient Care Services.

I, _____, have read and understand the above procedure.

_____ _____

Signature of the Employee Date

Florence Home Health Care

SUBMISSION OF CLINICAL NOTES AGREEMENT

I agree that all documents (assessments, clinical notes, patient visit records, etc.) will be submitted within the following schedule, according to Agency policy:

1. Comprehensive Assessments: **48 hours after the visit.**

2. Clinical notes, orders, patient visit records, route sheets: **within seven (7) days following the patient visit.**

Failure to comply with the above schedule will result in either suspension of assignments or re-assignments of visits in order for deadlines to be met.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____ _____

Signature of the Employee Date

_____ _____

Witness Signature Date

SKILL AND EXPERIENCE INVENTORY FOR THE SKILLED NURSE/LVN

Name _____ Position _____

Date of Hire _____ Date Completed by Employee _____

Check One: ☐ Orientation ☐ Annual Competency ☐ Other _____

Directions: Circle the number that best describes your experience with each particular skill
1 = Very Experienced 2 = Somewhat experienced 3 = Not experienced NA = Not Applicable
♠= Profiency Demonstration Required ❋= Follow guidelines in Care Staff Competency Policy

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
1.	Waived Laboratory test: Glucometer					
	a. Verbalizes purpose of test ♠	1 2 3 NA	1 2 3 NA			
	b. Specimen Collection ♠	1 2 3 NA	1 2 3 NA			
	c. Instrument Calibration ♠	1 2 3 NA	1 2 3 NA			
	d. Quality control mechanisms♠	1 2 3 NA	1 2 3 NA			
	e. Test correctly performed and interpreted ♠	1 2 3 NA	1 2 3 NA			
3.	Pulmonary System:					
	a. General exam and auscultation	1 2 3 NA	1 2 3 NA			
	b. Use and care of oxygen	1 2 3 NA	1 2 3 NA			
	c. Tracheostomy care	1 2 3 NA	1 2 3 NA			
	d. Nebulizer treatment	1 2 3 NA	1 2 3 NA			
	e. Oral/nasal suctioning	1 2 3 NA	1 2 3 NA			
	f. Breathing exercises/incentive spirometry	1 2 3 NA	1 2 3 NA			
	g. Percussion	1 2 3 NA	1 2 3 NA			
	h. Ventilator	1 2 3 NA	1 2 3 NA			
	i. Pulse Oximeter	1 2 3 NA	1 2 3 NA			

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
	j. Apnea Monitor	1 2 3 NA	1 2 3 NA			
4.	Cardiovascular System:					
	a. General exam and auscultation	1 2 3 NA	1 2 3 NA			
	b. Pulses (apical, radial, femoral, pedal, popliteal)	1 2 3 NA	1 2 3 NA			
	c. Edema assessment	1 2 3 NA	1 2 3 NA			
	d. Supine and orthostatic blood pressure	1 2 3 NA	1 2 3 NA			
	e. Nitroglycerine use	1 2 3 NA	1 2 3 NA			
	f. Energy conservation techniques	1 2 3 NA	1 2 3 NA			
5.	Neurologic					
	a. General exam including LOC and grasps	1 2 3 NA	1 2 3 NA			
	b. Aphasia care	1 2 3 NA	1 2 3 NA			
	c. Seizure precautions	1 2 3 NA	1 2 3 NA			
	d. Cognition assessment	1 2 3 NA	1 2 3 NA			
6.	Gastrointestinal					
	a. General exam and auscultation	1 2 3 NA	1 2 3 NA			
	b. Abdominal Girth	1 2 3 NA	1 2 3 NA			
	c. Ostomy care	1 2 3 NA	1 2 3 NA			
	d. Ostomy irrigation	1 2 3 NA	1 2 3 NA			
	e. GT care and feedings	1 2 3 NA	1 2 3 NA			
	f. JT care and feedings	1 2 3 NA	1 2 3 NA			
	g. Dysphagia precautions	1 2 3 NA	1 2 3 NA			
	h. Impaction removal	1 2 3 NA	1 2 3 NA			
	i. Enema Administration	1 2 3 NA	1 2 3 NA			
	j. Ileostomy	1 2 3 NA	1 2 3 NA			
	k. Bowel training	1 2 3 NA	1 2 3 NA			
7.	Integumentary System:					
	a. General Exam	1 2 3 NA	1 2 3 NA			
	b. Sterile dressing change	1 2 3 NA	1 2 3 NA			
	c. Wet to dry dressing	1 2 3 NA	1 2 3 NA			

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
	d. Suture/staple removal	1 2 3 NA	1 2 3 NA			
	e. Decubitus care	1 2 3 NA	1 2 3 NA			
	f. Assessment and staging	1 2 3 NA	1 2 3 NA			
	g. Various wound treatments including transparent films and Duoderm	1 2 3 NA	1 2 3 NA			
	h. Documentation of a wound	1 2 3 NA	1 2 3 NA			
8.	Genitourinary System:					
	a. General Exam	1 2 3 NA	1 2 3 NA			
	b. Male urinary catheterization, care and patient education	1 2 3 NA	1 2 3 NA			
	c. Female urinary catheterization, care and patient education	1 2 3 NA	1 2 3 NA			
	d. Condom catheter	1 2 3 NA	1 2 3 NA			
	e. Incontinence care	1 2 3 NA	1 2 3 NA			
	f. Bladder training	1 2 3 NA	1 2 3 NA			
9.	Musculoskeletal System:					
	a. General exam	1 2 3 NA	1 2 3 NA			
	b. ROM (active and passive)	1 2 3 NA	1 2 3 NA			
	c. TED hose	1 2 3 NA	1 2 3 NA			
	d. Total knee replacement care	1 2 3 NA	1 2 3 NA			
	e. Total hip replacement care	1 2 3 NA	1 2 3 NA			
	f. Cast assessment and care	1 2 3 NA	1 2 3 NA			
	g. Walker use instruction	1 2 3 NA	1 2 3 NA			
	h. Wheelchair use instruction	1 2 3 NA	1 2 3 NA			
	i. Hoyer lift use	1 2 3 NA	1 2 3 NA			
10.	Metabolic System:					
	a. General exam	1 2 3 NA	1 2 3 NA			
	b. Insulin types and teaching	1 2 3 NA	1 2 3 NA			
	c. Glucometer instruction	1 2 3 NA	1 2 3 NA			
	d. Diet, exercise and sick day instruction of the diabetic	1 2 3 NA	1 2 3 NA			
	e. S/S of hypoglycemia and	1 2 3 NA	1 2 3 NA			

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
	hyperglycemia					
	f. Foot care and skin care	1 2 3 NA	1 2 3 NA			
11.	Medications					
	a. Oral Administration	1 2 3 NA	1 2 3 NA			
	b. Rectal Administration	1 2 3 NA	1 2 3 NA			
	c. IM administration	1 2 3 NA	1 2 3 NA			
	d. Subcutaneous administration	1 2 3 NA	1 2 3 NA			
	e. Z-track	1 2 3 NA	1 2 3 NA			
	f. Peripheral IV therapy ❋	1 2 3 NA				
	g. Hickman-Broviacs ❋	1 2 3 NA				
	h. Port-a-caths ❋	1 2 3 NA				
	i. PICC lines ❋	1 2 3 NA				
	j. TPN ❋	1 2 3 NA				
	k. Enteral feedings	1 2 3 NA				
	l. Chemotherapy ❋	1 2 3 NA				
	m. IV pumps	1 2 3 NA				
	n. Parenteral pain management	1 2 3 NA				
	o. Parenteral hydration	1 2 3 NA				
	p. Parenteral Dobutamine	1 2 3 NA				
12.	Venipuncture for lab draws	1 2 3 NA	1 2 3 NA			

ADMINISTRATIVE ORIENTATION
Post-Test

Orientee's Name _____ **Date** _____ **Score** _____

1. The primary purpose of our mission is to provide our clients with quality and compassionate care. ☐ True ☐ False
2. We reserve the right, not to respect the rights of all individuals to include employees, patients, physicians and service suppliers. ☐ True ☐ False
3. It is our company policy, that all forms of harassment, coercion or intimidation, including sexual harassment are prohibited. ☐ True ☐ False
4. Employees whose positions require licensure and/or certification, are not responsible for keeping them current, it's the agency's responsibility. ☐ True ☐ False
5. We rely on the integrity and honesty of each employee in reporting their correct hours worked on their timecards and their patient visit records. ☐ True ☐ False
6. We do not discriminate against any employee or applicant because of race, age, religion, sex, national origin, ancestry, or sexual orientation. ☐ True ☐ False
7. The use, sale, purchase, transfer or possession of any illegal drug by an employee while on company property or performing company business is prohibited. ☐ True ☐ False
8. All employees are responsible for insuring that equipment is handled with care and kept in good working order in its proper place. ☐ True ☐ False
9. The safety of patients, clients, the public and personnel is important to the company. ☐ True ☐ False
10. The agency is committed to total quality management. ☐ True ☐ False
11. The agency's quality management program does note involve quality improvement. ☐ True ☐ False
12. Good attendance and punctuality are crucial to the company's efficient operation and productivity. ☐ True ☐ False
13. All overtime must be approved by your supervisor prior to your working such overtime. ☐ True ☐ False

14. To achieve our goal of providing a completely safe work environment, everyone must be safety conscious. ☐ True ☐ False

15. All regular full-time patient care employees are expected to assume on-call status on an as needed basis. ☐ True ☐ False

16. Information regarding a patient's condition, care, treatment, personal affairs or records are strictly confidential. ☐ True ☐ False

17. The company is not interested in keeping the lines of communication open between the employee and management. ☐ True ☐ False

18. Outside employment must be discontinued if it affects an employees work performance adversely or represents a conflict of interest. ☐ True ☐ False

19. Solicitation, and/or the distribution of non-work related literature during working hours is prohibited. ☐ True ☐ False

20. Employees are required to dress and groom appropriate to the work situation, because it serves as good public relations for the company. ☐ True ☐ False

21. All field employees are required to submit all visit documentation to the office within 48 hours of providing the service to the patient. ☐ True ☐ False

22. Employees must work at least six months of continuous employment before being eligible for family leave. ☐ True ☐ False

23. Eligible employees are entitled to use any accrued sick and/or vacation time during a pregnancy leave of absence. ☐ True ☐ False

24. It is the responsibility of the employee to immediately inform their supervisor (in writing) of any change in name, address, marital status, or any other personal changes. ☐ True ☐ False

UNIVERSAL PRECAUTIONS / INFECTION CONTROL / TB Post-Test

Orientee's Name _____ **Date** _____ **Score** _____

1. Aseptic is another word for sterile. ☐ True ☐ False

2. The purpose of the Infection Control/Exposure Plan is to insure:

   a. An ongoing, effective and consistent method of evaluating infections
   b. Improving patient/staff safety and patient care.
   c. Both a and b
   d. None of the above

3. Bloodborne pathogens refer only to HIV/HBV. ☐ True ☐ False

4. Only some staff members must be knowledgeable in reportable communicable diseases. ☐ True ☐ False

5. We must maintain an Infection Log noting all infections present in both patients and staff. ☐ True ☐ False

6. Hands must be washed with soap and water before and after all patient care. ☐ True ☐ False

7. Hands must be scrubbed with soap and water under a steady stream of water for at least:

   a. Two seconds
   b. Fifteen seconds
   c. Thirty seconds

8. There are some occasions in which it is appropriate to recap needles. ☐ True ☐ False

9. The use of Universal Precautions replaces handwashing. ☐ True ☐ False

10. If a staff member is exposed to bloody or body fluids, hands and any other skin are cleansed with 1:50 bleach solution or the waterless hand cleanser that is viricidal. ☐ True ☐ False

11. All Biohazardous/infectious waste management records shall be maintained for three years. ☐ True ☐ False

12. The following reusable equipment must be cleansed with alcohol swabs before each patient's use:

    a. Stethoscope
    b. Blood glucose monitoring devices
    c. Bandage scissors
    d. Scales
    e. Only a and c
    f. All of the above

13. All staff members are responsible for the cleaning of their reusable equipment. ☐ True ☐ False

14. Staff members must observe Universal Precautions in the collection of laboratory specimens. ☐ True ☐ False

15. It is acceptable to place a blood specimen in the trunk of the staff member's vehicle during transportation. ☐ True ☐ False

16. Only skilled nurses are required to attend an annual mandatory Universal Precautions/Infection Control/TB In-service. ☐ True ☐ False

17. Staff members must always wear gloves when performing fingersticks for glucose testing. ☐ True ☐ False

18. Handwashing is the single most important way to prevent the spread of infectious organisms. ☐ True ☐ False

19. Spills of blood and body fluids are to be cleaned with soap and water or household detergents and followed by decontamination with 1:10 bleach solution. ☐ True ☐ False

20. We offer the Hepatitis B vaccine series free of charge to all Of our employees. ☐ True ☐ False

21. It is acceptable to use out-of-date products on certain occasions. ☐ True ☐ False

22. What is the easiest source control method to use that reduces air contamination?

    a. Cover patient's mouth with tissues when coughing
    b. Use a particulate respirator
    c. Wear a surgical mask

23. Filtering air through a HEPA filter is 100% effective in removing all tuberculosis particles and is the only means necessary to disinfect the air. ☐ True ☐ False

24. An HBV or HIV carrier may have no symptoms but can spread the disease to others. ☐ True ☐ False

25. You can get HIV and HBV from puncture wounds, broken Skin contact and mucus membrane contact. ☐ True ☐ False

SAFETY ORIENTATION
Post-Test

Orientee's Name _____ **Date** _____ **Score** _____

1. When a person bends from the lower back, the weight of their upper body is added to the weight of the load. ☐ True ☐ False

2. Most back injuries are bl amed on one "bad lift". ☐ True ☐ False

3. When lifting or transferring a patient, what lifting techniques should you use to protect yourself from back injury? _____

4. When there is fire or smoke present in the home, what is your first priority?
_____

5. What techniques should you use if there is fire or smoke present in the home? _____ _____ _____ _____

6. Preplanning for an emergency means evaluating steps that should be taken, and planning how to react to them before they happen. ☐ True ☐ False

7. When using a fire extinguisher, it is important to spray the base of the fire in a sweeping motion. ☐ True ☐ False

8. In the case of an earthquake during a home visit, you should immediately evacuate the premises with the patient. ☐ True ☐ False

9. What is the most common injury on the job? _____

10. All equipment supplied by a medical supply company should be JCAHO certified. ☐ True ☐ False

11. Healthcare reports more job related injuries than any other occupation. ☐ True ☐ False

12. Any employee who has occupational exposure/contact to body fluids or blood, should be sure they are provided with what? _____
_____

13. What is the most common communicable bloodborne disease?
_____

14. What are two common and effective ways to reduce the spread of infection?
_____ and _____

15. When disposing of contaminated infectious waste such as gloves and blood-soiled materials, how should you dispose of them?
_____

16. No matter how minor an incident may appear, you should always report any work-related injury or exposure to your supervisor. ☐ True ☐ False
17. When traveling to a patient's home, you should always practice alertness and carry a survival kit in your car at all times. ☐ True ☐ False

18. What are some ways to ward off or protect yourself against potential attackers?

_____

19. When making home visits, you should always check your surroundings, and if it appears unsafe, leave. ☐ True ☐ False

20. Health care workers are exposed to risks everyday. ☐ True ☐ False

21. MSDS stands for what? _____

22. The MSDS provides information for what? _____

23. When exposed to a chemical, what should you do? _____

_____

24. When working with chemicals, you should refer to the MSDS for information about different types of personal protective equipment you should use. ☐ True ☐ False

25. Safety is everyone's business. If you observe any condition(s) that may seem unsafe, you should report it right away. ☐ True ☐ False

Florence Home Health Care

Licensed Vocational Nurse Pre-Employment Examination

(CIRCLE THE BEST ANSWER)

1. **Before giving an adult patient prescribed daily dose of digoxin, the nurse finds the patient's apical pulse in 54. Before administration of medication:**

   a. re-check order, then give the dose
   b. hold medication, notify the physician
   c. break the tablet in half, give half dose
   d. give the medication in divided doses

2. **The patient's blood sugar level registered at 45 mg/dl per glucometer reading. Based on the reading, the patient should have the following symptoms:**

   a. tachycardia
   b. pallor, perspiration
   c. twitching, unsteady gait
   d. confusion, erratic behavior
   e. all of the above

3. **Universal Precautions include all <u>EXCEPT</u>:**

   a. use of goggles to perform daily bath
   b. use gloves to start peripheral I.V.
   c. use of gown, gloves to clean patient's bloody diarrhea
   d. disposal of used syringes without recapping needles

4. **While eating, the patient starts to choke and cough. The first thing you do is:**

   a. give an abdominal thrust
   b. give four back blows
   c. check apical pulse
   d. ask, "can you speak?"

5. **In trach suctioning, you must remember the importance of:**

   a. inserting catheter until resistance is met
   b. initiating suctioning as catheter is gently withdrawn
   c. untying neck tapes when cleansing the stoma
   d. removing the inner cannula prior to suctioning

6. **A bedridden patient, taking oral antibiotics now has RLL pneumonia. Which action is <u>NOT</u> appropriate?**

   a. chest percussion and postural drainage q 4 hours
   b. auscultate breath sounds q 2-4 hours
   c. administer expectorants as ordered
   d. encourage low fluid intake to prevent fluid overload

7. **Which of the following would be safety hazards?**

   a. scattered throw rugs on the floor
   b. overload electrical outlets
   c. frayed electrical wiring
   d. all of the above

8. **For a small grease fire in the kitchen, you would <u>NOT</u>:**

   a. move the patient out of the house
   b. call "911"
   c. pour water on flames
   d. use baking soda or fire extinguisher if fire is contained

9. **Otto was injured in an accident and discharged in a body cast. Otto should have his position changed at least:**

   a. once a shift
   b. every two hours
   c. twice a day
   d. at bath time and bed time

10. **Patient with bruises on her arms states her son is abusive. Which of the following in <u>NOT</u> appropriate?**

    a. notifying your supervisor
    b. confronting son with the information
    c. notification of MD, MSW and protective services
    d. all of the above

11. **A comatose patient in your care receives all medication via NG tube. Caregiver pours meds directly from bottle into the tube. Your family education would include:**

a. always check tube for placement first, otherwise it's OK
b. check tube for placement and measure dose every time
c. measure correct dosage, but no need to check placement
d. all of the above

12. **You're asked to perform an in-and-out cath on a patient who often has it done at home. Without orders, you would:**

a. perform the procedure since it's routinely done by wife
b. refuse to do the procedure without doctor's orders
c. do the procedure, then call for a doctor's order
d. call MD to explain, get orders, then do

13. **Signs and symptoms of digitalis toxicity are:**

a. anorexia and nausea
b. generalized muscle weakness and hallucination
c. arrhythmias and hypotension
d. all of the above

14. **The following about AIDS and blood are <u>FALSE</u> except:**

a. AIDS can be contracted by giving blood
b. risk of AIDS from a blood transfusion is now low
c. blood infected with HIV is treated at very high temps
d. all of the above

15. **A patient receiving oxygen @ 2LPM via nasal prongs complains of "air hunger." Which action is <u>NOT</u> appropriate?**

a. increase oxygen to 10LPM
b. elevate HOB to 90 degrees
c. assist patient to do "purse-lipped" breathing
d. administer IPPB as ordered

16. **When manually ventilating a patient with an ambu bag due to ventilator failure, adequate ventilation is determined by:**

a. patient's color
b. normal rise and fall of the chest
c. adequate air exchange on auscultation
d. all of the above

17. **Which of the following does NOT indicate wound infection?**

a. serous drainage from Penrose drain
b. low-grade temperature
c. erythema around incisional site
d. tenderness in the incisional area

18. **In teaching safe self-administration of Prednisone, you include all of the following <u>EXCEPT</u>:**

a. "you may need to increase your salt intake"
b. "protect yourself from infections"
c. "take the medication with meals or snack"
d. "never stop the medication abruptly"

19. **MD orders 3000u of drug dispensed in 5000u/ml:**

a. patient should receive 0.3ml
b. patient should receive 0.4ml
c. patient should receive 0.6ml
d. patient should receive 0.8ml

20. **Patient with difficulty swallowing receives 1.25mg of Elixir. On hand is 4ml = 0.625mg. What do you give?**

a. 8ml
b. 80ml
c. 0.8ml
d. 1ml

21. **Iron preparations should be administered:**

a. at bedtime
b. before breakfast
c. with meals
d. anytime

22. **For the patient receiving 40u regular insulin at 7:30 am, the most likely time for an insulin reaction is:**

a. by 8:00 am
b. at 4:00 pm
c. during the night
d. around 11:00 am

23. **The HIV virus is spread by all of the following <u>EXCEPT</u>:**

a. hugging and kissing on the cheek
b. sexual activity
c. receipt of blood/blood products
d. sharing needles/syringes

24. **To prevent thrombosis after an MI, the MD orders:**

a. coumadin
b. protamine
c. vitamin K
d. a and b

25. **When taking Lasix, patient is encouraged to increase:**
a. fluids
b. sodium
c. calcium
d. potassium

26. **Nitroglycerin (NTG) is most commonly used for:**

a. aches in lower back
b. pains in the chest
c. shortness of breath
d. edema of hands and feet

27. **A common side effect of Codeine is:**

a. diarrhea
b. constipation
c. slurred speech
d. increased pain

28. **For the patient with dyspnea, the most comfortable position would be:**

a. Sims left lateral
b. Fowlers
c. Trendelenberg
d. supine

29. **Which of the following is said to have a vital role in the healing process?**

a. vitamin A
b. vitamin B-12
c. vitamin C
d. vitamin D
e. all of the above

30. **Match the following:**

___ Short Term Insulin	a. Regular, Semilente
___ Intermediate Acting	b. PZI, Ultralente
___ Long Acting	c. NPH, Lente

31. **Manifestations of CHF include:**

a. edema
b. dyspnea on exertion
c. hepatomegaly
d. all of the above

32. **Patients experiencing urinary leakage should be instructed to cut back on the amount of liquids they drink.**

a. True
b. False

33. **Possible clinical manifestations of hypertension include:**

a. headache
b. fatigue
c. dizziness
d. palpitations
e. A, B and C

34. **Which is the most common form of arthritis:**

a. Rheumatoid
b. Osteoarthritis
c. Degenerative

35. **Assessment of a patient with a diagnosis of degenerative arthritis may reveal the following s/sx <u>except</u>:**

a. excessive dorsal kyphosis
b. moderate degree of limitation of motion
c. normal temperature, pulse rate and respirations
d. sleepiness and shortness of breath

36. **Possible side effects of radiation therapy are:**

a. skin reactions
b. nausea and vomiting
c. fatigue
d. all of the above

37. **Items that should be included in Patient Teaching Assessment:**

a. learning barriers
b. information needed by patient
c. readiness
d. resources
e. all of the above

38. **Signs and symptoms of digitalis toxicity include:**

1. Muscle cramps
2. Hallucinations
3. Pulse deficit
4. Paresthesia
5. Abdominal pain
6. Nausea, vomiting and diarrhea

a. 2, 4, 6
b. 2, 3, 5, 6
c. 1, 3, 4, 5
d. all of the above

39. **You suspect your patient is dehydrated, your physical assessment would reveal all of the following data except:**

a. flattened neck veins
b. rapid, strong pulse
c. dry mucous membranes

40. **Major complications of continued bedrest include:**

a. urinary tract infections
b. disuse osteoporosis
c. constipation
d. neuropathy
e. a, c, d
f. a, b, c
g. a, c

Printed Name:

_____

Signature:

_____

Date:

_____

Job Duty Performance-Based Evaluation

POSITION: Licensed Vocational Nurse

Key:
1 = Below Standard Level of Performance
2 = Meets Acceptable Level of Performance
3 = Exceeds Standard Level of Performance
4 = N/A for Evaluation Period

Essential Duties and Responsibilities

1	Contributes to the development of a plan of nursing action based on existing problems, expected patient response, and the Plan of Care.	1	2	3	4
2	Performs duties consistent with the Licensed Vocational Nursing Practice Act.	1	2	3	4
3	Implements safe, therapeutic care of patients with overt needs in supervised/controlled situations as initiated in the Plan of Care by the physician in consultation with the Case Manager/RN and the interdisciplinary team.	1	2	3	4
4	Utilizes resources (patient, family, staff, outside personnel, agencies/organizations) to contribute to the Plan of Care.	1	2	3	4
5	Maintains current knowledge and skills for documenting care to meet Regulatory and third party payer requirements. Prepares documentation and clinical notes. Documents clearly and concisely, using proper notation and Agency abbreviations. Submits all documentation within the timelines established by the Agency.	1	2	3	4
6	Explains test, procedures, disease process, and provides other health education to patient, family, and/or caregiver. Documents patient/family/caregiver response to care and instructions.	1	2	3	4
7	Notifies the patient's attending physician, dentist, or podiatrist and other professional persons and responsible staff of significant changes in the patient's condition. "Significant changes" include those changes that suggest the need to modify or develop a plan of treatment or plan of care.	1	2	3	4
8	May teach basic patient care to ancillary personnel and CHHAs.	1	2	3	4
9	Participates in coordination of home health services, appropriately reporting the need for other disciplines to the case manager and/or clinical supervisor.	1	2	3	4
10	Reports on the patient's condition and changing patient status to the Case Manager and/or clinical supervisor.	1	2	3	4
11	Regularly attends and participates in scheduled case conferences, staff meetings and Agency in-services.	1	2	3	4
12	Participates in appropriate continuing education as may be requested and/or	1	2	3	4

required by you immediate supervisor. In addition, it is expected that personnel will accept personal responsibility for other educational activities to enhance job-related skills and abilities.

13	Attends mandatory educational programs. Attends and/or participates in Clinical Record Reviews and other Quality Improvement functions as directed by supervisor.	1	2	3	4
14	Prevents spread of infection and disease by proper disposal of contaminated materials and by adhering to Standard Precautions.	1	2	3	4
15	Maintains/conserves confidentiality of patient and Agency information at all times.	1	2	3	4
16	Regularly assesses own nursing skills and educational needs to meet the nursing care requirements of patients assigned for care. Upgrades professional skills and attends in-services and continuing education classes as needed.	1	2	3	4
17	Provides those services requiring nursing skills in accordance with the plan of treatment of plan of care.	1	2	3	4
18	Educates and instructs the patient, patient's family, or staff as required. Teaching patient information is limited to that which is outlined in and consistent with the licensed Vocational Nurse Practice Act.	1	2	3	4
19	Assists the patient in learning appropriate self-care techniques.	1	2	3	4
20	Assists the physician and registered nurse in performing specialized procedures. Prepares equipment and materials for treatments observing aseptic technique as required.	1	2	3	4
21	Conforms to all agency policies and procedures.	1	2	3	4

Comments:

_____

_____

_____

_____

_____

By providing my signature below, I attest that I have seen and discussed the preceding review.

Employee Name _____

Employee Signature _____

Reviewer Signature _____

Date of Review _____

Job Description

Title: Licensed Vocational Nurse

Reports To: Clinical Supervisor

QUALIFICATIONS

1. Current California License for Vocational Nurse issued by the California Board of Vocational Nurse and Psychiatric Technician Examiners.
2. Minimum one year experience as a professional nurse. Community/home health or medical/surgical experience is preferred.
3. Has excellent clinical judgment, knowledge of current nursing practices, and observation.
4. Must be able to communicate effectively, both verbally and in writing.
5. Must have dexterity, coordination, and visual and auditory acuity to perform all job responsibilities.
6. Current CPR Certification.
7. Current and satisfactory report on pre-employment physical examination including Mantoux TB Test or chest X-ray as required by Agency policies and procedures.
8. Must be free from signs of infection and illness.
9. Able to walk, bend, stoop, and lift objects weighing up to 25lbs.
10. Is fluent in English.
11. Is self-directed and able to work with little supervision and has good organizational skills.
12. Must be a licensed driver with an automobile that is insured in accordance with state and/or organizational requirements and is in good working order.
13. Is able to use professional judgment in reporting and seeking assistance from both peers and supervisors.

POSITION SUMMARY

The Licensed Vocational Nursing provides skilled nursing care to patients following a plan of care established by the physician in consultation with the Case Manager/RN and the interdisciplinary team members.

ESSENTIAL DUTIES AND RESPONSIBILITIES

The following is representation of the major duties and responsibilities of this position. The Agency will make reasonable accommodations to allow otherwise qualified applicants with disabilities to perform essential functions.

1. Contributes to the development of a plan of nursing action based on existing problems, expected patient response, and the Plan of Care.

2. Performs duties consistent with the Vocational Nursing Practice Act.

3. Implements safe, therapeutic care of patients with overt needs in supervised/controlled situations as initiated in the Plan of Care by the physician in consultation with the Case Manager/RN and the interdisciplinary team.

4. Utilizes resources (patient, family, staff, outside personnel, agencies/organizations) to contribute to the Plan of Care.

5. Maintains current knowledge and skills for documenting care to meet Regulatory and third party payer requirements. Prepares documentation and clinical/progress notes. Documents clearly and concisely, using proper notation and Agency abbreviations. Submits all documentation within the timelines established by the Agency.

6. Explains test, procedures, disease process, and provides other health education to patient, family, and/or caregiver. Documents patient/family/caregiver response to care and teaching.

7. Notifies the patient's attending physician, dentist, or podiatrist and other professional persons and responsible staff of significant changes in the patient's condition. "Significant changes" include those changes that suggest the need to modify or develop a plan of treatment or plan of care.

8. May teach basic patient care to ancillary personnel and CHHAs.

9. Participates in coordination of home health services, appropriately reporting the need for other disciplines to the case manager and/or clinical supervisor.

10. Reports on the patient's condition and changing patient status to the Case Manager and/or clinical supervisor.

11. Regularly attends and participates in scheduled case conferences, staff meetings and Agency inservices.

12. Participates in appropriate continuing education as may be requested and/or required by you immediate supervisor. In addition, it is expected that personnel will accept personal responsibility for other educational activities to enhance job-related skills and abilities.

13. Attends mandatory educational programs. Attends and/or participates in Clinical Record Reviews and other Quality Improvement functions as directed by supervisor.

14. Prevents spread of infection and disease by proper disposal of contaminated materials and by adhering to Standard Precautions.

15. Maintains/conserves confidentiality of patient and Agency information at all times.

16. Regularly assesses own nursing skills and educational needs to meet the nursing care requirements of patients assigned for care. Upgrades professional skills and attends in-services and continuing education classes as needed.

17. Provides those services requiring nursing skills in accordance with the plan of treatment of plan of care.

18. Educates and instructs the patient, patient's family, or staff as required. Teaching patient information is limited to that which is outlined in and consistent with the licensed Vocational Nurse Practice Act.

19. Assists the patient in learning appropriate self-care techniques.

20. Assists the physician and registered nurse in performing specialized procedures. Prepares equipment and materials for treatments observing aseptic technique as required.

21. Conforms to all agency policies and procedures.

I have reviewed and understand the requirements of the job including the job description outlined above including the physical requirements of the job.

_____ _____

Employee Signature Date

Employee Confidential Medical Information Section

☐ Health History and Physical Examination Expiration ___/___/___ ___/___/___

☐ Hepatitis B Vaccination Waiver Acceptance / Declination Statement

☐ TB Skin Test /or Chest X-ray, if POSITIVE Expiration ___/___/___ ___/___/___

☐ Other CONFIDENTIAL Medical Information [MD Release to return to work Orders]

☐ Other: _____

MEDICAL HISTORY

Check below any recurrent illnesses or conditions that the individual experiences and make any additional comments:

- ☐ Headaches: _____
- ☐ Sinus Problems: _____
- ☐ Sore Throat: _____
- ☐ Colds: _____
- ☐ Seizures: _____
- ☐ Dizzy Spells: _____
- ☐ Impaired Vision: _____
- ☐ Impaired Hearing: _____
- ☐ Nervousness: _____
- ☐ Chest Pain: _____
- ☐ Stomach or Abdominal Pain: _____
- ☐ Bleeding: _____
- ☐ Bowel Problems: _____
- ☐ Kidney Problems: _____
- ☐ Urinary Tract Problems: _____
- ☐ Back Pain or Back Problems: _____
- ☐ Leg/Arm Pain or Numbness: _____
- ☐ Permanent Limitations: _____
- ☐ Surgeries (Previous or Anticipated): _____

_____

Applicant/Employee Statement: I know of no illness or condition or disability either current or previously existing, which would impair my physical capability in the performance of my duties. Failure to acknowledge some or withholding information would be grounds for dismissal. I fully understand this principle.

_____ _____

Employee Signature Date

HEALTH HISTORY AND PHYSICAL EXAMINATION

Employee Name/Title: _____

Social Security #: _____ Date of Employment: _____

HISTORY (To be filled out by Applicant/Employee)

Have you had or do you have any of the following conditions:

Allergies	☐ Yes	☐ No		Hepatitis	☐ Yes	☐ No	
Back Pain	☐ Yes	☐ No		High Blood Pressure	☐ Yes	☐ No	
Chest Pains	☐ Yes	☐ No		Low Blood Pressure	☐ Yes	☐ No	
Chronic Cough	☐ Yes	☐ No		Seizures	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No		Shortness of Breath	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No		Tuberculosis	☐ Yes	☐ No	
Fainting or Dizziness	☐ Yes	☐ No		Varicose Veins	☐ Yes	☐ No	
Headaches (frequent)	☐ Yes	☐ No		Venereal Disease	☐ Yes	☐ No	
Hearing Disability	☐ Yes	☐ No		Visual Disability	☐ Yes	☐ No	
Heart Trouble	☐ Yes	☐ No		Other _____	☐ Yes	☐ No	

PHYSICAL EXAMINATION (To be filled out by physician)

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____

PPD Test: Date Administered _____ Indicate: ☐ Positive ☐ Negative

Chest X-Ray (if indicated): Date Administered _____ Indicate: ☐ Positive ☐ Negative

Comments: _____

_____

_____

_____

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone Number: _____

I certify that the applicant is free from health conditions, which would interfere in his/her ability to perform his/her assigned duties, and is free from symptoms of infectious disease.

_____ _____

Physician Signature Date of Examination

HEPATITIS B VACCINATION WAIVER

Employee Name/Title: _____

DECLINATION STATEMENT:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be a risk of acquiring Hepatitis B Virus (HBV) infection.

I, the undersigned, have been offered the opportunity to receive a Hepatitis B Vaccination free of charge as an employment benefit provided by the agency.

I DECLINE THIS OPTION:

☐ I have already been vaccinated against the Hepatitis B virus.

☐ I do not wish to be vaccinated.

I understand I may rescind this waiver at any time during my employment, and at that time exercise my right to receive the Hepatitis B vaccination series at no charge to me.

_____ _____

Employee Signature Date

EMPLOYEE TUBERCULOSIS RISK SCREENING ASSESSMENT

SYMPTOMS

Cough (non-productive)	☐ Yes	☐ No
Cough (productive)	☐ Yes	☐ No
Significant weight loss	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No
Persistent fatigue	☐ Yes	☐ No
Persistent weakness	☐ Yes	☐ No
Chills and fever	☐ Yes	☐ No
Hemotysis	☐ Yes	☐ No

HIGH RISK GROUP

Health Care worker	☐ Yes	☐ No
Recent Exposure to active TB case	☐ Yes	☐ No
History of positive chest x-ray	☐ Yes	☐ No
Pneumonia within past six months	☐ Yes	☐ No
Current immunosuppressive therapy	☐ Yes	☐ No
10% or below ideal body weight	☐ Yes	☐ No
Chronic Illness:		
Diabetes Mellitus	☐ Yes	☐ No
End Stage Renal Disease	☐ Yes	☐ No
Silicosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Three (3) or more "Yes" responses require physician verification of the following:

- Employee is free from health conditions which would interfere with the employee's ability to perform assigned duties
- Employee is free from symptoms of infectious disease

Employee Signature _____ Date _____

PPD TUBERCULIN TEST FORM

I hereby agree to have a PPD tuberculin skin test.

To my knowledge, I have not previously had a positive skin test for TB, nor have I had a chest x-ray that was positive for TB.

I understand that there may be a reaction to this test in the form of a small skin eruption at the site of the injection.

I have also been informed that should this test be positive, I will be required to have a chest x-ray.

I am not pregnant at this time.

_____ _____

Employee Signature Date

This is to certify that _____ was given a

PPD skin test on: _____ by _____.

This test was checked on: _____ by _____.

and was found to be ☐ Negative ☐ Positive

_____ _____

Signature Date

Florence Home Health Care

ACKNOWLEDGEMENT OF UNIVERSAL PRECAUTIONS

The undersigned employee has been given the guidelines on AIDS and Hepatitis B as well as a copy of the policy and procedure on Universal Precautions. NOTE: The Center for Disease Control (CDC) advises that you greatest risk is up to twelve weeks after exposure to the bloodborne pathogens.

_____
Signature and Title of Orientee

_____
Printed Name of the Orientee

_____
Date

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☐ Other (see instructions) ▶

☐ Exempt payee

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

City, state, and ZIP code

Requester's name and address (optional)

Florence Home Health Care
2521 e Thousand Oaks Blvd
Thousand oaks, CA, 91362

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

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

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 08/31/12

Form I-9, Employment Eligibility Verification

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 *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

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 *(month/day/year)*

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 *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

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 *(if any)*:				
Document #				
Expiration Date *(if any)*:				

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 *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

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

A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)*

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 *(if any)*: _____

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 *(month/day/year)*

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:
- 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 _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- 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.
- 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

Employee's Withholding Allowance Certificate

▶ **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.**

OMB No. 1545-0074

2010

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 ☐ Single ☐ Married ☐ 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. ▶ ☐

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.
- 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)