Hunt Country Health Services

31 S. Braddock Street, Suite 109
Winchester, VA 22601

(540) 773-4941
(800) 317-0428
huntcountryhealthservices@gmail.com

EMPLOYMENT APPLICATION INSTRUCTION LETTER

Thank you for your interest in employment with Hunt Country Health Services. The following instructions are provided to assist applicants applying for advertised positions.

THE APPLICATION PACKET MUST BE COMPLETED IN ITS ENTIRETY.

*******INCOMPLETE APPLICATION PACKETS WILL NOT BE CONSIDERED*******

1. Complete Application for Employment in its entirety.

- Please list all **Certifications/Education**

2. Provide a copy of :

- Driver's License
- Social Security Card
- Certifications

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Agency Phone: (540) 773-4941 Agency Fax: (800) 317-0428

Application for Employment

Client hire date_____ **Client Company**_____

Personal information Date_____

Name_____ Social Security #_____

Present address _____
Street City State Zip

Permanent address _____
Street City State Zip

Phone #_(_____)_____ If you are under 18, can you furnish a work permit? ☐Yes ☐ No

Employment desired ☐Full time ☐Part time ☐Temp ☐Seasonal

Position_____ Date you can start_____ Salary_____

Are you employed now?_____ If so may we inquire of your present employer? ☐Yes ☐No

Ever applied for this company before? ☐Yes ☐No Where_____When_____

Are you on layoff and subject to recall? ☐Yes ☐No. Will you travel if required? ☐Yes ☐No

Will you relocate if job requires it? ☐Yes ☐No. Will you work overtime if required? ☐Yes ☐No

Are you able to meet the attendance requirements of this position? ☐Yes ☐No. Have you ever been

Bonded? ☐Yes ☐No. Have you ever been convicted of a felony in the past 7 yrs ☐Yes ☐No

Such conviction may be relevant if job related, but does not bar you from employment. If yes – explain

_____

_____

Driver's license number_____ State_____

Education		Name and location Of School	# of years Completed	Did you Graduate?	Subjects Studied
Academic	Currently Attending				
	Last Completed				
Trades of Business	Currently Attending				
	Last Completed				

Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with this company._____

_____

_____

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EMPLOYMENT APPLICATION

Date Month and Year	Name and address of employer	Salary	Job	Reason for Leaving
From				
To				
From				
To				
From				
To				

References: Give the names of three persons not related to you to whom you have known at least 1 year

Name	Address	Phone	Yrs acquainted

List any foreign language(s) and check the box that best describes your skill level.

Language	Read and write	Read and speak	Speak only

In case of
Emergency notify_____
Name Address Relationship Phone

INITIAL **Conditions of Employment – please read carefully**

_____ Reporting to work with impaired abilities; or the possession, consumption or distribution of drugs or alcohol on company premises and/or worksites, shall be grounds for disciplinary action, including discharge. A condition of employment includes willingness on the part of the applicant or employee to agree to physical examination, polygraph and/or substance testing. If required by the company. We are committed to operating a drug free workplace. Violations of our drug and alcohol policy will result in dismissal.

_____ It is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service if I have been employed. Furthermore, I understand that just as I am free to resign anytime, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

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EMPLOYMENT APPLICATION

_____ I give the employer the right to investigate all police, driving, and personal records and references, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

____ The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state or federal law.

____ Any controversy of any kind arising between the parties under this agreement or otherwise (or any agent, officer, director or affiliate of any party), including but not limited to common law, statutory, tort or contract claims, will be submitted to mediation and failing settlement in mediation, to binding arbitration. Unless otherwise agreed a mediation and arbitration designated by staff professionals will govern any mediation and arbitration. The parties will select the mediator or arbitrator from the designated company panel of mediators and will notify the designated company, in writing, to initiate the selection process. The arbitration will be subject to and governed by the provisions of the Federal Arbitration Act. 9 U.S.C. Section 1-et seq. The parties hereto stipulate that this agreement involves matters affecting interstate commerce.

____ This application is current for 60 days. At the conclusion of this time if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

_____ _____

Signature of Applicant **Date**

AGENCY MANAGEMENT NOTES:

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BACKGROUND CHECK CONSENT & SWORN STATEMENT FORM

DATE: _____

PRINT NAME: _____

Date of Birth: _____ **SSN:** _____

I, _____, have had no prior convictions of an offense described in 32.1-162.9:1 code or Virginia (Barrier Crimes), which would potentially bar employment.

I UNDERSTAND THAT THE HOME HEALTH AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT.

I, THE UNDERSIGNING, HEREBY AUTHORIZE HUNT COUNTRY HEALTH SERVICES TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

_____ _____

SIGNATURE OF EMPLOYEE ***SIGNATURE OF SUPERVISOR***

Hunt Country Health Services
PMB#122, 12787 Booker T, Washington Blvd,
Hardy, Virginia, 24101
Agency Phone: (540) 773-4941 Agency Fax: (800) 317-0428

EMPLOYEE SAFETY!

Employee Name: _____
Print Name

CELLULAR PHONE USE

Hunt Country Health Services does not permit employees while on company time to talk on the cellular phones while driving a vehicle. This is very dangerous and should be avoided any time. It is mandatory that I must pull over and stop my vehicle each time I conduct agency business per cellular phone.

The agency is not responsible for any moving violations, accidents or other incident that may occur while I am using my cellular phone and driving.

I have read and understand the above information of the agency regulation regarding cellular phone use and I will comply.

_____ _____
Employee Signature *Date*

_____ _____
Agency Representative *Date*

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CONFIDENTIALITY OF INFORMATION AGREEMENT

EMPLOYEE NAME: _____
PRINT NAME

Confidentiality of Information

- All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered, maintained, or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

- In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for the following this Confidentiality Policy Agreement & the Guidelines, both written and verbal.

_____ _____
Employee Signature *Date*

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EMPLOYEE WAGE & MILEAGE AGREEMENT

NAME: _____ DATE: _____

POSITION: _____ Date of Hire _____

DEPARTMENT: _____ SUPERVISOR: _____

EXEMPT _____ YES _____ NO

PAID MILEAGE _____ YES _____ NO _____ ALLOWANCE

PAY RATE _____ SALARY/HOURLY (please circle one)

_____
Annually

_____
Monthly

_____ _____
Two-weeks Weekly

***ALL INFORMATION RELATING TO SALARY, BONUS, AND WAGE INCREASE IS STRICTLY CONFIDENTIAL.**

_____ _____
EMPLOYEE SIGNATURE *DATE*

_____ _____
COMPANY REPRESENTATIVE *DATE*

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Employee Name: _____
Print Name

EMPLOYMENT AGREEMENT

1. The employee will carry out the duties and responsibilities listed in the job description/ list of assigned tasks, and signed by employee and employer.

2. Following are the hours the employee will work:

Monday	_____	Friday	_____
Tuesday	_____	Friday	_____
Wednesday	_____	Sunday	_____
Thursday	_____		

3. The employee will have the following time off:
_____

4. The employer will pay the employee $ _____.___ per hour.

5. When leaving, the employee will give the approximate time of return and, if possible, leave a phone number where he/she can be reached. Also, when the employee will be late in returning, he/she will call to let the employer know.

6. The employee is responsible for paying for long-distance telephone calls made/received by the employee.

7. The employee will not be paid for scheduled hours not worked unless the time not worked is covered by a benefit as provided by the employer.

8. Both parties to this agreement will respect each other's individuality and treat each other accordingly. Both will attempt to be flexible and work at solving problems as they arise.

9. At least 2 weeks notice will be given by employee regarding termination of this agreement.

Other agreements/ benefits:

_____
_____
_____

_____ _____
Employer Signature ***Date***

_____ _____
Employee Signature ***Date***

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Employee Name: _____
Print Name

FOLLOWING INFECTION CONTROL AGREEMENT

Hunt Country Health Services wants to improve patient outcomes by identifying and reducing the risk of infection in patients and agency staff.

The agency will document infections that are acquired while the patient is receiving services from the agency. The documentation will include at a minimum the date that the infection was detected, patients name or number, primary diagnosis, signs/symptoms, type of infection, pathogens identified and treatment.

The infection control program will include surveillance, identification, prevention, control, and reporting. Targeted surveillance of infections will focus on specific patient population or procedures.

Infection Control Standards are established in compliance with the recommendations of the National Center for Disease Control in Atlanta, Georgia. All staff is educated on these standards and they are practiced consistently. Any incidents of infection related to care and service are reported.

I recognize, and am fully aware of the fact that any patient may be contagious at any time and that this may not always be a known fact while care is being provided. I will follow all Infection Control and Universal Precautions Procedures of the agency. I also state that currently I am in excellent health and have no impairments that may alter my job performance.

_____ _____
Employee Signature *Date*

_____ _____
Agency Representative *Date*

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HBV VACCINE / WAIVER FORM

Employee Name: _____ **Date of Hire:**_____
Print Name

Social Security Number: _____

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) Infection. **I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself.** I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially Infectious materials and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

I have been advised to my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.

_____ **I choose to waive my rights to receive the HBV Vaccine**

_____ **I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3 part series.**

Series # 1 Date	Series # 2 Date	Series # 3 Date

_____ _____
Employee Signature *Date*

_____ _____
Agency Rep. Signature *Date*

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Employee Name: _____

ANNUAL TUBERCULOSIS QUESTIONNAIRE

For personnel who have a known positive PPD and previously negative chest x-ray, you are requested to complete this questionnaire with either a yes or no.

HAVE YOU NOTICED ANY OF THE FOLLOWING?

1. Unexplained Fevers	☐ **Yes** ☐ **No**
2. Night Sweats	☐ **Yes** ☐ **No**
3. Unintentional weight loss	☐ **Yes** ☐ **No**
4. Cough	☐ **Yes** ☐ **No**
5. Hoarseness	☐ **Yes** ☐ **No**
6. Bloody Sputum	☐ **Yes** ☐ **No**
7. Have you completed INH therapy?	☐ **Yes** ☐ **No**
8. Have you ever had a BCG vaccine?	☐ **Yes** ☐ **No**
9. Have you had an x-ray while employed here?	☐ **Yes** ☐ **No**

_____ _____

Employee Signature ***Date***

Follow-up needed ___ **Yes** ___ **No**

Comments: _____

_____

_____

_____

Agency Representative: _____ ***Date*** _____

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Name of Employee: _____
Print Name

DISCLAIMER AND WAIVER OF LIABILITY

I acknowledge and will adhere to the rules and regulations as set forth by the Office of Licensing and Certification and Medicare and Medicaid. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination.
I therefore hold Hunt Country Health Services, its shareholders, directors and officers, harmless from any falsified documents.

I have read and understand the above information. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination.

Employee Signature **Date**

Agency Representative **Date**

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EMPLOYEE DRESS CODE

Employee Name: _____ **Date:** _____
Print Name

Hunt Country Health Services strives to present a professional and safe health care image to patients' families, the community, and other Health Care professionals. Hunt Country Health Services staff members adhere to the following standards in their dress appearance.

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1. All staff will wear an approved **Hunt Country Health Services** name badge when providing patient care.

2. Clothing shall be clean, neat, and well maintained.
   Allowed Clothing: Loose comfortable clothing, scrubs, walking shorts that are at least mid thigh in length, hemmed blue jeans, plain T-shirt, and Casual Street wear. Appropriate undergarments should be worn.
   Not Allowed: mini skirts, short shorts, tank tops, halter-tops, midriffs, cut offs, frayed blue jeans, or T-shirts with any sayings on them.

3. Shoes should be conservative and comfortable. We encourage closed toed shoes for personal safety and infection control while providing patient care. No flip-flops or thong sandals.

4. When attending school with a patient, the employee will be provided with a copy of the schools dress code and must adhere to it.

5. Nurses should keep a clean lab coat available to wear over their clothes when accompanying patients to any medical appointment. (These may be unexpected).

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Employee Name: _____
Print Name

6. **Hunt Country Health Services** employees will try to meet the requests of parents or primary caregivers within reason.

7. Employees are expected to keep their hair dry, neat, and clean. Long hair must be styled so it does not come in contact of the patient. Mustaches and beards must be clean and trimmed.

8. Perfume should be conservative. Strong odors can be offensive to patients.

9. Jewelry represents a safety hazard, so it must be worn with discretion, i.e. wedding rings, rings without large mountings, small earrings or studs. Visible piercing, except for earrings, should be removed when providing patient care. Both professionalism and safety should be considered when wearing jewelry.

10. Fingernails are to be kept clean, trimmed and moderately short for patient safety.

*** If an employee is sent home to change clothes due to inappropriate attire, the employee will be sent home on his/her own time and may result in disciplinary action.**

**** Interpretation of compliance to this dress code policy is subject to the discretion of the Administrator, DOSS, or acting supervisor.***

_____ _____
Signature ***Date***

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EMPLOYEE ORIENTATION

Employee Name: _____ Position: _____

Date of Hire: _____ Date of Orientation: _____

GENERAL ORIENTATION WITH HUMAN RESOURCES

- HIPAA Privacy Regulations- Review handbooks and examination
- Discuss policies and procedures included in employee handbook, with focus on new and added updated policies and review policy and procedure examination
- Review employee benefits as applicable to various employee statuses
- Review complaint and grievances procedures
- Review sexual harassment policy
- Review Body Mechanics video and materials

GENERAL ORIENTATION WITH NURSING

- **Instructive Memos from DOSS to clinical staff**
- **Sample Nurse's Notes**
- **Nursing Peer Review Process**
- **OSHA Infection Control**
- **Nursing Skills Checklist**
- **Detecting Patient Abuse: Child Abuse and Abuse of the Elderly**

_____ _____

Employee Signature **Nursing Supervisor Signature**

_____

HR Signature

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Employee Name: _____
Print Name

HEALTH & SAFETY AGREEMENT

I do understand the physical requirements of my job and understand proper lifting and moving techniques, which I am expected to use in moving and lifting objects and/or patients.

I have been informed and do fully understand that any injury claimed by me while on the job must be reported immediately to my supervisor and documented on an Accident/Incident Report form. I understand that unless and incident report is completed immediately and signed by me, the agency may not consider a voluntary payment of any medical bills or any other benefits as a result of my injury. I further understand that if the accident/injury is proven to be a result of my failing to follow policy/procedure, the agency may not be expected to cover medical payments.

I do fully understand that I am not encouraged to lift or transfer any object or patient by myself unless I know that I can safely lift or transfer alone. If I believe there is no one readily available to assist me in lifting or moving patients or equipment while on duty, I am to wait until I can obtain assistance before moving or lifting.

I have had the opportunity to review and have all questions answered regarding *Health & Safety.*

_____ _____
Employee Signature ***Date***

_____ _____
Agency Representative ***Date***

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NON-COMPETE AGREEMENT

As an employee of Hunt Country Health Services, the employee acknowledges that they will be in receipt of confidential information. This information shall include but not be limited to, procedures manuals, in-house policies, patient lists, patient's medical records, financial information and billing records, certifications and applications, actual and prospective markets an patient's, business plans and marketing strategies, customer lists, sales and marketing data, operating systems, income statements, asset and liability information, financial projections and any other confidential information gathered, revealed, acquired or generated by or for Hunt Country Health Services Each employee shall protect and hold in confidence the confidential information to anyone except with the express written consent of Dorin Takwa, Administrator. The employee acknowledges and understands the competitive sensitivity of the confidential information and the potential for significant material harm that could result to Hunt Country Health Services in the event that confidential information is disseminated to others, in particular competitors. Therefore, the employee agrees that the appropriate remedy would be an immediate injunction against the violating employee in joining and prohibiting the use and continued dissemination of the confidential information. Further, each employee agrees that the dissemination of the confidential information would cause damages for which damages could not be readily ascertained and would constitute a breach of duty owed by the employee to Hunt Country Health Services Each employee agrees to pay Hunt Country Health Services in any action to enforce this confidentiality agreement or cost of litigation, including attorney's fees and other damages found by the trier of fact.

As consideration for employment and for the release of this confidential information, employee agrees not to compete against Hunt Country Health Services or to utilize any of the confidential information for a period of two (2) years from the date of their employment terminated with Hunt Country Health Services. This Non-Compete Agreement shall be limited to Frederick County and contiguous counties. This Non-Compete Agreement is not intended to prohibit employee from working as a nurse, therapist or other position in the health service industries but is intended to prohibit employee from working with a competitor of Hunt Country Health Services in the home health industry and utilizing any of the confidential information of Hunt Country Health Services or contacting any of Hunt Country Health Services patients. Employee agrees and warrants that they will not contact, engage, discuss, negotiate or contract with any patient or family member of a patient for those purpose of developing or promoting home health care services of said patient. All parties acknowledge that this confidential information is of a proprietary nature to Hunt Country Health Services and if the confidential information was revealed to the general public or to a competitor, the revelation would destroy or impair the expected success of Hunt Country Health Services

ANY CONTROVERSY OR CLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT SHALL BE SUBMITTED TO ARBITRATION BEFORE ONE (1) ARBITRATOR IN F, VIRGINIA, IN ACCORDANCE WITH THE COMMERCIAL ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION. JUDGMENT UPON THE AWARD RENDERED BY THE ARBITRATOR MAY BE ENTERED BY ANY COURT HAVING JURISDICATION THEREOF. ARBITRATION SHALL BE THE EXCLUSIVE, FINAL AND BINDING METHOD OF RESOLUTION OF ANY CLAIM OR CONTROVERSY BETWEEN HUNT COUNTRY HEALTH SERVICES AND EMPLOYE ARISING FROM THIS AGREEMENT.

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

_____ _____

Employee Name ***Date***

_____ _____

Agency Representative ***Date***

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NAME OF EMPLOYEE: _____
Print Name

POLICIES & PROCEDURES ORIENTATION ACKNOWLEDGEMENT

I acknowledge that I have been oriented to agencies Policies and Procedures Manual and agree to follow all guidelines, both written and verbal. I understand that, if the guidelines, policies and procedures are not followed, that I may be immediately terminated. I also had the opportunity to ask questions regarding the Policies and Procedures Manual and I know where it's located for future reference.

Employee Signature	**Date**
Agency Representative Signature	**Date**

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REPORTING: ABUSE / NEGLECT / EXPLOITATION

EMPLOYEE NAME: _____
PRINT NAME

REPORTING:

- **ABUSE**
- **NEGLECT**
- **EXPLOITATION**

All agency staff is required to report suspected abuse/neglect/exploitation and develop a plan to minimize the risk of such. The home health employee is responsible to report & document:

- A child's susceptibility to abuse includes self-abuse and neglect.
- Elderly individuals as children are susceptible to abuse as well.
- Physical components, such as impairments and the ability of patient/caregiver to provide adequate care.
- Mental impairments, such as mental retardation, Alzheimer's disease, disorientation, confusion, etc.
- Emotional status, such as passive personality, depression, etc.
- Physical environment, such as safety in or outside the home.
  The employee is responsible to report all incidents to DOSS and/or Supervisor. A written report may be forwarded for Social Services with the request for referral. The Supervisor will review the situation and investigate to determine if this is a reportable incident. If, so it will be reported to the appropriate agency or Adult/ Child Protection Agency by the DOSS/Administrator or an appropriate designee.

*** I have read and understand the information above. As a home health employee it is my responsibility to report & document any suspected Abuse, Neglect, or Exploitation.**

_____ _____

Signature Date

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Employee Name: _____
Print Name

SEXUAL HARASSMENT

Hunt Country Health Services does not tolerate **Sexual Harassment,** as it is a form of gender-based discrimination.

Definition:
Under Title VII of the Civil Rights Act of 1964, any type of discrimination based on an individual's gender (male or female) is illegal. Sexual harassment is considered to be a form of gender discrimination. According to the Equal Employment Opportunity Commission, sexual harassment is "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to the conduct enters into employment decisions and/ or the conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment."

The Agency will not tolerate any form of sexual harassment from any of its employees. The Agency encourages that any behavior which could be construed as sexual harassment be reported immediately to the supervisor and/ or Administrator. There is no need to fear retaliation. Both females and males can be sexually harassed when exposed to unwelcome sexual advances or to a pattern of verbal abuse, threatening, crude, impolite, or unprofessional conduct.

- Quid pro quo sexual harassment is also against company policy.
- The Agency encourages and urges an employee to come forward and discuss any sexual harassment that may have occurred with an Administrator.
- Every complaint will be taken seriously and investigated immediately. Investigations will be documented.
- Any employee involved in a sexual harassment complaint will have a full opportunity to give a full account of their recollection of the incident or incidents.
- The incident(s) will be investigated thoroughly and appropriate action will be taken.

_____ _____
Employee Signature *Date*

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UNIVERSAL PRECAUTIONS
Training Document

Name: _____ Date: _____
PRINT NAME

✓ LESSON 1- BLOOD BORNE INFECTION

Definition of exposure
Spread of HIV infection in the general population
Symptoms and effects of HIV infection
Spread of Hepatitis B, including number of infections, hospitalization, and deaths caused by HBV each year.
Symptoms of effects of HBV infection and HBV vaccination
The hepatitis B virus and HIV virus can transmitted in the workplace
It is estimated that there are 1 and ½ million HIV carriers in the U.S.
There may be as many as one million carriers of HBV

✓ LESSON 2 – TRANSMISSION OF BLOOD BORNE INFECTION

Sources of blood borne infections in the workplace
Four primary ways of getting blood borne infections outside the workplace
Three primary ways of getting blood borne infections at work
Risky jobs, tasks, and work practices

✓ LESSON 3 – EXPOSURE CONTROL

The HBV vaccine for all workers who come into contact with blood or other potentially infectious body fluids on the job.
The definition of Universal Precautions
The steps that should be taken after an exposure incident in order to prevent infection
My rights in case of exposure and / or infection
I have the right to have HBV vaccinations provided to me free of charge if I am at risk for infection. If I refuse it at this time, I have the right to be vaccinated free of charge at any time in the future provided I am still at risk for infection.

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Name: _____
PRINT NAME

Training Documentation on Universal Precautions (continued):

✓ **LESSON 4 –USING PERSONAL PROTECTIVE EQUIPMENT**

Types of personal protective equipment (PPE) required for different tasks or situations
Key requirements for selecting, providing, using, and disposing of or cleaning PPE
Limitations of personal protective equipment

✓ **LESSON 5 – WORK PRACTICE CONTROLS**

Disposing of used needles or other sharps
Working with lab materials
Decontaminating work areas, instruments, and equipment
Identifying and handling regulated waste
Hand washing and other personal hygiene and health practices

*** I have received training covering all of the above topics and been informed of my rights accordingly.**

_____ _____
Employee Signature *Date*

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Employee Name: _____
Print Name

DRUG TESTING POLICY

Agency employees may not possess, distribute and or use alcoholic beverages or controlled substances. Including inhalants while on premises of property controlled by the Agency or while in the course of conducting company business or engaged in any company sponsored activity.

Patients or visitors may not possess, distribute and or use alcoholic beverages or controlled substances, while on the premises of the property controlled by the Agency.

Any employee who has knowledge of a person or persons violating this policy must report it to his/her supervisor immediately.

Based on reasonable cause, the agency may conduct searches or inspections of an employee's personal belongings and may be asked to take a drug test. Refusal to consent may result in termination.

*** I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.**

_____ _____
Employee Signature *Date*

Hunt Country Health Services
31 South Braddock St, Suite 109, Winchester, Virginia, 22601
Agency Phone: (540) 773-4941 Agency Fax: (800) 317-0428

Date of Hire:

VERIFICATION OF PROFESSIONAL LICENSE

Employee Name: _____
Print Employee Name

✓ **CHECK OFF DISCIPLINE NEEDING VERIFICATION**

☐ **RN** ☐ **LPN** ☐ **PT** ☐ **OT** ☐ **ST** ☐**MSW** ☐**HHA**

LICENSE NUMBER	EXPIRATION DATE OF LICENSE

DATE VERIFIED: _____

LICENSE VERIFIED BY:

_____ **Written** _____**Phone** _____**Fax**

Action Outstanding: ☐ **YES** ☐**NO**

COMMENTS:

I HAVE READ THE LICENSE OF THE ABOVE INDIVIDUAL ACCORDING TO THE AGENCY POLICY. THE LICENSE IS CURRENT AND IN GOOD STANDING WITH THE STATE OF VIRGINIA.

_____ _____

Signature of Agency Representative ***Date***

Hunt Country Health Services
31 South Braddock St, Suite 109, Winchester, Virginia, 22601
Agency Phone: (540) 773-4941 Agency Fax: (800) 317-0428

New Employee Processing Checklist

The following is a checklist of items required during processing:

Name_____ Hire Date_____

Title_____ Department_____

Category (check one)
- ☐ Full time
- ☐ Part time
- ☐ Per Diem
- ☐ Independent Contractor

Pay/FLSA (check one)
- ☐ Hourly/nonexempt
- ☐ Salaried/nonexempt
- ☐ Salaried/exempt
- ☐ Per visit
- ☐ Independent Contractor

Hiring paperwork to be completed
- ☐ Employment application
- ☐ Employer references
- ☐ Proof of professional license or certification
- ☐ Written proof of freedom from Tuberculosis
- ☐ Hepatitis B vaccination record
- ☐ Current CPR card (copy)
- ☐ I-9 Form
- ☐ Confidentiality agreement
- ☐ Emergency contact record
- ☐ Voluntary self identification form
- ☐ Workers Comp. notice (if applicable)
- ☐ Statement of employability (if applicable)
- ☐ Auto liability insurance (if applicable)
- ☐ Criminal history check (if applicable)

Benefits
- ☐ Pension plan
- ☐ Cafeteria plan
- ☐ Holiday's
- ☐ PTO
- ☐ Jury duty pay
- ☐ Military leave

Insurance
- ☐ Group medical insurance
- ☐ Group dental insurance
- ☐ Life insurance
- ☐ COBRA rights

Personnel Policies
- ☐ Education / Training
- ☐ Promotion from within
- ☐ Performance appraisals
- ☐ Discipline
- ☐ Absences and tardiness
- ☐ Rest breaks
- ☐ Smoking in the workplace
- ☐ Sexual harassment
- ☐ Drug free workplace
- ☐ Ethical/professional conduct
- ☐ Dress code

Pay forms
- ☐ Employment agreement
- ☐ Employee pay status report

Other
- ☐ Organizational chart
- ☐ Employee handbook
- ☐ Personal policy manual (supervisors)
- ☐ Safety information
- ☐ Orientation checklist
- ☐ Skilled Nursing clinical checklist
- ☐ Skilled Nursing specialized skills competency

Hunt Country Health Services
31 South Braddock St, Suite 109, Winchester, Virginia, 22601
Agency Phone: (540) 773-4941 Agency Fax: (800) 317-0428

Date:

✓ EMPLOYEE REFERENCE CHECK

Hunt Country Health Services has my authorization to check my references.

PRINT EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

_____

Company Contacted: _____

Mr. / Mrs.:_____ is seeking employment with our company. It is our policy to ask for references prior to employment. Please complete this form for our records and ***sign below***. We would greatly appreciate your assistance.

PLEASE VERIFY EMPLOYMENT DATES:

From: _____ To:_____

ELIGIBLE FOR REHIRE? ☐ **YES** ☐ **NO**

COMMENTS:

_____
_____
_____
_____

INFORMATION WAS RECEIVED BY: ☐ **Phone** ☐ **Mail** ☐ **Fax**

Name of company _____

* (IF FAXED) **Company Contact Signature** _____

_____ _____

Signature of Agency Representative & Title *Date*

Form W-4 (2016)

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 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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 can 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. 505 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. 505 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. 505 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. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

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 $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	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 are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 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.

---------- **Separate 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

2016

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, 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 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Hunt Country Health Services

31 S. Braddock Street, Suite 109
Winchester, VA 22601

(540) 773-4941
(800) 317-0428
huntcountryhealthservices@gmail.com

MEMO

TO: All Employees

FROM: Management

RE: Direct Deposit Options

Along with this cover letter you will find a Direct Deposit sign-up sheet. Direct Deposit is an optional benefit that we are offering to our employees. Though we prefer all employees' sign up for Direct Deposit, it is not mandatory. If you wish to participate in receiving payments for your services by direct deposit, please carefully and clearly fill out the accompanying form and return it along with a voided check, as required to the Office at the above address.

Once your direct deposit begins, monies owed you for each pay period will automatically be deposited into your account on the scheduled pay date(s). You will no longer receive an actual check. You will receive your pay stub only. Your pay stub can be mailed to you, or you may pick it up in the office on the scheduled pay date.

Authorization for Direct Deposit

I authorize _____to deposit my pay automatically to the account(s) indicated below and, if necessary, to adjust or reverse a deposit for any payroll entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford _____ a reasonable opportunity to act on it.

Name on bank account: _____

Bank account number: _____Checking ___ Savings ___

Bank routing number: _____

Amount: $ _____ or entire paycheck: ___

***Balance of pay to**:

_____ Manual (paper check)

_____ Account described below

***Note**: Split payments are not available for contractors.

Name on bank account: _____

Bank account number: _____Checking ___ Savings ___

Bank routing number: _____

Important: Please attach a voided check for each bank account to which funds should be deposited.

Employee/Contractor signature: _____

Date: _____

Payers: Do not send this form with your Direct Deposit enrollment. Keep for your records.