EMPLOYMENT APPLICATION

PLEASE PRINT OR TYPE			
Name		Preferred Name/Nickname	
Street Address	City	State	Zip Code
Mobile Phone	Alternate Phone	Email Address	

PLEASE PLACE A CHECK BY YOUR RESPONSE OR PROVIDE THE APPROPRIATE INFORMATION				
Position desired				
Are you interested in?	Full Time	Part Time	Temporary	
What schedules would you prefer?	Weekdays	Weekends		
How did you hear about us?	Walk-in	Referral	Advertisement	Other:_____
Have you worked for our company before?	No	Yes	Dates:	
Do you know anyone who works here	No	Yes	Name:	
Desired Pay	Hourly Pay $	Annual Pay $		
When are you able to start work?				
In what local area do you prefer to work?				

Are you authorized to work in the United States? Yes No

Federal law requires that employers hire only individuals who are authorized to be lawfully employed in the United States. In compliance with these laws, **Saving Life Home Health** will verify the status of every individual offered employment with the Company. In this connection, all offers of employment are subject to verification of the applicant's identity and employment authorization, and it will be necessary for you to submit such documents as are required by law to verify your identification and employment authorization.

Are you under 18 years of age? Yes No

If yes, can you furnish a work permit? Yes No

Are you capable of performing functions of the job for which you are applying with or without a reasonable accommodation? Yes No

WORK HISTORY Start with your present or most recent employment and work back.		
Job Title 1	Start Date	End Date
Company Name	Supervisor's Name	Phone Number
Address		
City	State	Zip
Briefly describe your major duties		
Reason for leaving		

Job Title 2	Start Date	End Date
Company Name	Supervisor's Name	Phone Number
Address		
City	State	Zip
Briefly describe your major duties		
Reason for leaving		

Job Title 3	Start Date	End Date
Company Name	Supervisor's Name	Phone Number
Address		
City	State	Zip
Briefly describe your major duties		
Reason for leaving		

Job Title 4	Start Date	End Date
Company Name	Supervisor's Name	Phone Number
Address		
City	State	Zip
Briefly describe your major duties		
Reason for leaving		

Job Title 5	Start Date	End Date
Company Name	Supervisor's Name	Phone Number
Address		
City	State	Zip
Briefly describe your major duties		
Reason for leaving		

Job Title 6	Start Date	End Date
Company Name	Supervisor's Name	Phone Number
Address		
City	State	Zip
Briefly describe your major duties		
Reason for leaving		

EDUCATION

NAME AND ADDRESS OF SCHOOL	ADDRESS	DID YOU GRADUATE?	TYPE OF DEGREE OR DIPLOMA
HIGH SCHOOL OR PREP			
COLLEGE			
COLLEGE OR GRADUATE			
OTHER			

PROFESSIONAL DESIGNATIONS

DESIGNATION	ORGANIZATION GRANTING DESIGNATION	DATE COMPLETED
DESIGNATION	ORGANIZATION GRANTING DESIGNATION	DATE COMPLETED

PROFESSIONAL LICENSES

TYPE OF LICENSE	STATE GRANTING LICENSE	LICENSE NUMBER
TYPE OF LICENSE	STATE GRANTING LICENSE	LICENSE NUMBER

REFERENCES: Please list three professional references not related to you

NAME	RELATIONSHIP	COMPANY	PHONE NUMBER

PLEASE READ CAREFULLY BEFORE SIGNING APPLICATION

I have submitted the attached form to the company for the purpose of obtaining employment. I acknowledge that the use of this form, and my filling it out, does not indicate that any positions are open, nor does it obligate the company to further process my application.

My signature below attests to the fact that the information that I have provided on my application, resume, given verbally, or provided in any other materials, is true and complete to the best of my knowledge and also constitutes authority to verify any and all information submitted on this application. I understand that any misrepresentation or omission of any fact in my application, resume or any other materials, or during any interviews, can be justification for refusal of employment, or, if employed, termination from the Company's employ.

I also affirm that I have not signed any kind of restrictive document creating any obligation to any former employer that would restrict my acceptance of employment with the Company in the position I am seeking.

I understand that this application is not an employment contract for any specific length of time between the Company and me, and that in the event I am hired, my employment will be "at will" and either the Company or I can terminate my employment with or without cause and with or without notice at any time. Nothing contained in any handbook, manual, policy and the like, distributed by the Company to its employees is intended to or can create an employment contract, an offer of employment or any obligation on the Company's part. The Company may, at its sole discretion, hold in abeyance or revoke, amend or modify, abridge or change any benefit, policy practice, condition or process affecting its employees.

References: I hereby authorize the company and its agents to make such investigations and inquiries into my employment and educational history and other related matters as may be necessary in arriving at an employment decision. I hereby release employers, schools, and other persons from all liability in responding to inquires connected with my application and I specifically authorize the release of information by any schools, businesses, individuals, services or other entities listed by me in this form. Furthermore, I authorize the company and its agents to release any reference information to clients who request such information for purposes of evaluating my credentials and qualifications.

Temporary/Contract Employment: If employed as a temporary or contract employee, I understand that I may be an employee of the company and not of any client. If employed, I further understand that my employment is not guaranteed for any specific time and may be terminated at any time for any reason. I further understand that a contract will exist between the company and each client to whom I may be assigned which will require the client to pay a fee to the company in the event that I accept direct employment with the client, I agree to notify the company immediately should I be offered direct employment by a client (or by referral of the client to any subsidiary or affiliated company), either for a permanent, temporary (including assignments through another agency), or consulting positions during my assignment or after my assignment has ended.

SIGNATURE: _____ **DATE:** _____

CALIFORNIA APPLICANTS

I am providing my contact information to the Company for limited purposes only and consider such information to be private. I understand that from time-to-time individuals file class action lawsuits against companies and that the mere filing of a lawsuit does not mean that the claims in the lawsuit have merit. I also understand that it is possible that individuals or their attorneys may ask that the Company provide them with my contact information as part of a class action lawsuit. I do not consent to the Company providing my contact information to any individual or attorney in any such lawsuit that may be filed, unless I later give my express written consent, or unless the Company is required to do so by law or the Company determines that I am a witness to that lawsuit.

SIGNATURE: _____ **DATE:** _____

APPLICANTS CERTIFICATION AGREEMENT

I understand and agree that:

If I misinterpret, falsely or deliberately leave out fact in my application or materially omit information on the application, I may be refused employment or be terminated.

The Agency has my authorization to thoroughly investigate my work, medical and personal history. I authorize all individuals whom the agency contract to provide the agency any and all information in this investigation and, release all parties and persons from any and all liability for any damages that may result from furnishing such information to the agency as well as from the use or disclosure of such information by the agency or any of its agents, employees, or representatives.

If employed, I further agree that my employment & compensation can be terminated at will, with or without cause and with or without notice, at any time, either at my opinion of the option of the agency. In consideration of my employment, I agree to conform to the rules and regulations of the agency.

Any doctor, hospital or testing laboratory may conduct medical tests and may release all information necessary for the agency to determine my abilities to perform job duties, now or in the future.

The needs of the agency may make the following conditions mandatory: over-time shift work, a rotating work schedule, or a work schedule other than Monday through Friday, I accept these conditions of employment.

If employed, I understand that my employment is for no definite period of time and if terminated, the agency is liable only for wages or salary as of the date of termination.

I also understand that all offers of employment are conditioned in the provision of satisfactory proof of all applicants identify and legal authority to work in the United States and the completion of satisfactory medical examination.

I have read and agree to the above and hereby certify that the information I have provided in my employment application is true and complete to the best of my knowledge and agree to have any of the statements checked by the agency unless I have indicated to the contrary.

SIGNATURE: _____ **DATE:** _____

SAVING LIFE HOME HEALTH, INC.

Emergency Contact Form

Employee Name			Address	
Phone Number				

Special Instructions:

In the event of a medical emergency, are there any emergency procedures or restrictions on medications of whichemergency personnel should be aware? If yes, please explain.

Emergency Contacts:

Primary Contact in case of emergency:

Name _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Phone Number _____

Secondary Contact in case of emergency:

Name _____ Relationship _____

Address _____ Phone Number

_____ Alternate Phone Number _____

Physician Contact

Doctor's Name _____ Address _____

Phone Number _____ _____

Employee Authorization

I have voluntarily provided the above contact information and authorize Saving Life Home Health (hereinafter called Agency) and its representatives to contact any of the above individuals on my behalf in the event of an emergency.

_____ _____

Employee Signature Date

CRIMINAL HISTORY CHECK, EMPLOYEE MISCONDUCT REGISTRY, NURSEAIDE REGISTRY NOTIFICATION AND STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency that a criminal history check will be performed on my name. I have informed that Agency of all names (for example, maiden name, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the criminal history check. I also understand that if I have been convicted of the following offenses, that I may not be employed by this Agency. I also understand that the Agency will search the Employee Misconduct Registry and the Nurse Aide Registry (if applicable) to determine whether any acts of abuse, neglect or exploitation have occurred and whether my name is designated on either registry. If my name is designated on either registry. I understand the Agency must deny me employment

Offenses which constitute a bar to employment and for which an administrative review is not available, are offenses under:

Chapter 19, Penal Code	(Criminal homicide)
Chapter 20, Penal Code	(Kidnapping and unlawful restraint)
Chapter 21.11, Penal Code	(Indecency with a child)
Chapter 22.02, Penal Code	(aggravated assault)
Chapter 22.04, Penal Code	(injury to a child, elderly individual, or disabled individual)
Chapter 22.041, Penal Code	(abandoning or endangering a child)
Chapter 25.031, Penal Code	(agreement to abduct from custody)
Chapter 25.06, Penal Code	(solicitation of a child)
Chapter 25.11, Penal Code	(sale or purchase of a child)
Chapter 28.08, Penal Code	(arson)
Chapter 29.02, Penal Code	(robbery)
Chapter 29.30 Penal Code	(aggravated robbery)

A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice of an offense containing elements that are substantially similar to the elements of an offense listed under the above Subdivision. A person convicted of an offense under Chapter 31, Penal Code (theft), that is punishable by a felony may not beemployed in a position the duties of which involve direct contact with a consumer in a facility before the fifth anniversary of the date of the conviction. A person convicted of an offense under section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony. An offense under section 30.02, Penal Code (burglary).
An offense under section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or as a felony; or an offense under section 32.45 Penal Code (securing execution of a document by deception), that is punishable as a Class A misdemeanor of a felony.

I understand that all information obtained by this Agency regarding any criminal history will remain confidential. By signing this form, I certify that the information on this form contains no willful misrepresentation and that the information is true and complete to the best of my knowledge.

_____ _____
Employee Signature Date

_____ _____
Saving Life Home Health Date

DRUG AND/OR ALCOHOL TESTING CONSENT TO DRUG AND/OR ALCOHOL TESTING

I hereby agree, upon a request made under the drug/alcohol testing policy of ORGANIZATION, to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the Company and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize the Company to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly-authorized Company officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

I will hold harmless the Company, its company physician, and any testing laboratory the Company might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from suchtesting, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if a Company or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Company, its company physician, and any testing laboratory the Company might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I UNDERSTAND THAT THE COMPANY WILL REQUIRE A DRUG SCREEN AND/OR ALCOHOL TEST UNDER THIS POLICY WHENEVER I AM INVOLVED IN AN ON-THE-JOB ACCIDENT OR INJURY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL INTHE ACCIDENT OR INJURY EVENT, AND I AGREE TO SUBMIT TO ANY SUCH TEST.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

CONFIDENTIALITY/TRAINING AGREEMENT

As an employee / volunteer of this company, which is involved in the evaluation and monitoring of the quality of care rendered to our patient and their families, I recognize that confidentiality is vital. I also understand that preservation of this confidentiality is the policy of ORGANIZATION.

Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and otherinformation generated in connection with the activities of ORGANIZATION I will make no voluntary disclosure of such information except the person authorized to receive it by ORGANIZATION.

I understand the agency is entitled to undertake such action as is deemed appropriated to ensure that this confidentiality is maintained. Any breach of this agreement may result in termination.

I understand I am required to complete the privacy training during this orientation program and prior to patient care. I understand and will honor all of the organization's/ agency privacy policies and procedures. I am aware that violations of the privacy policies and procedures may result in sanctions and/or termination.

Furthermore, I recognize the importance of patient confidentiality and safeguard of clinical records against an unauthorized use. I assure ORGANIZATION that if placing and / or storing any patient information using my computer, that information will be password protected and accessible only by me. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it isconducted in a private area.
- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patientbeing discharged.

I pledge to make every effort to keep patient's Protected Health Information, protected at all times.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

HIPAA CONFIDENTIALITY AGREEMENT

EMPLOYEE CONFIDENTIALITY AGREEMENT OF PATIENT HEALTH INFORMATION AND PERSONAL INFORMATION IN ACCORDANCE WITH HIPAA REGULATIONS

For good consideration and as an inducement for Saving Life Home Health to employ _____(Employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any patient health information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines relate d to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain. The Employee agrees to not copy and to return all such Agency supplied information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

_____ _____

Employee Signature Date

CORPORATE COMPLIANCE POLICY

Acknowledgment of Receipt and Understanding: As you are aware, ORGANIZATION and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.

Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.

I hereby acknowledge that I have apprised of and agree to comply with the ORGANIZATION Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.

_____ _____

Employee Signature Date

CHILD/ADULT ABUSE AND DOMESTIC VIOLENCE REPORTING REQUIREMENTS

Sections 11160-11166 and 15632 OF THE California Health and Welfare Code and ORGANIZATION policy require that all employees of Health Care System be provided with copy of this statement, and that all employees sign this statement. It will be retained in the employees file or in another appropriate file. The Health and Welfare Code provides as follows:

For Child Abuse - Any employee who has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment who he/she knows or reasonably suspects has been the victim of child abuse shall report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 24 hours of receiving the information concerning the incident.

For Dependent Adult Abuse - Any employee who in his/her professional capacity or within the scope of his/her employment, either has observed an incident that reasonably appears to be a victim of physical abuse, has observed a physical injury where the nature of the injure, the location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred, or is told by an elder or dependent adult that he/she has experienced behavior constituting physical abuse, shall report the known or suspected instance of physical abuse either to the long term care ombudsman coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report thereof within 24 hours.

For Domestic Violence - Any employee who in his/her professional capacity or within the scope of his/her employment, who had knowledge of or has observed domestic violence or injuries caused by a deadly weapon, orhe/she knows or suspected instance of domestic violence, or whom he/she knows or reasonably suspects has been a victim of domestic violence, to report the known or suspected instance of domestic violence to the appropriate police/sheriff department and to Adult Protection Services immediately or as soon as practically possible by telephone, and to prepare and send a written report thereof within 24 hours of receiving the information concerning the incident.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

CODE OF CONDUCT AND ETHICS

To aid ORGANIZATION in the attainment of its mission of providing quality health care to the public on the home setting, certain standards of conduct have been developed and approved by the Board of Directors and the agency's leadership. It is therefore expected that all employees and contracted individuals will thoroughly understand and conduct themselves according to the tenets below:

1. The employees will complete scheduled visits and assignments on a timely basis.
2. The employees will complete required classes, orientation, and educational requirements to maintain current licensure and compliance with ORGANIZATION
3. The employee will submit accurate records of employment, application and timecards/ route sheets.
4. The employee will conduct themselves in a professional manner in all interactions with supervisors, peers and clients. Licensed and certified employees will hold to the standards of their accrediting board.
5. The employees will present themselves in a professional manner by proper grooming as well as appropriate attire.
6. The employee will respect the right of property of the agency, other employees and patient/client.
7. The employee will refrain from excessive or unexcused absences.
8. The employee will not engage in any of the following:
    a. Negligence
    b. Possession or being under the influence of alcohol or illegal substances.
    c. Possession of weapons while on duty.
9. The employee will be aware of and practice safety policies and procedures.
10. The employee will perform his duties as stipulated in the criteria based on job descriptions.
11. The employee will be aware of and adhere to the fraud or abuse laws as stated in the Medicare Act.
12. The employee will refrain from use of prejudicial or offensive language.

The type of disciplinary action, which may be taken in response to violation of this code of conduct, will be determined on an individual basis to include, but not limited to the following: report incidents to licensing agencies where applicable, oral warning, written warning, suspension without pay, demotion, probation or termination.

I have read and agree to comply with the above **Code of Conduct and Ethics.**

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my personal responsibility to access and to read the policies, it is also my responsibility to conform and comply with all applicable periodic Agency changes policies and including revisions. I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the Policy.

I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meetings and in-service training. Home Health aides are required to have 12 hours of in-service training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of client/ employee confidentiality is subject to civil and criminal penalties.

If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will. I acknowledge receipt of the above policies.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

SEXUAL HARASSMENT POLICY

On June 26, 1998, the United State Supreme Court handed down two decisions that dramatically altered the legal landscape of sexual harassment. These Two decisions establish a clear set of rules for employers to follow. The implications of the two decisions require that all employers have an anti-discriminations/sexual harassment policy.

We at ORGANIZATION instituted a sexual harassment policy; it is not necessary to reiterate this policy and Rs complaint procedure:

1. The Company is committed to providing a work environment free from discrimination. This commitment includes a prohibition of sexual harassment. Harassment, in any from, including verbal, physical, and visual harassment, is prohibited and will not be tolerated. It shall; therefore, constitute a violation of company policy in any of the acts of behavior defined herein as sexual harassment.

2. Sexual harassment can arise from a wide range of physical or verbal acts inclusive of, but not limited to, the following:
    a. Slurs or verbal abuse of a sexual nature such as sexual jokes or sexual comments.
    b. Unwelcome sexual advances, flirtation, proposition, or touching.
    c. Display of sexually explicit or offensive posters, calendars, or any other objects.
    d. Offensive or graphic comments regarding a person's attire or physical attribute.
    e. Sexually degrading comments describing a person.

Conducts similar to the above are prohibited and will not be tolerated.

3. Any employee who believes he or she has been harassed should promptly report the facts of the incident or incidents, the name of the individuals involved and the names of any witness to one of the management representatives.

ORGANIZATION is committed to provide a work environment free from discrimination. In addition to other forms of unlawful discrimination, the company maintains a strict policy prohibiting sexual harassment. This policy applies to all employees. Harassment in any form, including verbal, physical, physical and visual harassment is prohibited.

Sexual harassment includes, but not limited to, making unwanted sexual advances and requests for sexual favors where: 1) Submission to such conduct is made an explicit or implicit tremor condition of employment; 2) submission to or rejection of such conduct by an individual is used as a basis for any employment decision affecting that individual; 3) such conduct has the purpose or effect if substantially interfering with as individual's work performance or creating an intimidating, or offensive working environment.
Any employee who believes he or she has been harassed should promptly report the facts of the incident or incidents and the names(s) of the individual(s) involved to his or her supervisor or to the administrator. Supervisors will immediately report any incidents of sexual harassment, to the administrator and the Company will investigate all such claims and take appropriate action.

By signing below, I hereby acknowledge that I have received a copy of the "Statement of Policy: Sexual Harassment Policy"

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

PHOTOGRAPHY WAIVER FORM

I, the undersigned, hereby grant to ORGANIZATION, its officers, and employees (collectively referred to herein as ORGANIZATION and its agents and assigns the worldwide, perpetual, irrevocable right to: (1) photograph and video the undersigned; (2) reproduce, distribute, display, create derivative works of and otherwise use the undersigned's name, photograph, video, image and likeness for and in connection with ORGANIZATION's public relations, publicity, promotional, educational and recruitment purposes, for all but commercial purposes, by any means, methods and media (print and electronic) now known or in the future developed that ORGANIZATION deems appropriate.

I make this grant of rights with the understanding that no compensation will be paid to me by ORGANIZATION for such grant I understand and agree that all right, title and interest, including copyrights, in the materials created by ORGANIZATION pursuant to this agreement are the exclusive property of ORGANIZATION and that I will obtain no rights in such materials. I also understand that ORGANIZATION is not actually required to use my photograph or likeness in any way.

I hereby waive any right that I may have to inspect or approve any photograph, likeness, or derivative work thereof made pursuant to this agreement. I understand that under Federal and California law individuals have the legal right to control the use of their names, likenesses, medical privacy, and images and I hereby release all such rights and hold harmless ORGANIZATION, its agents, licensees, and assignees from, and will neither sue nor bring any proceeding against, any such parties for any liability, whether now known or arising hereafter, resulting from or arising in connection with the exercise of such parties' rights pursuant to this agreement.

I have read the above agreement and fully understand its contents. I represent and warrant that I am of full age, that I have the right to contract in my own name, and that I have no pre-existing obligation that may restrict or limit my ability to sign this agreement.

This agreement will be governed by the laws of the State of California and represents the final and exclusive agreement between ORGANIZATION and myself on this subject.

- ! By checking this box, I agree to the above-mentioned criteria regarding the use of my photograph.
- ! By checking this box, I DO NOT agree with the above-mentioned criteria regarding the use of photography.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

UNIVERSAL BLOOD BODY FLUID

In order to reduce the risk of an employee's exposure to blood-borne conditions (Hepatitis, AIDS, etc., this agency practices Universal Blood Body Fluid Precautions. The basic principles of Universal Blood Precautions are that the need to use a barrier is focused on the caregiver's INTERACTIONS with the patient, NOT on the DIAGNOSIS of the patient.

To assist the staff in deciding if a barrier is necessary, categories have been assigned to most procedures. The interpretation of these categories is as follows:

CATEGORY I Tasks that involve blood, body fluids or tissues. All procedures or other job-related tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids or tissues, or a potential for spills or splashes of them. Use of appropriate protective measures ARE REQUIRED of every employee in Category 1 tasks.

Gloves should always be discarded, and hands washed immediately after every procedure. Gloves do not replace hand washing.

CATEGORY II Tasks that involve no exposure to blood, body fluids or tissues, but doing the procedure may require performing unplanned Category I tasks.

The normal work routine involves no exposure to blood, body fluids, or tissues, but exposure or potential exposure may be required as a condition of doing the task. Appropriate protective measures SHOULD be readily available to every employee engaged in Category II task.

CATEGORY III Tasks that involve no exposure to blood, body fluids or tissues, and Category I tasks are not a condition of the procedure. The normal work routine involves no exposure to blood, body fluid, or tissues. Tasks that involve handling of instrument or utensils, use of public or shared bathroom facilities or telephones and personal contacts, such as handshaking, etc., are Category Ill tasks.

I acknowledge that I have to undergo training during this orientation process and receive a copy of Safety and Infection Control Module and the Equipment necessary to follow Universal Blood Body Precautions and guidelines with all patient contact to ensure my safety.

I have been issued the following equipment:

□ Gloves (1 box) ! Fluid Resistant Gown (1) ! Resuscitative aid (1) !Mask

□ CPR Shield Face Barrier ! Needle Disposal Container (1) ! Biohazard Bag ! 3M Respirator

□ Barrier Safety Goggles (1)

□ As a non-clinical employee, none of the above supplies are applicable

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

CONFLICT OF INTEREST

Act in the course of duties solely in the best interests of the organization without consideration to the interests of any other agency, organization, or association with which you are associated, and refrain from taking part in any transaction where such person(s) does not believe in good faith that you can act with undivided loyalty to ORGANIZATION

Disclose any material, financial, or other beneficial interest to any entity engaged in the delivery of goods or services to the organization or its members.

Disclose any transactions with the organization that would result in any benefit to yourself, your immediate family/caregivers, or any entity in which you hold a significant financial ownership or other interests, and refrain from participation in any action on such matters, except upon approval of the Governing Body after full and frank disclosure.

Refrain from utilizing any inside information as to the business activities of the organization for the benefit of yourself, your immediate families, or any entity with which they may be associated.

Agree to devote their best efforts to the organization and not directly or indirectly be engaged in or connected with any other commercial pursuits whatsoever without written authorization of the organization.

Engage in private practice of a service similar to that provided by the organization within the geographic area serviced by the organization, without the written permission of the Executive Director/Administrator. Persons violating this policy will be subject to probation or termination. Disclosure of a potential employee conflict and the Executive Director/Administrator's decision regarding actions taken will be noted in a log file kept by the Executive Director/Administrator.

In the event that a situation arises whereby a member of the Governing Body could use confidential or privileged agency information for personal gain, he/she is obligated to report that potential to the Governing Body. The Governing Body will render a decision of that member's eligibility to be part of voting, if applicable. Disclosure of a potential conflict and the Governing Body's decision regarding voting will be noted in the minutes of the meeting.

Attestation Statement: I have read the Conflict-of-Interest policy set forth above and agree to comply fully with its terms and conditions at all times during my service as an employee or Governing Body/Professional Advisory Committee member. If at any time following the submission of this form, I become aware of any actual or potential conflicts of interests, or if the information provided below becomes inaccurate or incomplete, I will promptly notify the Executive Director/Administrator in writing.

Disclosure of Actual or Potential Conflicts of Interest:

_____
_____
_____
_____

_____ _____
Employee Signature Date

_____ _____
Saving Life Home Health Date

FIELD EMPLOYEE STANDARDS AND PROCEDURES

Welcome! This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/client/family. This includes personal hygiene, jewelry, hair and makeup.
2. Please do not smoke in the presence of a patient/client.
3. Always wear your ID Badge. Licensed personnel must always carry their current nursing license and CPR care while on assignment.
4. You are expected to arrive on time to all assignments that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR PATIENT DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. A NO-CALL,NO-SHOW IS GROUNDS FOR TERMINATION!
5. If you have any problem, incident or accident on the job, do not discuss it with the patient/client, but call the Agency immediately.
6. If the patient/client asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they WILL NOT, UNDER ANYCONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.
8. UNDER NO CIRCUMSTANCES are you to ask for or accept any money from your patient/client or take home property that belongs to the patient client.
9. There shall not be any involvement with the patient/client's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient/ client information which is obtained in the regular course of your employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with the patient/client/family.
13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient/client contact us.
14. It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule. If the patient/client is unable to sign your note, a family member responsible party may sign.
15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.
16. Never leave your patient/client unattended.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

The Agency requires that the Employee avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee agrees to refrain from prohibited competition with the Agency and to maintain the confidentiality of information regarding employees, clients and the Agency business.

The Employee will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any client or entity to discontinue any relationship with the Agency, solicit any client of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee is required to return all of the Agency's property including keys, client records, forms, manual, phone, computer, etc. to the Agency and will not retain copies. Failure to return a key may result in a $25.00 charge, failure to return a phone will result in a $800.00 charge, failure to return a nursing bag will result in a $300.00 charge and failure to return an iPad will result in a $600.00 charge.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency. Employee will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee to resign at any time or of the Agency to terminate employment without prior cause, noticeor liability and does not modify any other Agency policy.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

FRAUD AND ABUSE LAWS OF THE MEDICARE ACT

To aid ORGANIZATION in the attainment of its mission of providing quality health care to the public on the home care setting it is expected that all employees and contracted individuals will thoroughly understand and conduct themselves according to the tenets stated below:

The Medicare statutes prohibited the following:

1. Submission of false claims for the purpose of obtaining payment or benefits. Omission of information for this purpose is also prohibited.
2. The provision of false information or material misrepresentations of facts to obtain and maintain certification as a Medicare participating agency.
3. Conversion of any payment from the programs to use other than for use of the person on whose behalf the payment was made.
4. Solicitation, receipt, offer or payment of any remuneration (kickbacks, bribes, rebates) in return for referral of Medicare patients or in return for recommending or arranging for the purchase, lease or ordering of any Medicare related services. This prohibition is known as the Anti-kickback Statute. {42 U.S.C 1320a-7b.}
5. Submitting a claim for services that were never rendered to the beneficiary or that the Agency knew was not medically necessary for the beneficiary.
6. Submitting a claim for services that were actually rendered and were medically necessary but providing false information to substantiate the claim.
7. Receiving Medicare benefits that are rightfully due to another Agency.
8. Submitting duplicate bills, such as submitting two claims to Medicare for the same service or one claim to Medicare and another claim to the beneficiary for the same service.
9. Submitting claims for services provided whom practitioners have excluded from participation in the programs or who are unlicensed.
10. Submitting claims at higher prices for Medicare and Medicaid patients than for other patients.

The type of disciplinary action, which may be taken in response to violation of this Fraud and Abuse Laws, will be determined on an individual basis to include, but not limited to the following: report incidents to licensing agencies where applicable, oral warning, written warning, suspension without pay, demotion, probation or termination. Violations of the Medicare Fraud and Abuse Laws may result in fines up to $25,000 and 5 years of imprisonment. I have read and agree to comply with the above Fraud and Abuse Laws of the Medicare Act.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

GENERAL HANDBOOK ACKNOWLEDGMENT

This Employee Handbook is an important document intended to help employees become acquainted with ORGANIZATION This document is intended to provide guidelines and general only; it is not the final word in all cases. Individual circumstances may call for individual attention. Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of Management. Please read the following statements and sign below to indicate your receipt and acknowledgment of this Employee Handbook.

I have received and read a copy of the ORGANIZATION Employee Handbook. I understand that the policies, rules, and benefits described in it are subject to change at the sole discretion of the Company at any time. I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no contract of employment other than "at will" has been expressed or implied, and that no circumstances arising out of my employment will alter my "at will" status.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

_____ _____

Employee Signature Date

_____ _____

ORGANIZATION Date

CALIFORNIA MEAL PERIOD AND REST BREAK POLICY ACKNOWLEDGEMENT

I acknowledge that I have been provided with and understand the Company’s California Meal Period and Rest Break Policy and understand that it is ineffective immediately. I agree to comply with this Policy.

I acknowledge, understand and agree that I must notify my supervisor immediately if I am required to work through some or all of a timely 30-minute meal period or 10-minute rest break, and that I should complete a premium form and submit it to my manager to ensure that I am properly compensated.

I understand that I may be subject to disciplinary action, up to and including termination of employment if I violate this Policy.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

MEAL PERIOD WAIVER FOR LESS THAN 6-HOUR WORKDAY

I understand the Company provides a 30-minute, uninterrupted meal period to any employee who works five hours or more hours on any given workday. I further understand that employees who work six or fewer hours on any given workday may waive the opportunity to receive that meal period. By signing below, I confirm that I am voluntarily electing to waive my employer's obligation to provide a meal period on any day I am scheduled to work six or fewer hours.

I understand I may revoke this waiver at any time by providing notice of the decision to do so. This waiver will remain in effect unless I exercise the option to revoke it. If I decide to revoke this waiver, I understand my revocation will be effective the next business days.

I understand that any day that I am scheduled to work in excess of six hours, or any day that I do work in excess of six hours, this waiver does not apply and I am required to comply with the California Meal Period and Rest Break Policy.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

DECLINATION FOR INFLUENZA VACCINATION

(Only complete page if declining seasonal flu vaccine otherwise leave blank and obtain vaccination information from HR)

I_____, an employee/volunteer of Saving Life Home Health, have been provided with sufficient information regarding the Influenza vaccination. I am making an Informed decision to DECLINE the vaccination. I understand that due to my occupational exposure to infect ed patients, I may be at risk for acquiring the influenza virus. I also understand I may acquire influenza from the community and may be at risk of transmitting a vaccine-preventable disease. I understand if I refuse to receive the influenza vaccine, or I have not received the influenza vaccine elsewhere, I must follow state specific Department of Health requirements which may include wearing the designated respiratory mask when providing patient care or visiting a medical facility, clinic, or medical provider office. I have been given the opportunity to be vaccinated with the influenza vaccine at no charge to myself. However, I declined, and I understand that by declining the vaccine, I continue to be at risk of acquiring influenza. I also understand that I may change my mind at any time and receive the vaccine. As a result of my decision to decline the influenza vaccine, I hereby release ORGANIZATION, as well as any and all officers, directors, employees, agents, or associates from any and all liability for any injury, illness, damage, claim or cause of action which arises or may arise in association with this decision and my work.

! I have received the vaccination elsewhere. Date: _____ Location: _____

! I plan to receive the vaccination elsewhere. Please provide us with documentation of such.

! I am allergic to eggs or egg products.

□ l am allergic to (circle all that apply); mercury / Thimerosal /formaldehyde/ Streptomycin.

! I have had a previous reaction to an influenza vaccination.
Explain:_____

! I simply do not want vaccine.

□ Receiving the vaccination is against my religious, moral, or ethical beliefs.

□ Other.
Explain:_____

_____
Employee Name

_____ _____
Signature of Employee Date

EMPLOYEE HEALTH QUESTIONNAIRE

Routine annual chest X-rays are no longer recommended for symptomatic, tuberculin skin-test "positive" employees. Annual chest X-ray screening has been replaced by this document. It is more important that Individuals be assessed for signs and symptoms that may be suggestive of tuberculosis.

Should you develop signs and symptoms of tuberculosis (listed below) AT ANYTIME, report promptly to your supervisor for a chest X-ray and follow-up

This questionnaire is to protect the health of our employees and patients. The employee health coordinator confidentially handles all answers. Answers will not affect job status, consideration for advancement, or issues related to your employment. If your answers suggest the possibility of a problem, the office to assist you in obtaining any necessary care may contact you.

	YES	NO
1. Do you have a cough that has lasted longer than three weeks?		
2. Do you have a fever that has lasted longer than three weeks?		
3. Have you coughed up blood?		
4. Are you losing weight without trying to do so?		
5. Are you having frequent night sweat?		
6. Have you experienced the following combination of symptoms?		
i. Fatigue, fever, weight loss, and night sweat?		
ii. Coughing, chest pain, blood-streaked sputum?		

This information is correct to the best of my knowledge.

_____ _____

Employee Signature Date

_____ _____

Saving Life Home Health Date

SAVING LIFE HOME HEALTH, INC.

HEPATITIS B VACCINATION DECLINATION FORM (MANDATORY)

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

_____ _____

Applicant Name and Signature Date

I decline to receive a Hepatitis B Vaccination because I have been previously vaccinated. I agree to provide Saving Life Home Health with a record of the vaccination and any antibody testing that may have been performed.

_____ _____

Applicant Name and Signature Date

Acknowledged:

_____ _____

Saving Life HH Human Resources Date

Declination of COVID-19 Vaccination

My employer (or affiliated health facility), SAVING LIFE HOME HEALTH, recommends that I receive COVID-19 vaccination to protect myself, patients, staff, and others in the healthcare facility.

I acknowledge that I am aware of the following facts (please read and check each box):

- ☐ COVID-19 is a serious contagious virus that can easily spread from person to person. Some infected persons may have severe disease and die. No one knows how COVID-19 may affect them.
- ☐ COVID-19 vaccination is recommended for me and for all other healthcare workers to help prevent spreading the disease to friends, family and staff and to protect me from getting COVID-19, or from serious illness if I do get infected.
- ☐ I understand that, if I contract COVID then, I am potentially contagious for 2 days before any symptoms appear. During this time, and for 10-14 days after infection, I can potentially transmit COVID-19 to patients and staff in this facility and to my family.
- ☐ I understand that, if I become infected with COVID-19 then, even if my symptoms are mild or non-existent, I can spread the virus to others. Symptoms that are mild or non-existent in me can still cause serious illness and death in others.
- ☐ I understand that, if I get COVID-19 then, I will be required to isolate away from others and will not be able to work for a minimum of 10 days after symptoms appear or 10 days from the date I test positive if I have no symptoms.
- ☐ I understand that I cannot get COVID-19 from the vaccine and getting the vaccine is a safer way to build up immunity.
- ☐ I understand that side effects usually go away on their own within a week and are a sign that the immune system is working.
- ☐ The consequences of my refusal to be vaccinated could be life threatening for me and the health of everyone with whom I have contact, including my co-workers and all patients in this healthcare facility.

Despite all of these facts, I choose to decline COVID-19 vaccination for the following reasons:

_____

- ☐ I understand that I can change my mind at any time and accept the COVID-19 vaccination.

I have read and fully understand the information on this declination form.

Signature_____Date_____

Name (print) _____

Department _____

References: CDC. Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/hcp/vaccination.html

CDC: Questions on COVID-19 Vaccine: https://www.cdc.gov/vaccines/covid-19/hcp/answering-questions.html

SAVING LIFE HOME HEALTH, INC.

EMPLOYEE FILES

Section 1

DATE FILED	FILED BY	ITEM
		LETTER OF ACCEPTANCE/ OFFER LETTER
		EMPLOYMENT APPLICATION
		REFERENCE CHECKS
		CERTIFICATE OF COMPLIANCE
		TELEPHONE REFERENCE CHECK
		APPLICATION CERTIFICATION AGREEMENT
		FALSE CLAIMS ACT EDUCATION POLICY
		EMPLOYEE HANDBOOK: COVID 19 EMPLOYEE GUIDANCE
		EMERGENCY CONTACT FORM
		CRIMINAL HISTORY CHECK, EMPLOYEE MISCONDUCT REGISTRY AND STATEMENT OF EMPLOYABILITY
		CONSENT TO DRUG AND/OR ALCOHOL TESTING
		CONFIDENTIALITY/TRAINING AGREEMENT
		HIPAA CONFIDENTIALITY AGREEMENT
		CORPORATE COMPLIANCE POLICY
		CHILD/ADULT/ABUSE AND DOMESTIC VIOLENCE REPORTING REQUIREMENT
		CODE OF CONDUCT AND ETHICS
		EMPLOYEE POLICIES AND PROCEDURE
		SEXUAL HARRASSMENT POLICY
		PHOTOGRAPHY WAIVER FORM
		UNIVERSAL BLOOD BODY FLUID
		CONFLICT OF INTEREST
		FIELD EMPLOYEES STANDARDS AND PROCEDURES
		CONFIDENTIALITY AND NON-COMPETITION AGMT
		FRAUD AND ABUSE LAWS OF THE MEDICARE ACT
		GENERAL HANDBOOK ACKNOWLEDGEMENT
		MEAL PERIOD WAIVER FOR LESS THAN 6-HOUR WORKDAY
		DECLINATION FOR INFLUENZA VACCINATION
		HEPATITIS B VACCINATION DECLINATION FORM
		COVID VACCINE DECLINATION
		EMPLOYEE HEALTH QUESTIONNAIRE

SAVING LIFE HOME HEALTH, INC.

EMPLOYEE FILES

Section 2

DATE FILED	FILED BY	ITEM
		E-VERIFY
		OIG EXCLUSION CHECK
		SEXUAL OFFENDER
		BACKGROUND CHECK
		PROFESSIONAL LICENSE/ CERTIFICATE VERIFICATION
		DIPLOMA/ DEGREE (IF APPLICABLE)

CREDENTIALS	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE
PROFESSIONAL LICENSE						
DRIVERS LICENSE						
AUTO INSURANCE						
LIABILITY INSURANCE						
BASIC LIFE SUPP. AHA CPR						

EMPLOYEE FILES

Section 3

DATE FILED	FILED BY	ITEM
		PERSONNEL ORIENTATION CHECKLIST
		SIGNED JOB DESCRIPTION
		PERFORMANCE EVALUATION AT 90 DAYS
		H.R. STATUS CHANGE
		COUNSELING/ DISCIPLINARY ACTION
		PERFORMANCE IMPROVEMENT PLAN

NOTES:_____

SAVING LIFE HOME HEALTH, INC.

EMPLOYEE FILES

Section 4

DATE FILED	FILED BY	ITEM
		INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST
		PERFORMANCE OBSERVATION REPORT
		PERFORMANCE CRITERIA

NOTES:_____

SAVING LIFE HOME HEALTH, INC.

EMPLOYEE FILES

Section 5

DATE FILED	FILED BY	ITEM
		INITIAL RELIAS LEARNING CERTIFICATE
		INSERVICE CERTIFICATES
		CONTINUING EDUCATION UNITS
		ADDITIONAL TRAINING
		RESUME

SAVING LIFE HOME HEALTH, INC.

EMPLOYEE FILES

Section 6

DATE FILED	FILED BY	ITEMS
		W4: EMPLOYEE'S WITHHOLDING CERTIFICATE
		CALIFORNIA NEW HIRE FORM
		PAYROLL FORMS
		DEVICE CHECK-OUT FORM

		MEDICAL BENEFITS

		TERMINATION PROFILE:
		REQUEST FOR TRANSFER
		SEPARATIONS CHECKLIST
		CA CHANGE IN RELATIONSHIP FORM
		EXIT INTERVIEW
		UNEMPLOYMENT CLAIMS
