IDEAL CARE HOME HEALTH, INC.
21021 Devonshire Street, Suite 203, Chatsworth, CA 91311
Telephone: (818) 882-1178 Fax: (818) 882-1187
Email: info@idealcarehomehealth.com
www.IdealCareHomeHealth.com

EMPLOYMENT APPLICATION

Ideal Care Home Health, Inc. is an Equal Opportunity Educational Institution and EEO/Affirmative Action Employer committed to excellence through diversity. Employment offers are made on the basis of qualifications and without regard to race, sex, religion, national or ethnic origin, disability, age, veteran status, or sexual orientation.

PLEASE TYPE OR PRINT. Complete the entire application. You may attach a resume, but you must still complete all questions; or your application will be deemed incomplete and may not be considered. Please fill out each box (don't just indicate "See Resume.") Applications with missing or invalid job numbers will not be considered for any position.

Position Applying For: JOB #:	Name (Last, First, Middle):		Other names under which you have attended school or been employed:
Street Address:		City, State & Zip:	
Social Security Number:	Home Phone:	Work Phone:	Other Phone:

Are you eligible to work in the United States?	☐Yes ☐No	
Are you 18 years of age or older?	☐ Yes ☐ No	If NO, what is your current age?
Are you currently employed at Ideal Care Home Health, Inc.?	☐Yes ☐ No	If YES, what is your current job title & department?
Have you ever been employed by Ideal Care Home Health, Inc.?	☐ Yes ☐No	If YES, dates of employment & reason for leaving:
Are you related to any current Ideal Care Home Health, Inc. employee?	☐Yes ☐ No	If YES, their name & their relationship to you?
If required for position, do you have a valid driver's license?	☐ Yes ☐ No	If YES, State of issuance, license #, and expiration date:

How did you learn about this employment opportunity at ? Check all that apply: ☐ Ad in *newspaper*
☐ Job Bulletin (Posting) /Walk-in ☐ Website ☐Dept. of Labor ☐Ad in *magazine*
☐ Referral by employee ☐ ☐Other:

EDUCATION

Name of School	City/State	Did you graduate?	If No, # of years left to graduate	If Yes, date of Graduation	Degree received	Major
High School:		☐Yes ☐ No				
GED:		☐Yes ☐ No				
Other School:		☐Yes ☐ No				
College:		☐Yes ☐ No				
College:		☐Yes ☐ No				

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College:		☐ Yes ☐ No				
Other credentials/ licenses/ professional affiliations, etc., which are relevant to the job(s) for which you are applying.						

SKILLS: Please list technical skills, clerical skills, trade skills, etc., relevant to this position. Include relevant computer systems and software packages of which you have a working knowledge, and note your level of proficiency (basic, intermediate, expert)

WORK EXPERIENCE-Please detail your work history for the last 10 years. Begin with your current or most recent employer. If you held multiple positions with the same organization, detail each position separately. Attach additional sheets if necessary. Omission of prior employment may be considered falsification of information. Please explain any gaps in employment. Include full-time military or volunteer commitments. **PLEASE NOTE: Ideal Care Home Health, Inc.** reserves the right to contact all current and former employers for reference information.

Dates Employed (most recent position) From: To	☐ Full time ☐ Part-time If part-time, # hrs./wk: ☐	Title:
Starting Salary: Final Salary:	Organization Name and Address:	
Supervisor's Name, Title and Phone #:	Other Reference Name, Title and Phone #:	Contact my current references: ☐ At any time ☐ Only if I am a finalist candidate
Primary duties:		Reason for Leaving:
Dates Employed (most recent position) From: To	☐ Full time ☐ Part-time If part-time, # hrs./wk: ☐	Title:
Starting Salary: Final Salary:	Organization Name and Address:	
Supervisor's Name, Title and Phone #:	Other Reference Name, Title and Phone #:	Contact my current references: ☐ At any time ☐ Only if I am a finalist candidate
Primary duties:		Reason for Leaving:

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EMPLOYMENT APPLICATION

PLEASE READ CAREFULLY AND SIGN THAT YOU UNDERSTAND AND ACCEPT THIS INFORMATION.

I certify that the information on this application and its supporting documents is accurate and complete. I understand and agree that failure to fully complete the form, or misrepresentation or omission of facts, represent grounds for elimination from consideration for employment, or termination after employment if discovered at a later date. I authorize ***Ideal Care Home Health, Inc.*** *to investigate, without liability, all statements contained in this application and supporting materials. I authorize references and former employers, without liability, to make full response to any inquires in connection with this application for employment. I agree to submit to a physical exam, criminal and credit background investigation, and/or screening for illegal substances upon conditional offer of employment. I understand that this document is NOT an offer of employment, and that an offer of employment, if tendered, does NOT constitute a contract for continued guaranteed employment. I understand that staff employees of* ***Ideal Care Home Health, Inc.*** *serve at-will, and the employment relationship may be terminated any time by either party, or any or no reason, other that a reason prohibited by law. If employed, I will be required to furnish proof of eligibility to work in the United States. I understand that any benefits I receive may be subject to change or discontinuation at any time without prior notice. I understand that the first SIX MONTHS of regular employment represent a provisional period, during which I would not be eligible to apply for transfer or promotion and during which I may be terminated without right of appeal.*

Applicant Signature: _____ Date: _____

IDEAL CARE HOME HEALTH, INC.

EMPLOYMENT INFORMATION

NAME OF EMPLOYEE: _____

MOBILE PHONE: _____ **OTHER PHONE:** _____

PHYSICAL ADDRESS: _____

_____

_____

EMAIL ADDRESS: _____

CITIES/AREAS WHERE YOU CAN WORK: _____

_____

LANGUAGES SPOKEN: _____

INSTRUCTIONS: This form is used to acknowledge receipt of our Application Packet and confirm your understanding and agreement with its contents. Your initials and signature on the following page indicates your approval.

CONSENT OF APPLICATION INFORMATION

I certify that the information on this application and its supporting documents is accurate and complete. I understand and agree that failure to fully complete the form, or misrepresentation or omission of facts, represent grounds for elimination from consideration for employment, or termination after employment if discovered at a later date. I authorize **Ideal Care Home Health, Inc.** to investigate, without liability, all statements contained in this application and supporting materials. I authorize references and former employers, without liability, to make full response to any inquires in connection with this application for employment. I agree to submit to a physical exam, criminal and credit background investigation, and/or screening for illegal substances upon conditional offer of employment. I understand that this document is NOT an offer of employment, and that an offer of employment, if tendered, does NOT constitute an contract for continued guaranteed employment. I understand that staff employees of **Ideal Care Home Health, Inc.** serve at-will, and the employment relationship may be terminated any time by either party, or any or no reason, other that a reason prohibited by law. If employed, I will be required to furnish proof of eligibility to work in the United States. I understand that any benefits I receive may be subject to change or discontinuation at any time without prior notice. I understand that the first SIX MONTHS of regular employment represent a provisional period, during which I would not be eligible to apply for transfer or promotion and during which I may be terminated without right of appeal.

Initial Here: _____

SUBMISSION AND REPORTING OF CLINICAL NOTES*

This to acknowledge that I have read and understood the agency's policy regarding timely submission of documentation (Nurses, Physical Therapists, Occupational Therapists, Speech Therapists, Medical Social Workers, notes and route sheets etc.). I also agree that all of these documents will be submitted to Ideal Care Home Health, Inc. within the following schedule:

1. New Assessment & Resumption of Care: 48 hours after the initial visit
2. Recertification: 48 hours after assessment
3. Discharge: 48 hours after discharge
4. Electronic Notes & Route Sheets ***MUST*** be submitted and ***ESIGNED*** within 30 days (RNs must submit within 48 hours). Completed submissions from 1st – 15th will be paid on the 25th. Those from the 16th – 30th or 31st will be paid on the 10th
5. Very important to report to Case Manager:
   RN/PT/OT/ST/MSW – Within 24 hours of assessments
   LVN – At least twice per week

Failure to comply with the above will mean reassignment of visit's load to reduce or suspension of assignment in order to meet such compliance and a reduction in pay ***per*** visit. Notes that are more than 30 days late will not be accepted unless otherwise specified by management.

Email and Faxes are permitted

Initial Here: _____

DISCLAIMER AND WAIVER OF LIABILITY

I, undersigned, do hereby acknowledge the rules and regulations as set forth by the California Department of Health and Medicare. I further understand that falsification of documents, particularly those regulations pertaining to the submission of visit notes where in fact no visit was made, is considered to be MEDICARE FRAUD and is subject to civil and/or criminal prosecution. I therefore hold **Ideal Care Home Health, Inc.**, its Shareholders, Directors, and Officers, harmless from any falsified documents that I might submit without their knowledge. I further understand that the submission of falsified documents will result in my immediate termination, with cause, and filing of criminal grievance.

I have read and understand this statement and still adhere to the Federal and State rules and regulations and Policies and Procedures of **Ideal Care Home Health, Inc.**

Initial Here: _____

JOB AVAILABILITY

In applying for work with **Ideal Care Home Health, Inc.,** I understand my position may be Full Time, Part Time or Per Diem as the work is available. I understand and accept there may be times in the work schedule when there is no work available, or I am cancelled from a job, due to lack of staffing needs. I agree to prepare myself financially and with alternate back up support if such an event should occur. I also understand that I should have reliable transportation to ensure that I am able to get to (and from) my assigned area of work on time and complete the working hours agreed to in my scheduling. I agree to work the geographical areas as stipulated under the guidelines of **Ideal Care Home Health, Inc..** I understand and agree to work hours available, or if I decline such hours I will make other financial arrangements to supplement my income from alternate working sources. I understand my job requires hours that encompass day, evening and possibly night coverage. This is 24 hour coverage, in most cases **Ideal Care Home Health, Inc.** will try to staff me within the time frame I would like. Office employees also realize that all information contained above may pertain to them and they should act accordingly. Probationary Office Staff/Regular Staff Members agree to flexible hours in the event the Administration needs to minimize time in the office due to budget demands. Office Staff will thereby be accountable for all information as indicated above.

Persons who leave *Ideal Care Home Health, Inc.* without Notice or due to Disciplinary Action agree they shall complete all required work within one week which will be compliant with the Standards of the Agency.

Initial Here: _____

NON-COMPETE AGREEMENT

Any employee of **Ideal Care Home Health, Inc.** agrees not to be hired by a facility that the employee worked at under **Ideal Care Home Health, Inc.** in any capacity. This means if a facility offers an **Ideal Care Home Health, Inc.** employee a position in any capacity, the employee must wait a period of sixty (60) days from the day the employee notifies **Ideal Care Home Health, Inc.** before he/she may begin working at the facility.

Employees of **Ideal Care Home Health, Inc.** also agree not to encourage a patient to transfer to a different agency that has previously been, or is, assigned to **Ideal Care Home Health, Inc..**

Initial Here: _____

AT-WILL EMPLOYMENT AGREEMENT

In consideration of my employment with **Ideal Care Home Health, Inc.** I understand that my employment and compensation are at-will and therefore can be terminated, with or without cause, at any time without prior notice, at my option or **Ideal Care Home Health, Inc.'s** option. This at-will employment relationship will remain in effect throughout my employment with **Ideal Care Home Health, Inc.** unless it is specifically modified by an express written employment agreement executed by an authorized representative of **Ideal Care Home Health, Inc.** and myself. I understand that this at-will employment relationship may not be modified by any oral or implied agreement, and that neither employee handbook, nor any course of conduct, practice, policy, award, promotion, performance, evaluation, transfer, or length of service can modify this at-will relationship.

I acknowledge that I have carefully read this Agreement, that I understand its terms, and that I have entered into this agreement voluntarily. I further acknowledge that I have been given the opportunity to discuss this Agreement with my private legal counsel before signing it and have availed myself of that opportunity to the extent I wish to do so.

Initial Here: _____

OATH OF CONFIDENTIALITY

In the course of your work for **Ideal Care Home Health, Inc.,** you may have access to confidential information regarding patients, fellow employees, or the company. One of the most serious responsibilities which you have as an employee is that you do not reveal or divulge any such information and that you use it only in the performance of duties; you should not misuse or remove from

premises without written authorization any employee list, company records, patients' list of confidential information of any nature. Violation of this policy shall warrant discipline, up to and including termination of employment.

I recognize my ethical and moral obligation to protect the privacy of **Ideal Care Home Health, Inc.** and I will take care never to reveal information or names that may be exposed to due to my position, either personal or medical, unless it is related to the care of the patient.

Initial Here: _____

PATIENT CONFIDENTIALITY

Ideal Care Home Health, Inc. is proactive in acknowledging the Patient's Right to Privacy. The patient's confidentiality shall be maintained at all times both in written record and verbally. All HIPPA regulations shall remain enforced. Information shall include but not be limited to the following:

1. Documentation of the Medical Record
2. Information contained in any computer file
3. Information contained on any fax document
4. Information heard or anything observed regarding any patient any patient living or deceased
5. All PATIENT INFORMATION shall be contained per the PRIVACY REGULATIONS as stipulated under the HIPPA guidelines and patient information shall not be visible to the public eye

Ideal Care Home Health, Inc. staff members will not divulge patient information to any person or agency not involved in the care of the patient. Breach of confidentiality will be grounds for immediate termination and/or severe disciplinary action dependent on the nature of the violation. I also understand that the unauthorized use, possession or dissemination of any confidential information related to the company or the business matters pertaining to this company are to be kept in confidence at all times. Employees who breach this confidence shall be considered for disciplinary measures (including termination).

I have read, considered and understand the above confidentiality statement and agree to follow all HIPPA regulations of Privacy and the policy of **Ideal Care Home Health, Inc.**.

Initial Here: _____

CHILD ABUSE REPORTING STATEMENT

Section 11166 of the Penal code requires any child care custodian, medical practitioners, non-medical practitioner or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his/her employment whom he/she show or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and prepare and send a written report thereof within thirty-six (36) hours of receiving the information concerning the incident.

"Child Care Custodian" includes teachers, administrative officers, supervisors of child welfare and attendance of certified, pupil personnel employees of any public or private school, administrators of a public or private day camp; licensed day care workers; administrators of community care facilities licensed to care for children; headstart teachers; licensing workers or evaluator; public assistance workers; employees of child care institution including, but not limited to foster parents, group home personnel and personnel or residential care facilities and social workers or probation officers.

"Medical Practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentist, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professional Code.

"Nonmedical Practitioner" includes state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; marriage, family or child counselors; and religious practitioners who diagnose, examine or treat children.

Initial Here: _____

IDEAL CARE HOME HEALTH, INC. **EMPLOYMENT INFORMATION**

EMPLOYEE STATEMENT: SUSPECT DEPENDENT ADULT ABUSE

California Welfare and Institutions Code Section 15632 requires the home care agency to provide all "dependent adult care custodians" and "health practioners" who are employees after January 1, 1986 (both continuing and new employees), with the following statement. The legal definition of "care custodian" includes all employees of a hospital. California law requires that this statement be signed by the employees as a prerequisite to employment and be retained by the home care agency.

Section 15630 of the Welfare and Institutions Code requires any custodian, health practitioner, or employee of an adult protective services agency or a local law enforcement agency who has knowledge of, or observes a dependent adult in his/her professional capacity, or within the scope of his/her employment, who he/she knows has been the victim of physical abuse, who has injuries under the circumstances which are consistent with the abuse, where the dependent adult statement indicate, or in the case of a person with development disabilities, that abuse has occurred, to report the known or suspected instance of physical abuse to an adult protective service agency or local enforcement agency immediately, or as soon as practically possible, by telephone and to prepare and send a written report thereof within thirty-six (36) hours of receiving the information concerning the incident.

Report should be made to independent adult protective agencies, County Welfare or Social Services Department. "Care Custodian" means an administrator or an employee of any of the following public or private facilities:

1. Health Facility
2. Clinic
3. Home Health Agency
4. Educational Institutions
5. Sheltered Workshop
6. Camp
7. Respite Care Facility
8. Residential Care Institution including Foster Homes and Group Homes
9. Community Care Facility
10. Adult Day Care Facility
11. Regional Center for Persons with Development Disability
12. Licensing Worker or Evaluation
13. Public Assistance Worker
14. Adult Protection Services Agency
15. Patient's Rights Advocate
16. Nursing Home Ombudsman
17. Legal Guardian or Conservator
18. Skilled Nursing Facility
19. Intermediate Care Facility
20. Local Law Enforcement Agency
21. Any other person who provides goods or Services necessary to avoid physical harm or mental suffering and who performs such duties

"Health Practitioner" means a physician and a surgeon, psychiatrist, psychologist, dentist, resident podiatrist, chiropractor, licensed nurse, dental hygienist, marriage, family and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Profession Code, any emergency medical technician 1 or 11, paramedic, a person certified pursuant to Section 4980.03 of the Business and Professional Code, a State County Public Health employee treats a dependent adult for any condition, a coroner, or a religious practitioner who diagnoses, examines or treats dependent adults.

I certify that I have read and understand this statement and will comply with my obligations under the Dependent Adult Reporting Law.

Initial Here: _______

=~*=

I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am no longer employed with **Ideal Care Home Health, Inc.**. I also understand that I may revoke this consent in writing at any time. I certify that the signature below applies to all four pages of this application.

Printed Name of Employee	Signature of Employee	Date
Printed Name of Witness	Signature of Witness	Date

IDEAL CARE
Home Health, Inc.

EMERGENCY NOTIFICATION FORM

Employee's Name: _____

Effective Date: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

Name (please print)	Relationship
Street Address	Home Phone
City State Zip	Work/cell/pager

ALTERNATE PERSON TO NOTIFY (OPTIONAL):

Name (please print)	Relationship
Street Address	Home Phone
City State Zip	Work/cell/pager

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UNACCEPTABLE HOME CARE ABBREVIATIONS

The following abbreviations have been identified by Joint Commission (JCAHO) as the minimum required PROHIBITED ABBREVIATIONS (effective 1/1/04) under the National Patient Safety Goals (NPSG 2B):

U.....unit

IU..... International unit

Q.D. .....once daily

Q.O.D .....every other day

"x".0 mg.....trailing zero in medication use

."X" mg.... lack of leading zero in medication use

MS, MSO_4, $MgSO_4$ ..... Morphine sulfate . or magnesium sulfate

Additional abbreviations, symbols, and acronyms identified by JCAHO to be considered as prohibited or unacceptable include the following:

Ug.....micrograms

H.S .....half strength or bed-time

T.I.W. .....three times a week

S.C. or S.Q. ..... subcutaneous

D/C.....discharge

c.c ..... cubic centimeter

A.S., A.D., A.U. .....left, right, or both ears

_____ _____

Employee's name / Signature Date

_____ _____

Witness Date

Licensed Physical Therapy Assistant (LPTA)

Job Summary:

A Licensed Physical Therapy Assistant (LPTA) administers physical therapy to patients on an intermittent basis in their place of residence. This is performed in accordance with physician orders and plan of care under the direction and supervision of the Registered Physical Therapist (PT).

Qualification:

1. Graduate from a two-year college level program approved by the American Physical Therapy Association.
2. Currently licensed in California.
3. Two (2) years experience, preferred.
4. Acceptance of philosophy and goals of Agency.
5. Ability to exercise initiative and independent judgment.

Responsibilities:

1. Understands and adheres to established Agency policies and procedures.
2. Provides physicians prescribed physical therapy under a plan of care established by the PT.
3. Improves or minimizes residual physical disabilities of the patient.
4. Returns the individual to optimum and productive level within the patient's capabilities.
5. Participates with all other health care personnel in patient care billing.
6. Performs all skilled procedures as ordered by physician and according to the plan of care established by the PT.
7. Consults with PT regarding changes in treatment
8. Instructs patients and family members in home programs and activities of daily living.
9. Participates in in-service programs and presents in-service programs as assigned.
10. Participates in performance improvement activities as assigned.
11. Attends all patient care conferences as needed.
12. Prepares medical records, progress notes and updates care plans for each patient visit in a timely manner as per Agency Policy
13. Performs services planned, delegated and supervised by the PT.
14. Assists in preparing clinical and progress notes.
15. Participates in educating the patient and family.

Working Environment:

Works indoors and Agency office and patient homes and travels to/from patient homes.

Job Relationship:

1. Supervised by: Registered Physical Therapist/Director of Clinical Services/Nursing Supervisor

Organizational Relationship:

- Reports directly to the licensed Physical Therapist and DPCS

Functional Abilities:

- Must be able to read 12 point or larger type
- Must be able to hear and speak in a manner understood by most people
- Must be able to stoop and bend
- Must be able to lift and carry effectively so as to be able to perform the above-listed functions
- Must be able to travel to prospective clients' residences

_____ _____

Print Name/Signature Date

_____ _____

Signature of DPCS Date

IDEAL CARE HOME HEALTH, INC.

EMPLOYEE HEALTH SCREEN

The following information is required by Title XXII of the Health Code of the State of California for all persons working in the health care field.

Name	**Date of Birth**	**Social Security No**
Address	**Position**	

HISTORY

Have you had or do you have any of the following conditions (Please check all that apply):

Allergies ____
Back Pain ____
Chest Pains ____
Chronic Cough ____
Diabetes ____
Epilepsy ____
Fainting or Dizziness ____

Headaches (frequent) ____
Hearing Disability ____
Heart Trouble ____
Hepatitis ____
High Blood Pressure ____
Low Blood Pressure ____
Seizures ____

Shortness of Breath ____
Tuberculosis ____
Varicose Veins ____
Venereal Disease ____
Visual Disability ____
Other: _____
Other: _____

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

HEPATITIS B VACCINATION

( ) I have received the Hepatitis B vaccine

( ) I decline the Hepatitis B vaccine at this time. I understand that I will continue to be at risk of acquiring Hepatitis B. I understand I may, at a later date, accept the Hepatitis B vaccination at my request. I also understand that it is my responsibility to initiate a request for vaccination if I so desire.

Initial Here: _____

FLU VACCINATION

( ) I have already received the Flu Vaccination on _____ **(proof attached)**

( ) I would like to be vaccinated with the Flu vaccine by **Ideal Care Home Health, Inc.** who has given me the opportunity to be vaccinated.

( ) I decline the Flu vaccine at this time and ***I will wear a mask at all times when visiting patients as is required***. Reason for Declination: _____

Initial Here: _____

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TUBERCULOSIS SCREENING

Skin Test/PPD Date Given: _____ Site: ☐ LFA ☐ RFA Induration: _____ Mm

Date of Results: _____ Results: ☐ NEGATIVE ☐ POSITIVE

IF PPD IS POSITIVE a chest X-Ray is required. **Results:** ☐ NEGATIVE for TB ☐ POSITIVE for TB
Please attach proof of PPD and/or X-Ray Report

Initial Here: _____

MEASLES WAIVER

I have received information on recommendations from the Los Angeles County Department of Public Health as to advisability of receiving on additional MMR (Measles, Mumps, and Rubella) vaccine to increase my protection against infection.

Ideal Care Home Health, Inc. is proactive with recommendations made that all employees be immunized for Measles, Mumps, and Rubella.

In the event, having refused immunization, I should contact Measles, Mumps, or Rubella, my choice to waive the vaccine will be considered with all other circumstances in deterring hospital liability.

I understand that if I am pregnant now, or become pregnant, this will be a risk to my unborn child.

Reason for Declination of MMR vaccine:

( ) I have had the measles previously
( ) I have received two immunizations in the past
Dates: ___/___/___ and ___/___/___
( ) Serologic evidence of Immunity to Measles ***Documentation must be attached***
( ) I am pregnant or plan to become pregnant within the next three months
( ) I am allergic to eggs and/or Neomycin
( ) Other – Please Explain: _____

_____

Initial Here: _____

I certify that the above information is correct and complete. I also certify that the signature below applies to Page 1 and Page 2 of this Employee Health Screen Form.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date
_____	_____	_____
Printed Name of Witness	Signature of Witness	Date

PHYSICAL EXAM

(To be used if no current physical exam)

TB Clearance

Skin Test Placement Date:_____ Read Date: _____ □Positive □Negative

Chest X-Ray Date:_____ Result:_____

Questionnaire (BCG Positive)

Have you ever been vaccinated against TB with BCG? If yes, please note date(s):	□YES □NO
Do you currently have a persistent or productive cough?	□YES □NO
Have you been coughing up or spitting up and blood?	□YES □NO
Are you experiencing any night sweats?	□YES □NO
Have you experienced any unexplained weight loss in the past year?	□YES □NO
Have you been experiencing any unusual fatigue?	□YES □NO
Are you experiencing symptoms of an acute infectious illness?	□YES □NO
Are you immune-suppressed by disease or drugs (i.e. corticosteroids)? If yes, list drug(s) and dosage:	□YES □NO
Do you currently have a rash, allergic dermatitis?	□YES □NO
Have you received a recent vaccination (live virus) in the past **6 weeks**?	□YES □NO
Have you lived in a foreign country for 2 months or greater?	□YES □NO
Have you been exposed to an individual with TB in the past year?	□YES □NO
Do you have any food or drug allergies? If yes, please list	□YES □NO

Physical Exam

BP:_____ Pulse:_____ RR: _____ Temp: _____ Height: _____ Weight: _____

System	Normal	Abnormal (Explain)
ENT	□Within Normal Limits	
Cardiac	□Within Normal Limits	
Respiratory	□Within Normal Limits	
GI	□Within Normal Limits	
GU	□Within Normal Limits	
Muscular/Skeletal	□Within Normal Limits	
Endocrine	□Within Normal Limits	
Mental	□Within Normal Limits	

This physical confirms that the patient is in good health and free from any communicable diseases and is capable of performing the job duties of the position named above.

Physician's Name: _____ Telephone Number: _____

Address: _____

Physician's Signature: _____ Date: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) **Social security number**
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $

Multiply the number of other dependents by $500 . . . . ▶ $

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

CAUTION ***Multiple jobs.*** *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

IDEAL CARE
Home Health, Inc.

HANDWASHING

COMPETENCY EVALUATION

NAME: _____

PERFORMANCE CRITERIA	DATE COMPETENCY EVALUATED	METHOD USED (OBSERVATION, SIMULATION, CHART AUDIT, OR TESTING)
1. Wets hands and wrists completely; points finger downward.		
2. Applies soap over entire hand/wrist area; lathers well.		
3. Scrubs hands and wrists well, paying attention to fingernails and between fingers.		
4. Rinses well, keeping fingers pointed downward.		
5. Dries hands and wrists completely using a paper towel or a clean hand towel.		
6. Turns off faucet with the paper towel or cloth towel.		
7. If no running water or hand washing facilities not available, uses a packaged hand washing product or hand sanitizer.		
Additional Comments:		

Signature/Title of Evaluator: _____ **Date:** _____

Signature/Title of Employee: _____ **Date:** _____

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