Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

New Hire Packet

We will need a copy of the following:

	Driver's license
	Social security card
	Professional license
	Degree or transcripts
	TB test or chest x-ray
	CPR card
	Auto insurance

Payroll Forms

	W-4
	MI W-4
	W-9 (1099 employee)
	I-9

*** Office Use only***

	Pay rate
	ADP
	ICHAT
	National Sex offender
	State sex offender

	Audit completed
	File Scanned

Initial _____

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APPLICATION FOR EMPLOYMENT

Pre- Employment Questionnaire – An Equal Opportunity Employer

PERSONAL INFORMATION **DATE OF APPLICATION:** _____

Name: _____
Last First Middle

Address: _____
Street (Apt) City/State Zip

Alternate Address:

_____
Street City/State Zip

Contact Information:
(_____)_____ (____)_____ _____
Home Phone Cell Phone E-mail

How did you learn about our company? _____

POSITION SOUGHT: _____ **Available Start Date:** _____

Desired Pay Range: _____ **Are you currently employed?** _____
Hourly or Salary
If so, may we contact your current employer? _____ **Phone Number:** _____

Have you ever applied for work at this company? _____ **When?** _____

Separation Reason: _____

EDUCATION & TRAINING

SCHOOL LEVEL	NAME AND LOCATION OF SCHOOL	GRADUATE? DEGREE?	MAJOR /SUBJECTS OF STUDY
HIGH SCHOOL			
COLLEGE			
TRADE OR BUSINESS			

MILITARY SERVICE RECORD

Branch Of Service	Discharge date rank

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Please list your areas of highest proficiency, special skills or other items that may contribute to your abilities in performing the above mentioned position.

_____

_____

_____

PREVIOUS EXPERIENCE

Please list beginning from most recent

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving: May we contact this employer? Yes No

_____

_____

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving: May we contact this employer? Yes No

_____

_____

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving: May we contact this employer? Yes No

_____

_____

Have you been convicted of a felony in the past 5 years? ○ Yes ○ No

If yes please explain: _____

Authorization:

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed; falsified statements on this application shall be grounds for dismissal.

Initial _____

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I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal otherwise and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

I also acknowledge that this company reserves the right to require a pre-employment fingerprinting/ criminal history check. (Michigan Public Acts 27, 28, and 29 or 2006)

This company is an equal opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this company depends solely on your qualifications.

Signature of Applicant: _____ Date: _____

For interviewer's use only

Interviewed by: _____ Date: _____

Comments:

_____

_____

Interviewed by: _____ Date: _____

Comments:_____

_____

Hire Date: _____ For Position: _____

Salary /Wages: _____ Will Report: _____

Approved 1	Director of Nursing	Date
Approved 2	President	Date
Approved 3	HR Manager	Date

Acknowledgment of Policy and Procedures

I, _____ am aware that the Policy and Procedure Manual is available to me at all times and is located in the Reference Book Shelf in the office during normal business hours. If I have any questions regarding the

agency's Policies and Procedures it is a reference for me along with any office staff including the Administrator and Clinical Manager.

Signature: _____ Date:_____

Badge Receipt

I _____, have received a company badge and will wear it while working for Fusion Home Health Care. It is my responsibility to keep it protected. If I lose my badge I will report it immediately to Human Resources for a reissued badge.

Signature: _____ Date:_____

Computer Key/ Password Statement

I, _____, understand the need and responsibility to maintain a high level of security with computer access. I will not allow anyone to use my computer key/ password and accept full responsibility for the security of my computer key/ password.

Signature: _____ Date:_____

Non- Compete

In consideration of my being employed by Fusion Home Care, I _____, hereby agree that upon the termination of my employment and notwithstanding the cause of termination, I shall not compete with the business of the company or its successors or assigns, and shall not directly or indirectly , as an owner, officer, director, employee, consultant, or stockholder, engage in business of Fusion Home Care, or a business substantially similar or competitive to the business of the company.

This non-compete agreement shall extend only for a radius of 100 miles from the present location of the company, and shall be in full force and effect for two (2) years, commencing with the date of employment termination.

I agree not to do business directly or indirectly with any individual or business entity that Fusion Home Health Care has introduced to me or by entering into employment with such individuals or businesses.

Confidentiality and Non–Disclosure Agreement

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

Fusion Home Health Care deals with confidential records relating to our patients, business operations, business associates, health care professionals, and employees. Such information(s) is vital to the operation of our company in providing quality care and services to our patients; it is our goal to protect it. Being a covered entity, Fusion Home Health Care is bound to comply with current HIPAA regulations and agency policies governing the access, use, and disclosure of protected health information; you have the responsibility to protect such data.

As an employee of this company, you may have access to protected health information; the purpose of this agreement is to provide you with information to assist you in understanding your duty and obligations relative to protected health information. Your signature on this document indicates that the information contained herein has been explained to you, you received a copy of this document, and that you understand the rules set forth. You agree:

1. To respect the privacy and confidentiality of any information you may have access to through our computer system/network or documentation and that you will access or use only that information necessary to perform your job.
2. To refrain from communicating information about a patient in a manner that would allow others to overhear such information or to discuss a patient's information with anyone not permitted access to such information in accordance with the agency's established policies.
3. To disclose confidential patient, business, financial, or employee information **ONLY** to those authorized to receive it.
4. To safeguard and not disclose your password or user ID code or any other authorization you may have that allows your access to protected information. You accept responsibility for all entries and actions recorded using your password and user ID code.
5. Not to attempt to learn or use another employee's password and user ID code to log on to our agency's computer system or network.
6. To immediately report to the HIPAA compliance officer any suspicion that your password and user ID code have been compromised.
7. Not to release or disclose the contents of any patient or agency record or report except to fulfill your work duties.
8. Not to remove or copy any protected information or reports from their storage location except to fulfill your work duties.
9. Not to have your computer terminal or workstation unattended without logging off or using your systems screen saver function before leaving your work area or securing hardcopy information so that it may be disclosed/ accessible to unauthorized persons.
10. Not to access or request any protected information that is not necessary to perform your assigned job function.
11. Not to permit others to access our agency's computer system or network using your password or ID CODE.

Initial _____

12. To permit your access to our agency's information systems to be monitored.
13. Not to download or make copies of any software or applications without proper authorization or license.
14. To report any suspected or known unauthorized access, use, or disclosure of protected information.
15. Upon termination of my employment with the agency, I agree to continue to maintain the confidentiality of any information I learned while an employee agrees to turn over keys, access cards, or any other device that would provide access to the agency or its information.
16. To abide by the Health Insurance Portability And Accountability Act Of 1996 (HIPAA) policies and procedures set forth by the agency as well as current regulations governing privacy issues
17. I understand that violation of this agreement may warrant appropriate disciplinary action up to and including termination of employment and /or civil action.

I, _____ further understand that the duties and obligations set forth in this document will continue after the termination, expiration, and cancellation of this agreement to include my termination of employment. I also understand my password and user ID code can be temporarily or permanently revoked if I fail to abide by the rules set forth.

Signature of employee: _____ Date: _____

CONFLICT OF INTEREST

All Agency Staff will disclose a potential conflict of interest to ensure staff performs in an ethical manner.

Any outside interest that could possibly involve a conflict of interest (directly or indirectly) with any person, vendor, family, purchaser, or competitor will be disclosed.

The nature of outside interest may be determined as:

- Ownership in a competing agency/ company
- Entertainment
- Money or gifts (other than of nominal value)
- Loans
- Employment status (e.g. working with a competitor)
- Related staff members

If a conflict does exist, the Governing Body member will disclose the interest and will refrain from voting on the matter.

If a conflict or potential conflict of interest arises for a staff member, the staff member must immediately reveal the conflict to his/her supervisor

The agency will review its relationship and staff's relationship with other care providers, educational institutions, and payers to ensure that those relationships are according to applicable law and regulation and to determine if conflicts exist.

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Please provide written disclosure of all professional or personal relationships or interests, direct or indirect that might present a conflict of interest.

_____
_____
_____
_____

Signature: _____ Date:_____

Electronic Signature overview, policy, and agreement

Electronic Signature Overview
Agency Manager's electronic signature system uses a dual password process to ensure authentic electronic signatures.

Each Agency Manager user has a system password (Login authentication password) that must be updated every 60 days to ensure continued access to the system. When an electronic signature is utilized to sign clinical documentation, the user will provide an additional signature password (Electronic Signature Passcode) to sign the document within the system. When an electronic signature is applied to a document, the time and date are stored for later retrieval. If at any time a document that has been electronically signed is re-opened or otherwise edited, the electronic signature will be destroyed and must be re-entered by the user upon resubmission of the clinical documentation.

Login authentication passwords are created and assigned at the agency level. Electronic Signature Passcodes are created by individual users, and subsequently managed by Kinnser Software, Inc. If a user forgets her/his Electronic Signature Passcode, the user must be authenticated by Kinnser prior to resetting the Passcode. Resetting the Electronic Signature Passcode cannot be done at the agency level to ensure the security of the dual password process.

Electronic Signature Policy

Policy:
Fusion Home Health Care Staff staff may use electronic signatures on all computer-generated documentation. An electronic signature will serve as an authentication on patient record documents generated via Agency Manager.
Purpose:
To utilize current technology in the provision of patient care

Responsibility:
All personnel

Procedure:

1. *Fusion Home Health Care Staff* staff may create patient documentation via a computer system.
2. For the purpose of the electronic medical record, and documents printed from the electronic medical record, the employee's use of an Electronic Signature Passcode after authenticating with their system Login password will serve as her/his legal signature.
3. The agency-based application administrator will issue each employee a system User Name and a temporary password. The user will create a new password upon initial login to the Agency Manager.
4. An Electronic Signature Passcode will be generated by the employee and will only be accessible to the employee.
5. Each user will be required to change their Login authentication password:
    a. upon his/her password being reset by an agency-based application administrator
    b. every 60 days
    c. at the employee's discretion
6. If an Electronic Signature Passcode must be reset, only the software vendor with employee authentication may reset the Electronic Signature Passcode.
7. After completion of a clinical document by the clinician, her/his Electronic Signature Passcode must be entered to submit the clinical document to the case manager.
8. Each employee documenting electronically in the electronic medical record will be required to sign an Electronic Documentation & Signature Authenticity Agreement. This Agreement will require that he/she:
    a. Ensure the security of his/her Login authentication password and Electronic Signature Passcode information, which may not be shared with anyone,
    b. Exit the electronic medical record software at the end of each working day, when the computer will not be used for clinical documentation, and when the computer is out of her/his possession, and
    c. Review all documentation prior to submission.
9. Each employee will review documentation and make necessary corrections per agency policy to documents returned by a case manager at which time the clinician will be required to re-enter the Electronic Signature Passcode to re-submit the documentation.
10. In the event of system downtime that results in the employee's inability to use the electronic documentation system, the employee will complete records manually.
11. Each user must keep his/her Login User Name, password, and Electronic Signature Passcode confidential. Only the agency-based administrator may reset a user's Login authentication password.
12. Upon termination of employment; the administrator will immediately disable the employee user's credentials to prevent access to the electronic medical record.

Electronic Signature Agreement

ELECTRONIC DOCUMENTATION & SIGNATURE AUTHENTICITY AGREEMENT

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3150 Livernois, Suite 210, Troy, MI 48084
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I understand that *Fusion Home Health Care Staff* may use electronic signatures on all computer-generated documentation. An electronic signature will serve as an authentication on patient record documents and other agency documents generated in the electronic system.

For the purpose of the computerized medical record and other documentation for agency purposes, I acknowledge the combined use of my Electronic Signature Password and login authentication password will serve as my legal signature. I further understand that an agency-based administrator issues initial employee passwords and that I will create an Electronic Signature Passcode within the software application.

Login authentication passwords must be updated every 60 days by the user, as well as on an as-needed basis if system security is breached. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of electronic signature, my documentation on the field-based or office computer. I understand that I am responsible for the security and accuracy of information entered into the Agency Manager, and as such, I will:

1. Not share or otherwise compromise my electronic signature credentials (Login authentication password or Electronic Signature Passcode)
2. Exit the online application at the end of each working day or whenever the computer is not in my immediate possession
3. Not save my Login password and Electronic Signature Passcode on the computer, but will enter them upon each access of the application
4. Review all of my documentation online prior to submitting to the agency server

Printed Name: _____ Credentials: _____

Signature: _____ Date:_____

Employee Signature Verification Form

I, _____, (title) _____
Verify my legal signature for medical/ employment related documentation as follows:

SIGNATURE	DATE

HANDBOOK ACKNOWLEDGEMENT

I_____, have read and understand the policies outlined herein and I understand that the Employee Handbook is a statement of policies and not an expression of implied contract of

employment. Fusion Home Health Care reserves the right to amend, add to, modify, and or change the terms of this Handbook at any time, without notice. The policies stated herein are only guidelines and cannot be relied on as creating any rights, contractual or otherwise, I further understand that the employee handbook cannot be considered to be a contract, express or implied.

I understand that I am employed at will, that Fusion Home Health Care may terminate my employment at its discretion, with or without notice or cause and that I cannot rely on any representation written or oral to the contrary.

By signing this statement, I agree to follow the personnel policies of Fusion Home Health Care to the best of my abilities and understand that failure to follow these policies may result in termination of my employment with Fusion Home Health Care I hereby acknowledge receipt and retention of a copy of the Fusion Home Health Care employee handbook.

Signature: _____ Date:_____

ORIENTATION CHECKLIST

EMPLOYEE: _____ POSITION:_____

Fusion Home Health Care
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ORIENTATION TO	YES	N/A	SIGNATURE/DATE
1. Basic Home Safety: bathroom, electrical, environmental and fire			
2. Safety program:			
a. Risks within Agency and patient's home			
b. Actions to eliminate, minimize or report risks			
c. Incident reporting and procedures to follow			
d. Reporting processes for common problems, failures and user errors.			
3. Storage/handling/access to/transport of supplies/medical gasses/drugs			
4. ID/handling/disposal of infectious wastes (Blood and Body Fluids/Precautions)			
5. ID/handling/disposal of hazardous waste (cytotoxic/ chemotherapy drugs)			
6. Infection Control and Prevention			
a. Personal hygiene (e.g., PPE and handwashing)			
b. Aseptic procedures			
c. Communicable infections (TB, AIDS, etc.)			
d. Cleaning/disinfecting reusable equipment			
e. Precautions to be taken (Standard Precautions, airborne transmission, direct/indirect contact, compromised immunity)			
7. Confidentiality of patient information/HIPAA policies and practices			
8. Community resources			
9. Policies/procedures			
10. Responsibilities related to safety and infection control			
11. Advanced directives policies/procedures			
12. Specific job duties/responsibilities and any limitations; performance standards; professional boundaries			
13. Screening for alleged or suspected victims of abuse/neglect reporting			
14. Emergency operations plan and role			
15. Equipment use/management relevant to job description			
16. Tuberculosis Program/Plan (OSHA)			
17. Hazardous Materials in the Workplace Program (SDS) (OSHA)			
18. Bloodborne Pathogen Program (OSHA)			
19. Managing the environment of care: (pt& Agency site)			
a. Safety			

Initial _____

b. Fire safety – fire escape, fire alarm system, fire extinguishers – and prevention			
c. Security – Personal safety during home visits			
d. Utilities			
e. Responding to emergencies			
20. Pt rights/responsibilities, including conveying charges for care			
21. Agency complaint mechanism/Medicare state hotline # and purpose			
22. QAPI program and role			
23. On-call and answering service			
24. Ethical aspects of care, treatment and services and process to address ethical issues			
25. Philosophy/mission/purpose/vision/goals/conflict of interest			
26. Interpreters/communicating with hearing/speech/ visually impaired			
27. Sentinel event policy/process			
28. Physical safety (e.g., body mechanics and safe lifting)			
29. Cultural diversity and sensitivity			
30. Role of the health team			
31. Family/State Medical Leave Act			
32. Organizational structure, lines of authority and responsibility; supervision process; Corporate Integrity Plan			
33. Hours of work; benefits			
34. Documentation requirements, including OASIS, if applicable			
35. Medical Device Reporting Act			
36. Equal Employment Opportunity Act			
37. Sexual Harassment Act			
38. Salary/hourly wage reimbursement			
39. Unemployment and Workers' Compensation			
40. Malpractice coverage			
41. Assessing and managing pain.			

Other: _____

Signature: _____ Date: _____

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Initial/ Annual Orientation/ in-service check off sheet

Subject	Initial
1. HIPPA	1. _____
2. Bloodborne Pathogens	2. _____
3. Infection Control	3. _____
4. TB/ Hepatitis Information	4. _____
5. MRSA	5. _____
6. Hand Hygiene	6. _____
7. Oxygen Safety	7. _____
8. Protect your back	8. _____
9. Abuse and Neglect	9. _____
10. Pain	10. _____
11. Restraint information	11. _____
12. Age related Care	12. _____
13. Safety in Home	13. _____
14. Latex allergy	14. _____
15. Diversity	15. _____
16. Skills Check off	16. _____
17. Receipt of Job description	17. _____
18. Medication Safety	18. _____
19. Policies (corporate/ clinical/personnel)	19. _____
20. Abbreviation List	20. _____
21. Performance Standards	21. _____
22. Professional Standards	22. _____
23. Ethics	23. _____
24. Medical Product. Device	24. _____
25. Documentation for payroll	25. _____
26. Employee Badge Received	26. _____
27. Fire and/or explosive	27. _____
28. Weather Drill	28. _____
29. Disaster Plan	29. _____
30. OSHA	30. _____
31. Advanced Directives	31. _____

Acknowledgement of Training

I, _____have read and understand the above training materials that have been given to me and I must receive a score of 80% or above prior to starting this position.

Employee Signature _____Date: _____

COVID- 19 Vaccination

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

My employer, Fusion Home Health Care has recommended that I receive COVID-9 vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- COVID-19 is a serious respiratory disease that kills thousands of people in the United States each year.
- COVID-19 vaccination is recommended for me and all other healthcare workers to protect this facility's patients from COVID-19, its complications, and death
- If I contract COVID-19, I can shed the virus for 5 days before COVID-19 symptoms appear. My shedding virus can spread COVID-19 to patients in this facility.
- If I become infected with COVID-19, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of the virus that cause COVID-19 infection change and even if they don't change my immunity declines over time. This is why vaccination against COVID-19 is recommended.
- I understand that I cannot get COVID-19 from the COVID-19 vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
    - All patients in this healthcare facility
    - My coworkers
    - My family
    - My community

Despite these facts, I am choosing to decline COVID-19 vaccination right now for the following reasons:

_____

_____

_____

- I would like to receive the COVID-19 vaccination

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

Signature: _____ Date: _____

Name (print): _____

Hepatitis B Vaccine Acceptance / Declination Form

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

Acceptance:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by Bloodborne pathogens, Including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of blood-prone pathogens. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself; In addition, I have received information regarding Hepatitis B (HBV) vaccine. Based on the training I have received; I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

Declination:

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 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.

CHECK ONE:

_____ I **ACCEPT** Hepatitis B vaccine inoculation: OR

_____ I **DECLINE** Hepatitis B vaccination inoculation

Employee's name: _____

Employee's Signature: _____ Date: _____

Influenza Vaccination

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

My employer, Fusion Home Health Care has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of the virus that cause influenza infection change almost every year and even if they don't change my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
    - All patients in this healthcare facility
    - My coworkers
    - My family
    - My community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

_____

_____

_____

- I would like to receive the influenza vaccination

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

Signature: _____ Date: _____

Name (print): _____

REFERENCE CHECK

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

Name of Former Employer: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Name of Supervisor: _____
Phone #: _____ Fax #: _____

Name of Applicant: _____
Social Security Number: _____

I _____ hereby give my permission to release the information listed below to Fusion Home Health Care.

Signature_____ Date: _____

The above applicant is being considered for a position with Fusion Home Health Care. We would very much appreciate it if you would check the appropriate spaces below that best describe the applicant's job performance. Please return the form to us at your earliest convenience.

Position Held: _____

Position held from: _____ to:_____

	Outstanding	Above Average	Average	Fair
Job Knowledge				
Quality of Work				
Dependability				
Attendance/ Punctuality				
Attitude/ Personality				
Motivation/ self-starter				
Independent Functioning				

Comments:_____
_____
_____

Signature & Title: _____ Date: _____

REFERENCE CHECK

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Phone: 313.885.5580 Fax: 313.885.5582

Name of Former Employer: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Name of Supervisor: _____
Phone #: _____ Fax #: _____

Name of Applicant: _____
Social Security Number: _____

I _____ hereby give my permission to release the information listed below to Fusion Home Health Care.

Signature_____ Date: _____

The above applicant is being considered for a position with Fusion Home Health Care. We would very much appreciate it if you would check the appropriate spaces below that best describe the applicant's job performance. Please return the form to us at your earliest convenience.

Position Held: _____

Position held from: _____ to:_____

	Outstanding	Above Average	Average	Fair
Job Knowledge				
Quality of Work				
Dependability				
Attendance/ Punctuality				
Attitude/ Personality				
Motivation/ self-starter				
Independent Functioning				

Comments:_____
_____
_____

Signature & Title: _____ Date: _____

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PERSONNEL RECORDS CHECKLIST

NAME: _____ TITLE: _____
DATE OF HIRE: _____ SOCIAL SECURITY#: _____ DATE OF BIRTH: _____
ADDRESS: _____
HOME PHONE #: _____ CELL PHONE #: _____
EMAIL: _____ FAX #: _____
EMERGENCY CONTACT NAME: _____
RELATIONSHIP: CONTACT #:

INITIAL REQUIREMENTS:
__Application; __Resume; __Interview Questionnaire; __Reference 1; __Reference 2; __Prof. License; __ Copy SS card
__Documentation of educational preparation, __Other _____

QUIZZES:
___ Medical device; ___ Bag technique; ___ infection control; ___ TB; ___bloodborne pathogens;
___Privacy/confidentiality/ HIPAA ***HHA additional quizzes 1.___, 2. ___, 3.___, 4. ___, 5. ___, 6. ____

AFTER HIRE REQUIREMENTS:		*** In separate binder***
___ Conflict of Interest	___ OSHA Orientation	___ Tax form MI- W4
___ Criminal Background Check letter	___ Orientation Checklist	___ Tax form-W-4
___ Probationary Evaluation (90 day)	___ Policy & Procedure Ack.	___ I-9
___ Confidentiality/ non-disclosure	___ Employee Handbook	___ Tax form W-9 (1099 ONLY)
___ Consent for background check	___ Key release	___ Liability Insurance (1099 ONLY)
___ Skills Checklist/Competency Test	___ Computer Password	___ Hep. B Accept/Decline
___ Job Description	___ OIG inclusion - printed	___ TB Screen
___ Electronic Signature Agreement	___ Signature Verification	___ Affordable care act form
___ Badge	___ Non- Compete	___ LARA License verification
___ Contract/ Employment Agreement	___ _____	___ Flu vaccine Accept/Decline
	___ _____	COVID-19 vaccine Accept/Decline

UPDATE DOCUMENTS (Expiration Dates) (NEED COPY)	**20 —**	**20 —**	**20 —**	**20 —**	**20 —**	**20 —**	**20 —**	**20 —**	**20 —**	**20 —**
Annual Performance Evaluation										
Annual Skills Competency										
Auto Insurance										
Auto Registration										
CPR/ACLS										
Driver's License										
Flu Vaccine (offered)										
Hand Washing (performed)										
Bag technique (reviewed)										
Liability Insurance (1099)										
Professional License										
Professional License Check (LARA/NAHC)										
TB test (PPD 2 tests within 1 yr., CXR UNLTD) yearly screens										
Inservice Quiz certification (12 hours HHA, 6 hours for lic./yr)										

*Please be sure to calibrate your equipment MONTHLY (BP cuffs, TENS, US, Glucometer, Pulse OX) *