PHYSICAL 4U, INC

Application for Employment

Personal Information	Name		Date		
	Current Address		Home Phone Number	( )	
			Work Phone Number	( )	
	Previous Address		Social Security Number		
	Are you prevented from being lawfully employed in the United States?			( ) Yes	( ) No
	Are you 18 years of age or older?			( ) Yes	( ) No
	For reference purposes, have you worked or attended school under a former name? If yes, please list former name:			( ) Yes	( ) No
	Have you ever applied here before? If yes, when?			( ) Yes	( ) No
	Have you ever been employed here before? If yes, when?			( ) Yes	( ) No
	Are any relatives currently employed here? If yes, , give full name			( ) Yes	( ) No
	Are you able to perform the essential functions of the job you are applying for? If no, what accommodation would assist you?			( ) Yes	( ) No
	How did you hear about the company?				

Education, Training and Special Skills	**Type of School**	**Name and Location**	**Did you graduate?**	**Grade average**	**Major/Minor**
	High School		( ) Yes ( ) No		
	Trade School or Junior College		( ) Yes ( ) No		
	College or University		( ) Yes ( ) No		
	Graduate School		( ) Yes ( ) No		
	Military or Other		( ) Yes ( ) No		
	Seminars and Classes				
	Professional License or Certification				
	Software or Equipment				

Objectives	**Employee Preference**			
	Position Desired		Earnings Desired	
	Location Desired		Are you available to travel? ( ) Yes ( ) No Are you willing to relocate? ( ) Yes ( ) No	
	Career Objectives			

Employment History

List employment history for the last 10 years, starting with most recent employment

Employer		Phone Number ( )	
Address		Start Date (month/year)	
		End Date (month/year)	
Supervisor Name		Starting Salary	
And Phone Number	( )	Ending Salary	
May we contact this employer? ( ) Yes ( ) No		Last Bonus or Incentive	
Title or Position			
Duties and Responsibilities			
Reason for Leaving			

Employer		Phone Number ( )	
Address		Start Date (month/year)	
		End Date (month/year)	
Supervisor Name		Starting Salary	
And Phone Number	( )	Ending Salary	
May we contact this employer? ( ) Yes ( ) No		Last Bonus or Incentive	
Title or Position			
Duties and Responsibilities			
Reason for Leaving			

Employer		Phone Number ( )	
Address		Start Date (month/year)	
		End Date (month/year)	
Supervisor Name		Starting Salary	
And Phone Number	( )	Ending Salary	
May we contact this employer? ( ) Yes ( ) No		Last Bonus or Incentive	
Title or Position			
Duties and Responsibilities			
Reason for Leaving			

Background	
	Have you ever been convicted of a felony? If "YES" please explain and provide dates:
	Do you have any felony charges pending against you? If "YES" please explain and provide dates:
	** Conviction of a felony will not necessarily disqualify you. ** (Background Level I and/or II)

References	Please list references, do not include family members or people who live with you				
	Name	**Address**	**Phone Number**	**Occupation**	**Years Acquainted**

Certification	Important, please read carefully and sign
	I certify the information contained in this application is true and complete to the best of my knowledge. Any misrepresentation or omissions of any fact in my application can be justification for refusal of employment or if employed grounds for termination. I authorize the company to investigate all statements contained in this application and release all parties from any liability for any damage that may result from furnishing same to you. I understand that my employment may be terminated with or without cause or notice, at any time, at the option of either the Company or myself **Signature** _____ **Date** _____

PHYSICAL 4U, INC

EMERGENCY NOTIFICATION

EMPLOYEE NAME: _____ DATE: _____

Category: _____

In case of an emergency notify next of kin:

NAME: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Telephone: (_____) _____

SECOND EMERGENCY CONTACT (Friend or relative not living with you)

NAME: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Telephone: (_____) _____

PHYSICAL 4U, INC

REFERENCE REQUEST

(Applicant to complete to double line)

Reference Name: _____

Facility Name: _____

Telephone: (_____) _____

I have applied to **Physical 4U, Inc.** as a, _____.
I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

Applicant's Signature: _____

Print Applicant's Name: _____

I worked for you from _____ to _____ as a _____ position.

To be completed by former employer:

Would you rehire? Yes _____ No _____

Is the above information correct? Yes_____ No _____

If no please explain: _____

	EXCELENT	VERY GOOD	GOOD	POOR
JOB SKILL				
JOB KNOWLEDGE				
INITIATIVE				
ATTENDANCE				
ABILITY TO WORK WITH OTHERS				
HONESTY				
JUDGEMENT				
ABILITY TO ACCEPT DIRECTION				
GROOMING AND APPEARANCE				
TIME MANAGEMENT				

Comments:

_____

_____

Signature: _____ **Title:** _____ **Date:** _____

PHYSICAL 4U, INC

REFERENCE REQUEST

(Applicant to complete to double line)

Reference Name: _____

Facility Name: _____

Telephone: (_____) _____

I have applied to **Physical 4U, Inc.** as a, _____.
I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

Applicant's Signature: _____

Print Applicant's Name: _____

I worked for you from _____ to _____ as a _____ position.

To be completed by former employer:

Would you rehire? Yes _____ No _____

Is the above information correct? Yes_____ No _____

If no please explain: _____

	EXCELENT	VERY GOOD	GOOD	POOR
JOB SKILL				
JOB KNOWLEDGE				
INITIATIVE				
ATTENDANCE				
ABILITY TO WORK WITH OTHERS				
HONESTY				
JUDGEMENT				
ABILITY TO ACCEPT DIRECTION				
GROOMING AND APPEARANCE				
TIME MANAGEMENT				

Comments:

_____

_____

Signature: _____ **Title:** _____ **Date:** _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

TAX EXEMPT FORM

I, _____, HEREBY ACKNOWLEDGE THAT I AM AN INDEPENDENT CONTRACTOR; THEREFORE, I AM RESPONSIBLE FOR MY SOCIAL SECURITY AND TAXES. I ALSO ACKNOWLEDGE THAT I WILL RECEIVE AN IRS 1099 FORM FOR THE PRECEDING YEAR BY FEBRUARY 1ST OF EACH YEAR WHICH WILL ALSO BE SENT TO THE INTERNAL REVENUE SERVICE. AS AN INDEPENDENT CONTRACTOR, I AM NOT ELIGIBLE FOR ANY BENEFITS SUCH AS VACATIONS, DISABILITY OR UNEMPLOYMENT AND WILL NOT BE COVERED BY WORKMEN'S COMPENSATION.

EMPLOYEE SIGNATURE: _____

DATE: _____

SOCIAL SECURITY NUMBER: _____

POSITION: _____

PHYSICAL 4U, INC.

INDEPENDENT CONTRACT AGREEMENT

The Independent Contractor Agreement is entered this_____ day of _____(month)_____ between _____ ("Independent Contractor") and PHYSICAL 4U, INC.

WITNESSETH
WHEREAS, PHYSICAL 4U, INC. is a licensed Home Health Agency,
WHEREAS, Independent Contractor is duly licensed as a:

_____Registered Nurse	_____Licensed Practical Nurse
_____Home Health Aide	_____Certified Nurse Aide
_____Companion/Sitter	_____Homemaker
_____Physical Therapist or PT Assistant	_____Occupational Therapist or OT Assistant
_____Speech Therapist	_____Other_____

WHEREAS, PHYSICAL 4U, INC. desires to engage Independent Contractor to provide such services to PHYSICAL 4U, INC.'s patient and Independent Contactor desires to provide such services.

WHEREAS, it is explicitly understood and agreed that PHYSICAL 4U, INC.is fully responsible, liable and in control of the total operation of the agency and control over contracted services, **NOW THEREFORE,** in consideration of the promises contained herein, and other good valuable consideration, the receipt and sufficiency of which and hereby acknowledge the parties hereto agree as follows:

INDEPENDENT CONTRACT OBLIGATIONS:

1. To meet all professional state and federal requirements for the provision of health care services performed hereunder including, but not limited to, licensure and service education requirements.

2. To furnish services and requirement in conformance with PHYSICAL 4U, INC. personnel and patient care policies and procedures, the physician's Plan of Care (Plan of Care) and generally accepted community standards.

3. To participate, as required, in the development and coordination of the patient's care including the Plan of care and to participate in agency performance improvement activities.

4. To contact PHYSICAL 4U, INC. at least or as instructed if needed on the patient's condition and scheduling visits.

5.To perform duty/services and maintain records in accordance with PHYSICAL 4U, INC.'s policy.

6. To furnish PHYSICAL 4U, INC. a weekly record for each patient that includes, but is not limited to: initial evaluation, periodic re-evaluation, treatment notes, and daily itineraries for each visit, monthly update, notification of discharge, completed care plans, and the discharge summaries.

7. To submit by Monday of the following week (Tuesday upon request) in which services were performed all time sheets and notes for services prescribed by PHYSICAL 4U, INC.'s forms.

8. To provide general and professional liability insurance in such amounts as required based on your professional licensing requirements.

9. To not bill patients of PHYSICAL 4U, INC. for any services performed without PHYSICAL 4U, INC. prior approval.

PHYSICAL 4U, INC. AGREES AS FOLLOWS:

PHYSICAL 4U, INC.

INDEPENDENT CONTRACT AGREEMENT

1. To make Independent Contractor aware of PHYSICAL 4U, INC. policies and procedures.

2. To maintain the clinical records of the patient.

3. To pay the Independent Contractor for approved services performed hereunder on bi-weekly basis after required documentation has been received by PHYSICAL 4U, INC.

4. To bill the appropriate insurance, program or authorized party for service performed by Independent Contractor.

PAYMENT:
In full consideration of the services provided hereunder, PHYSICAL 4U, INC. agrees to pay Independent Contractor a fee agreed on by both parties per visit/per hour based on service to be provided.

_____Registered Nurse	_____Licensed Practical Nurse
_____Home Health aide	_____Certified Nurse Aide
_____Companion/Sitter	_____Homemaker
_____Physical Therapist or PT Assistant	_____Occupational Therapist
_____Speech Therapist	_____Other_____

BENEFITS:
PHYSICAL 4U, INC. shall not be responsible for the payment of any fee, tax, or any insurance benefit of Independent Contractor including but not limited to health insurance, disability income, insurance, retirement, worker's compensation insurance, unemployment tax, state or federal tax, including social security tax, federal withholding tax, professional dues and licensures fees.

TERM/TERMINATION:
This Agreement shall continue and be binding upon the parties hereto for one year unless terminated sooner as provided herein:

Either party may terminate this agreement at any time by giving fifteen (15) days' notice to the other party. Notwithstanding any other provision contained herein to the contrary, PHYSICAL 4U, INC. may terminate this Agreement immediately, upon notification of suspension or revocation of Independent Contractor's license, Independent Contractor's conviction of a felony, any action that threatens the well-being of a patient, and Independent Contractor's receipt of a notification of such breach.

INDEPENDENT CONTRACTOR:
Notwithstanding any provision contained herein to the contrary, it is understood and agreed that Independent Contractor is an independent contractor, and nothing herein is intended, nor shall be construed to create employer/
Independent Contractor, partners of a partnership or joint venture relationship between Independent Contractor and PHYSICAL 4U, INC. Independent Contactor agrees and acknowledges that he/she has no right to give authorization, express or implied, to act for PHYSICAL 4U, INC. or incur, assume or create any obligation, responsibility or liability on behalf of PHYSICAL 4U, INC. or bind PHYSICAL 4U, INC. in any manner whatsoever.

The Independent Contractor shall be solely being responsible for and PHYSICAL 4U, INC. will not withhold or pay for any income, social security, unemployment or worker's compensation taxes with respect to any amounts

paid
to Independent Contractor or Compensation hereunder.

PHYSICAL 4U, INC.

INDEPENDENT CONTRACT AGREEMENT

The Independent Contactor shall be fully responsible for the payment of all self-employment estimated taxes.

The Independent Contractor acknowledges that since it is not an employee of **PHYSICAL** 4U, INC., it is not covered under PHYSICAL 4U, INC.'s workers compensation policy.

NON-EXCLUSIVITY:
This agreement is non-exclusive and does not restrict either party from entering into similar contracts with any other party for provision of health care services.

MISCELLANEOUS:
Anything to the contrary notwithstanding, this Agreement shall remain in effect after the date of termination with respect to all covenants contained herein which are expressly made to extend beyond the term of this agreement, including without limitation, indemnities and access to books and records, to the extent necessary to allow for the resolution of all pending matters as of date of termination.

This Agreement may be amended by the written consent of both parties. All amendments to this agreement shall be attached to this Agreement and made a part hereof.

All medical records, case histories, photographs, x-rays or personal and regular files concerning PHYSICAL 4U, INC.'s patients consulted, interviewed, and treated, or cared for by Independent Contractor shall be PHYSICAL 4U, INC.'s sole property and shall be treated as confidential by Independent Contractor. Independent Contractor shall not be entitled to Contractor's participation in the preparation in the preparation of such records.

Independent Contractor agrees and acknowledge that for a period of four (4) years after the termination of this Agreement, it shall, upon written request, make available to the Secretary of the Department of Health and Human Services (HRS) or the Secretary's duly authorized representatives, or upon request to the Comptroller General or Comptroller General's duly authorized representatives, this Agreement, such books, documents and bills under this Agreement.

If Independent Contractor performs any of his/her duties hereunder by wat of a subcontract with a related organization and the value of such contracted duties Ten Thousand Dollars ($10,000.00) or more over a twelve month (12) period, such subcontract shall be incorporated by reference to this paragraph. The availability of Independent Contractor's books, documents and records shall be subject always to such criteria and procedures for seeking or obtaining access as may be promulgated of HRS in regulations and other applicable laws.

Independent contractor will not refuse to provide services to any PHYSICAL 4U, INC.'s patient based on such patient's races, age, color, handicap, sex or nationality.

Independent Contractor will promptly notify PHYSICAL 4U, INC. of any inquiries, investigations, complaints and any disciplinary actions taken by any entity based on Independent Contractor's actions or inactions.

Independent contractor hereby authorizes any entity regulating supervising Independent Contractor to release PHYSICAL 4U, INC. all information relating to such complaint disciplinary action.

Each of the parties hereto agrees to fully indemnify and hold harmless the other party, its director, officers,

Independent Contractors, servants, agents, heirs, successors, and assigns from and against any and all claims, losses, cost, expenses, actions and causes of actions, including reasonable attorney's fees at all levels, arising out of or by reason of any damage or injury to persons or property suffered, or claimed to have suffered, by any

PHYSICAL 4U, INC.

INDEPENDENT CONTRACT AGREEMENT

misconduct, omission or negligence of such party, its directions, officers, Independent Contractor, servant, and agents.

This agreement will remain in effect from today until some amendments are needed. This Agreement may be terminated at any time by either party upon fifteen (15) days advance written notice to the other party.

I_____ am accepting the above position with

I understand that, as a professional, I will not be paid overtime rates for any hours over forty (40) hours per week. All hours over forty (40) in any work week will be paid at my standard rate.

I understand that, as a professional, I shall be fully responsible for the payment of all self-employment estimated taxes.

I have read the personnel rules. I understand if I fail to follow them, I may be disciplined or discharged. My job duties and terms of hire have been explained to me. I have read and understand my job description.

PHYSICAL 4U, INC. is committed to staying in compliance with Civil Rights requirements pursuant to Chapter 760.F.S.

_____ _____

PHYSICAL 4U, INC. DATE

_____ _____

AGENCY REPRESENTATIVE SIGNATURE DATE

PHYSICAL 4U, INC

PHYSICAL 4 U, INC.
MUTUAL ARBITRATION AGREEMENT

THIS ARBITRATION AGREEMENT IS A CONTRACT AND COVERS IMPORTANT ISSUES RELATING TO YOUR RIGHTS. IT IS YOUR SOLE RESPONSIBILITY TO READ IT AND UNDERSTAND IT. YOU ARE FREE TO SEEK ASSISTANCE FROM INDEPENDENT ADVISORS OF YOUR CHOICE OUTSIDE THE COMPANY OR TO REFRAIN FROM DOING SO IF THAT IS YOUR CHOICE.

EL ACUERDO DE ARBITRAJE ES UN CONTRATO Y CUBRE ASPECTOS IMPORTANTES DE TUS DERECHOS. ES TU ABSOLUTA RESPONSABILIDAD LEERLO Y ENTENDERLO. TIENES LA LIBERTAD DE BUSCAR ASISTENCIA DE ASESORES INDEPENDIENTES DE TU ELECCION FUERA DE LA EMPRESA O DE ABSTENERTE DE BUSCAR ASISTENCIA SI ESA ES TU ELECCION.

1. Arbitration. This Arbitration Agreement ("Agreement") is governed by the Federal Arbitration Act (9 U.S.C. §§ 1 *et seq.*). If for any reason the Federal Arbitration Act does not apply, this Agreement shall be governed in accordance with the law of the state in which Employee works or last worked for Physical 4 U, Inc. ("Company"). Except as it otherwise provides, this Agreement applies to any dispute, past, present or future, arising out of or related to Employee's (sometimes "you" or "your") employment with the Company or relationship with any of its agents, employees, affiliates, successors, subsidiaries, assigns or parent companies or termination of employment regardless of its date of accrual and survives after the employment relationship terminates. Except as it otherwise provides, this Agreement is intended to apply to the resolution of disputes that otherwise would be resolved in a court of law or before a forum other than arbitration.

Except as otherwise stated in this Agreement, you and the Company agree that any legal dispute or controversy covered by this Agreement, or arising out of, relating to, or concerning the formation, scope, validity, enforceability or breach of this Agreement, shall be resolved by final and binding arbitration in accordance with the Employment Arbitration Rules of the American Arbitration Association ("AAA Rules") then in effect, and not by court or jury trial, to be held (unless the parties agree in writing otherwise) in the county and state where you are or were last employed by the Company. The arbitrator shall be an attorney familiar with the law governing the issues to be arbitrated or a retired judge. The AAA Rules may be found at www.adr.org or by searching for "AAA Employment Arbitration Rules" using a service such as www.google.com. If for any reason the AAA will not administer the arbitration, either party may apply to a court of competent jurisdiction with authority over the location where the arbitration will be conducted for appointment of a neutral arbitrator.

Except as it otherwise provides, this Agreement also applies, without limitation, to disputes with any entity or individual arising out of or related to the application for employment, background checks, privacy, the employment relationship or the termination of that relationship, contracts, trade secrets, unfair competition, compensation, classification, minimum wage, seating, expense reimbursement, overtime, breaks and rest periods, termination, retaliation, discrimination or harassment and claims arising under the Fair Credit Reporting Act, Defend Trade Secrets Act, Title VII of the Civil Rights Act of 1964, 42 U.S.C. §1981, Rehabilitation Act, Civil Rights Acts of 1866 and 1871, the Civil Rights Act of 1991, 8 U.S.C. § 1324b (unfair immigration related practices), the Pregnancy Discrimination Act, Equal Pay Act, Americans With Disabilities Act, Age Discrimination in Employment Act, Family Medical Leave Act, Fair Labor Standards Act, Employee Retirement Income Security Act (except for claims for employee benefits under any benefit plan sponsored by the Company and (a) covered by the Employee Retirement Income Security Act of 1974 or (b) funded by insurance), Affordable Care Act, Genetic Information Non-Discrimination Act, Uniformed Services Employment and Reemployment Rights Act, Worker Adjustment and Retraining Notification Act, Older Workers Benefits Protection Act of 1990, Occupational Safety and Health Act, Consolidated Omnibus Budget Reconciliation Act of 1985, False Claims Act, state or local statutes or regulations addressing the

same or similar subject matters, and all other federal, state or local statutory and legal claims arising out of or relating to your employment or the termination of employment.

All claims in arbitration are subject to the same statutes of limitation that would apply in court. You and the Company shall follow the AAA Rules applicable to initial filing fees, but in no event will you be responsible for any portion of those fees in excess of the filing or initial appearance fees applicable to court actions in the jurisdiction where the arbitration will be conducted. The Company otherwise shall pay all costs and expenses unique to arbitration, including without limitation the arbitrator's fees. Discovery will be conducted in accordance with the AAA Rules. The arbitrator must follow applicable law and may award only those remedies that would have applied had the matter been heard in court. The arbitrator's decision must be in writing and contain findings of fact and conclusions of law. Judgment may be entered on the arbitrator's decision in any court having jurisdiction.

This Agreement does not apply to litigation between you and the Company pending in a state or federal court or arbitration as of the date of your receipt of this Agreement and in which you are a party or a member or putative member of an alleged class. This Agreement does not apply to: (i) claims for worker's compensation, state disability insurance or unemployment insurance benefits (but it does apply to discrimination or retaliation claims based upon seeking such benefits); and (ii) disputes that an applicable federal statute expressly states cannot be arbitrated or subject to a pre-dispute arbitration agreement. Nothing contained in this Agreement shall be construed to prevent or excuse you (individually or in concert with others) or the Company from utilizing the Company's existing internal procedures for resolution of complaints, and this Agreement is not intended to be a substitute for the utilization of such procedures. A party may apply to a court of competent jurisdiction for temporary or preliminary injunctive relief in connection with an arbitrable controversy, including, without limitation, any disputes arising out of or relating to any non-compete agreement between the Company and You, in accordance with applicable law, and any such application shall not be deemed incompatible with or waiver of this agreement to arbitrate. The court to which the application is made is authorized to consider the merits of the arbitrable controversy to the extent it deems necessary in making its ruling, but only to the extent permitted by applicable law. All determinations of final relief, however, will be decided in arbitration.

Nothing contained in this Agreement prevents you from making a report to or filing a claim or charge with a government agency, including without limitation the Equal Employment Opportunity Commission, U.S. Department of Labor, U.S. Securities and Exchange Commission, National Labor Relations Board, or Office of Federal Contract Compliance Programs. Nothing in this Agreement prevents the investigation by a government agency of any report, claim or charge otherwise covered by this Agreement. This Agreement also does not prevent federal administrative agencies from adjudicating claims and awarding remedies based on those claims, even if the claims would otherwise be covered by this Agreement. Nothing in this Agreement prevents or excuses a party from satisfying any conditions precedent and/or exhausting administrative remedies under applicable law before bringing a claim in arbitration. The Company will not retaliate against you for filing a claim with an administrative agency or for exercising rights (individually or in concert with others) under Section 7 of the National Labor Relations Act. This Agreement also does not prevent or prohibit you in any way from reporting, communicating about, or disclosing claims for discrimination, harassment, retaliation, or sexual abuse.

2. <u>Class and Collective Action Waiver</u>. This Agreement affects your ability to participate in class or collective actions. Both the Company and you agree to bring any dispute in arbitration on an individual basis only, and not on a class or collective basis on behalf of others. There will be no right or authority for any dispute to be brought, heard or arbitrated as a class or collective action, or as a member in any such class or collective proceeding ("Class Action Waiver"). Notwithstanding any other provision of this Agreement or the AAA Rules, disputes regarding the interpretation, application, enforceability, revocability or validity of the Class Action Waiver, or any dispute relating to whether this Agreement precludes a class or collective action proceeding, may only be determined by the court and not by an arbitrator. If there is a

final judicial determination that all or part of the Class Action Waiver is unenforceable, the class and/or collective action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration. The arbitrator is nevertheless without authority to preside over a class or collective action, and any class or collective action (not otherwise precluded by this Agreement) must be brought in a court of competent jurisdiction—not in arbitration. The Class Action Waiver shall be severable in any case in which the dispute is filed as an individual action and severance is necessary to ensure that the individual action proceeds in arbitration.

3. Effective Date. By signing this Agreement, it becomes effective immediately. However, should you not sign this Agreement, continuing your employment with the Company for a period of 30 days after your first receipt of this Agreement constitutes mutual acceptance of the terms of this Agreement commencing upon completion of that 30-day period, and the Agreement will be binding on you and the Company. You have the right to consult with counsel of your choice concerning this Agreement.

4. Enforcement of This Agreement. This Agreement replaces all prior agreements regarding the arbitration of disputes and is the full and complete agreement relating to the formal resolution of disputes covered by this Agreement. In the event any portion of this Agreement is deemed unenforceable, the remainder of this Agreement will be enforceable.

AGREED:

Physical 4 U, Inc.

RECEIVED AND AGREED:

_____ _____

APPLICANT/EMPLOYEE SIGNATURE DATE

_____

APPLICANT/EMPLOYEE PRINTED NAME

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

A copy of the Exemption from Disqualification decision letter must be attached*

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screening conducted by: Date of Prior Screening: _____

- ☐ Agency for Healthcare Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Elder Affairs
- ☐ Department of Financial Services
- ☐ Department of Children and Families

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

PHYSICAL 4U, INC

INFLUENZA VACCINATION FORM

Name: _____ Title: _____

I have received a copy of Physical 4 U, Inc policy for the administration of influenza vaccine to Agency employees found in the Influenza Vaccination Program, as well as information about the influenza virus and vaccine. I have also had a chance to have my questions answered about influenza vaccination.

I understand the benefits and risks fo the vaccine, and:

☐ I AGREE to have the influenza vaccine administered for this influenza season.

Complete the following ***after*** vaccine has been administered:

Date vaccine was administered: _____

☐ I have ALREADY received the influenza vaccine for this influenza season on _____.
Date

☐ I DECLINE the influenza vaccination for the influenza season. I understand that I may rescind this declination at any time. I decline vaccination for the following reason(s):

- ☐ I do not believe in vaccines for religious or philosophical reasons.
- ☐ I am concerned about side effects and/or safety.
- ☐ I believe the influenza vaccine gives a person the flu.
- ☐ I don't believe the vaccine prevents the flu.
- ☐ It's not important - " I never get the flu"
- ☐ It's inconvenient.
- ☐ I don't like needles .
- ☐ I have an allergy or medical contradiction to receive the vaccine.
- ☐ Other reason - Please specify reason(s) for the declination:

_____

Did you receive the influenza vaccine during last year's influenza season? ☐ Yes ☐ No

Signature: _____ Date: _____

HEPATITIS B FORM

HEPATITIS B is a major infectious occupational health hazard in the healthcare industry. The critical risk for health personnel is contact with blood and other body fluids. Persons previously infected with B virus (HBV) are immune to the disease. For persons who have not had the disease, the Hepatitis B vaccine will provide immunity. The vaccine is given in three separate doses and failure to receive all doses may cause the vaccine to be ineffective and not result in immunity. Clinical studies have shown that 85% to 96% of those vaccinated evidence immunities. Periodic testing of the vaccinated persons for antibodies to the Hepatitis B will confirm immune status.

I understand that, due to my risk of occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have been given information on where I can obtain the vaccine.

[ ] I **decline** the Hepatitis B vaccination at this time because I have completed the three doses of the Hepatitis B vaccine.

[ ] I **decline** the Hepatitis B vaccination at this time. I understanding that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I continue to have occupational exposure to blood or other potentially infectious material, I will want to be vaccinated with the Hepatitis B vaccine, I can receive information on where I can obtain the vaccine.

[ ] I **accept** the Hepatitis B vaccination. I have received information on where I can obtain the vaccine.

Signature of applicant	Witness	Date

Employee Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
EMPLOYEE ACKNOWLEDGMENT OF PROBATION	I UNDERSTAND THAT I AM ON PROBATION AS AN EMPLOYEE FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STARTED ON _____ FOR THE PURPOSE OF THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW". I UNDERSTAND IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE UNDER THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW" HE WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE DETERMINED FOR IN THE FUTURE. I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.	
NOTICE TO APPLICANTS	We comply with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability, to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. If required, all entering employees in the same job category will be subjected to the same medical questionnaire and/or examination and all information will be kept confidential and in separate files. We are an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, or martial status. We assure you that your opportunity for employment with us depends solely upon your qualifications. **PLEASE READ AND SIGN STATEMENTS BELOW** I understand that in accordance with Florida Statute 443.131 (3) (a) (2), if hired, I will be placed on a 90 day probationary period. I further understand that if I am terminated for unsatisfactory work performance within the 90 day probationary period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination. I understand and agree that all policies, procedures, and the Employee Handbook may be modified, amerced, or deleted by my employer with or without notice to me of such amendment, modification or deletion; that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and that my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president. I understand that I may be required to undergo blood and/or urinalysis screening for drug or alcohol use as part of the pre-employment process. In addition, all employees are subject to blood and/or urinalysis screening for drug or alcohol use. I certify that all information given on this employment application, any resume that I submit to the company, and any related papers and answers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such information requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation of any derogatory information discovered as a result of this investigation may-subject-me-to-immediate-dismissal. I hereby release from liability all persons who provide information to my employer during the course of any such investigation.	
TRANSPORTATION RESPONSIBILITY CONTRACT	It has been explained to me that I am being offered employment by This Home Health Agency with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability of $ 10,000.00 / $ 20,000.00 for bodily injury and $ 5,000.00 in property damage. I also agree not to use my vehicle to transport any patient.	

Employee/Contractor Signature: _____ Date: _____

Employee Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
CONFIDENTIALITY STATEMENT	I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF THE MEDICAL RECORDS AND UNDERSTAND THAT THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE, EITHER INSIDE OR OUTSIDE THE AGENCY (EXCEPT AN NEEDED TO CONDUCT THE BUSINESS OF THE DAY). I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE HOME HEALTH AGENCY UNLESS A "RELEASE OF INFORMATION" FORM HAS BEEN COMPLETED AND SIGNED BY THE PATIENT. IT IN MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL. I HAVE BEEN FORMALLY INSTRUCTED IN THE POLICIES AND PROCEDURES OF THIS HOME HEALTH AGENCY, ALSO INFORMED REGARDING THE AGENCY'S POLICY FOR HIPAA COMPLIANCE, AND I HAVE READ AND SIGNED A JOB DESCRIPTION FOR MY SPECIFIC CLASSIFICATION.	
PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY _____ SIGNATURE OF INDIVIDUAL MAKING PLEDGE _____ SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE	I, the undersigned, have read and understand the this Home Health Agency, (hereinafter "this Home Health Agency") policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation. I also acknowledge that I am aware of and understand the Policies of the this Home Health Agency, regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information. In consideration of my employment or association with this Home Health Agency, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with this Home Health Agency, or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside this Home Health Agency, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and this Home Health Agency, policies governing proper release of information. I understand that my obligations outlined above will continue after my employment/contract/association/ appointment with this Home Health Agency, ends. I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with this Home Health Agency, or with any of the entities, which have an association with this Home Health Agency If for any reason I must complete any clinical documentation of any of my patient at later time, or at my residence, I assure that no Protected Health Information will be left unattended in my vehicle. In my residence, it will be placed in a secure location where children or any family member will not have access to it at any time. All family members will be alerted about the Confidentiality status of such records. I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant state and federal legislation, and a report to my professional regulatory body.	
POLICY ON JOBS	As an employee of this home health agency, I understand that the job I am being hired to perform belongs to this Agency. I also understand that it is illegal for me to transfer or attempt to transfer any case to another Agency or take ownership of any job that I am employed in. Should I act underhandedly and take over such a job so that I may be paid directly by the client, to the exclusion of my employer, or transfer any case to another Agency. I will be in violation of State, Federal and agency rules and will accordingly pay $10,000.00 to This Home Health Agency	

Employee/Contractor Signature: _____ Date: _____

Employee Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
NON DISCRIMINATION POLICY	As a recipient of Federal financial assistance, our Agency does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in admission to,participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by our Agency directly or through a contractor or any other entity with which our Agency arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.) In case of question please contact the Agency Section 504 Coordinator.	
ANTI-HARASSMENT POLICY	Our Agency strives to maintain a work environment that is free of discrimination, intimidation, hostility, or other offenses that might interfere with work performance. In keeping with this desire, we will not tolerate any unlawful harassment of employees by anyone, including any supervisor, co-worker, vendor, client, or customer. What Is Harassment? Harassment consists of unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's protected status, such as color, disability, gender, national origin, race, religion, age or other legally protected status. We will not tolerate harassing conduct that affects tangible job benefits, that interferes unreasonably with an individual's work performance, or that creates an intimidating, hostile, or offensive working environment. Harassment can take many forms, including, but not limited to: words, signs, jokes, pranks, intimidation, physical contact, or violence.	
UNIVERSAL PRECAUTIONS	It is the policy of our Agency that home health care providers will adhere to the following, when delivering care to all patients. By adhering to the following universal precautionary measures, the risk of transmission of disease, is decreased when the infection status of the patient is unknown. **Gloves** must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids. Gloves or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes. Gloves are to be worn when handling all specimens to prevent contamination from body specimen fluids or blood. **Mask and protective eyewear** or face shield must be worn during procedures that are likely to generate droplets of body fluids, blood or when the patient is coughing excessively. **Hand washing**: Hands must be washed before gloving and after gloves are removed. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood and after all patient care activities. Home health care providers, who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.	
CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM	I have been formally instructed that my Physical Examination Form, and any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency (except an needed to conduct the business of the day). I understand that no medical/criminal data are to be removed from the home health agency unless a **"Release of Information"** form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Agency to release my Physical/Background Information data to State/Federal surveyors at their request if needed for conduct the annual survey or any necessary investigation. I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.	

Employee/Contractor Signature: _____ Date: _____

Employee Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
INFECTION CONTROL	For your well being, and the well being of your patient, we outline the following procedures to guard against infection. 1. Please wash your hands before and after each procedure. 2. In the event of an exposure to a pathogen please make an immediate report to the Director of Nursing. This office must be notified immediately and the staff involved must report to the nearest hospital emergency room and will return to work only after a physician has cleared him/her of any communicable infection. 3. When working with an AIDS and other high risk infection's patient, remember to avoid any and all contact with the patient's body fluids, especially blood and blood products. Read and be familiar with the attached pamphlet on how to prevent catching the AIDS or any other virus. 4. This agency is not liable for our health care worker who contracts AIDS virus in the course of performing his/her professional duties. For more policies on infection control our agency asks all of its employees to read the accompanying scripts which are summaries from the CDC and the Department of Health and Rehabilitative Services. I hereby acknowledge that I have read and understand the Infection Control Policy contained in the Field Employees Procedure Manual. I am familiar with the procedures appropriate to my position as a field employee.	
USE OF PERSONAL PROTECTIVE EQUIPMENT	I, the undersigned, understand and agree that as a condition of employment I am required to wear/use the following personal protective equipment supplied and/or required by my employer: Company Supplied: _____ _____ Company Required (Supplied by Employee/Contractor): _____ _____ I agree to inform my employer immediately upon the failure of any of the above listed equipment so the same can be promptly repaired or replaced. In the event I sustain an on-the-job injury as a direct result of my failure to wear/use the personal protective equipment listed above, my workers' compensation benefits could be substantially reduced.	
WAIVER OF RIGHTS	I, the undersigned, understand that the hazards of my job; have been fully explained to me by my supervisor: _____ I further acknowledge that my employer has supplied me and/or I have supplied the following Personal Protective Equipment: _____ _____ _____ _____ I understand that it is necessary for me to use this Personal Protective Equipment to fully protect myself from the hazards of my job. I realize that in the event I do not use all of this Personal Protective Equipment and I sustain a personal injury caused by my failure to use/wear said Personal Protective Equipment, I may be denied up to 25% of the indemnity portion of my claim. As provided by this State's Workers' Compensation statutes.	
PERSONNEL POLICIES SAFE AND ADEQUATE CARE OF THE PATIENT (SAFETY OF THE PATIENT'S IMMEDIATE ENVIRONMENT)	This Home Health Agency, hereby sets forth the following guidelines to be adhered to by all employees of this agency: * Upon arrival at a patient's home, the nurse/employee shall make physical checks of the essential safety devices such as proper locks on doors, proper ventilation, proper beds/chairs, proper bedding, adequate bathroom systems, adequate kitchen with all electrical devices, to be sure they are in good working condition. * The employee shall also check the appropriate boxes on our "Patient Safety Checklist" and make the appropriate report to our offices as soon as possible * Upon receipt of such report, the Director of Nursing shall take necessary action to ensure that any safety deficiencies are corrected. I have received, read, (or it has been read to me) and understand the "Company Policy and Safety Rules and Regulations", and agree to abide by them. I further understand that failure to do so could result in disciplinary action or termination.	

Employee/Contractor Signature: _____ Date: _____

Employee Name: _____ Position: _____

ITEM	DESCRIPTION	INITIALS
EMPLOYEE STATEMENT OF COMMITMENT	I have read and understand The Agency, Personnel Policy Manual. In compliance with those policies I agree to conform to the following: -I will always maintain professionalism in the home to which I am assigned. -I will immediately contact The Agency, regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by The Agency -I have read and understand the Agency, job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by The Agency -I will abide with the Agency Standard Code of Dress as described in the Personnel Policy Manual. -I will arrive in time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the Agency, office of the situation and expected arrival time. -I will not accept any money or gifts from The Agency's Clients. I will receive payment for services rendered directly from The Agency -I will notify The Agency, immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand the Agency, office will then contact the client. I also understand that not calling The Agency, office when I am unable to meet my assignment commitment will be grounds for immediate termination. -I will not make or accept personal telephone calls on the client's home. -I will not transport a patient or family member in my personal vehicle. -I will not smoke in a patient's home.	
VOLUNTARY SUBSTANCE TESTING	In order to protect myself and my employer, I _____ voluntarily authorize blood and urine testing for alcohol and/or drug use. I agree to allow such samples and testing to be completed at a time and place to be chosen by my employer. I understand should such samples and testing be requested it is either due to the company's Drug Free Workplace Program, suspicion that I am under the influence of alcohol/drugs which could result in an on-the-job injury, or may affect the quality of my work. I further authorize the results of samples/testing to be released to my employer.	
POLICY ON PATIENT'S PROGRESS NOTES	It is the policy of The Agency that weekly Progress Notes shall be written on each of our patients, preferably each Friday. Such a Progress Note, to be written on our standard "Progress Notes" form, shall be written by a Skilled Nurse/Professional/field staff, who also should supervise the case in review, together with Supervisor RN/Staff if applicable. Completed progress notes, along with other pertinent patient records, shall be submitted to the Director of Nursing (at the office) once every week (Tuesday before 5:00 pm). During that period a note faxed from employee may be use in place of the original, until the regular 1 week delivery time frame, progress note is received in the office. Home health care staff members will ensure complete concise documentation of services, issues and conditions occurring during the period of services rendered to the client. It is our Policy that we allow the use of automatic mechanism to help our staff to complete their Progress Notes report like typing by Typewriter, Word Processor, or Computer Software, in compliance with the following steps: 1- Ensure the compliance of HIPAA regulations and guidelines, including the care of the Patient's Privacy Rights 2- Don't allow any other person access to any Patient Information needed to complete the work, if necessary finish the Notes at the staff's residence. 3- Destroy all Patient Information after completing the Progress Notes 4- Inform immediately to the Agency's Privacy Officer if any breach of HIPAA guidelines for Patient's Privacy Rights is suspected. 5- In the use of Computer Software or any electronic device to help complete the progress note, the staff can not save any Patient Information in the Staff Personal Computer/tablet, is the patient's information is used, the Staff must delete that information, immediately after completing their work.	

Employee/Contractor Signature: _____ Date: _____