GOLDEN OAKS HOSPICE

JOB APPLICATION PACKET

Included are the following:

1. Application Signature Form
2. Application for Employment Form
3. **Reference & Employment Verification – 2 pgs. (*for office use only)***
4. Authorization for Background Investigation
5. Invitation to Self-Identify

Follow the instructions, complete all forms and return to Golden Oaks Hospice, Inc.

GOLDEN OAKS HOSPICE

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE APPLICATION FORM BELOW:

Should a job offer be made, I understand I may be required to take and pass a job-related physical exam and such future examinations as required by **Golden Oaks Hospice, Inc.**

I understand that if I am employed, I will be required to wear or use all protective clothing or devices required and to comply with all safety policies and procedures.

I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I hereby certify that I, the undersigned applicant, have personally completed this application, or have noted the name of the individual assisting me in the completion of this application. I UNDERSTAND THAT ANY OMISSION OR MISSTATEMENT SHALL BE GROUNDDS FOR REJECTION OF THIS APPLICATION, OR FOR IMMEDIATE DISCHARGE IF I AM EMPLOYED, REGARDLESS OF THE TIME ELAPSED BEFORE DISCOVERY.

I hereby authorize **Golden Oaks Hospice, Inc.** to thoroughly investigate my references, work records, education, and other matters related to my suitability for employment. I further authorize my former employer to disclose to Golden Oaks Hospice any and all letters, reports, and other information related to my work records, without giving me prior notice of such disclosures. In addition, I hereby release **Golden Oaks Hospice, Inc.** my former employers, and all other persons, cooperation, partnerships, and associations from any and all claims, demands, or liabilities arising, or that may arise, out of, or in any way related, such investigation or disclosure.

As part of this application, I understand that if I am employed I will be required to comply with all policies and procedures for employees of **Golden Oaks Hospice, Inc.** I understand that these policies and procedures may be changed, interpreted, withdrawn or added to at the discretion of **Golden Oaks Hospice, Inc.** without prior notice to me.

I acknowledge and agree that this application will be considered by Hospice for no longer than 90 days from the date it was made.

I understand that nothing contained in the application or conveyed during any interview which may be granted is intended to create an employment contract between myself and **Golden Oaks Hospice, Inc.** In addition, I understand and agree that if I am employed, my employment is at-will and is for no definite or determinable period and may be terminated at any time, with or without prior notice, and for any reason or no reason, at the option of either myself or **Golden Oaks Hospice, Inc.** and that promises or representations contrary to the foregoing, or given at any time in the future, are not binding on **Golden Oaks Hospice, Inc.** unless made in writing and signed by myself and a designated representative of **Golden Oaks Hospice, Inc.** A designated representative is defined to mean the Vice President in my corporations, regions, or department to whom my Human Resources Department reports.

I understand it is the policy of Golden Oaks Hospice and its subsidiaries to comply with the Drug-Free Workplace Act of 1988.

Print Name: _____

Applicant's Signature: _____

If this application has been completed by an individual other than the above applicant above, please print his/her name here: _____

GOLDEN OAKS HOSPICE

APPLICATION FOR EMPLOYMENT

We are an equal opportunity employer, dedicated to a policy of non-discrimination in employment on any basis including race, color, age, sex, religion, disability or national origin. Consistent with the Americans with Disabilities Act, applicants may request accommodations needed to participate in the application process.

PERSONAL INFORMATION:

Date: _____ Social Security Number: _____

Name: _____
(Last) (First) (Middle)

Present Address: _____
(Street) (City) (State) (Zip)

Phone(s): _____ _____
(Day) (Evening)

Referred By: _____

EMPLOYMENT DESIRED:

Position: _____ Date You Can Start: _____ Desired Salary: _____

Are you employed now? _____ Yes _____ No If so, may we contact your present employer? _____ Yes _____ No

Ever applied to this company before? _____ Yes _____ No When: _____

EDUCATION:

	Name & Location of School	# Yrs Completed	Mo/Yr Last Attended	Major & Degree(s) Received
High School				
College				
College				
Grad School				

FORMER EMPLOYERS: List below your last four employers, starting with the most recent one first. PLEASE FILL THIS SECTION OUT EVEN IF YOU HAVE ATTACHED A RESUME TO THIS APPLICATION.

Date (Month/Year)	Name & Address of Employer Phone Number	Salary (Upon Leaving)	Position	Reason for Leaving
From				
To				
From				
To				
From				
To				
From				
To				

GOLDEN OAKS HOSPICE

REFERENCES: List below three persons not related to you, whom you have known for at least one year.

Name	Phone Number	Relationship	Years Acquainted
1.			
2.			
3.			

AUTHORIZATION:

I certify that the facts contained in this application (and accompanying resume, if any) are true and complete. I understand that any false statement, omission, or misrepresentation on this application is sufficient cause for refusal to hire, or dismissal if I have been hired, no matter when discovered by **Golden Oaks Hospice, Inc.**

I understand that any employment is conditioned on a background check and my ability and willingness to attest to my identity and employment eligibility and the presentation of any documents deemed necessary by the company to verify my identity and employment eligibility.

I authorize the Company to thoroughly investigate all statements contained in my application on resume, and I authorize my former employers and references to disclose information regarding y former employment, character and general reputation to **Golden Oaks Hospice, Inc.**, without giving me prior notice of such disclosure. In addition, I release **Golden Oaks Hospice, Inc.**, any former employers and all references listed above or other references provided from any and all claims, demands or liabilities arising out of or related to such investigation or disclosure.

I understand and agree that nothing contained in this application, or conveyed during any interview, is intended to create an employment contract. I further understand and agree that if I am hired, my employment will be “at will” and without a fixed term, and may be terminated at any time, with or without cause and without prior notice, at the option of either myself or **Golden Oaks Hospice, Inc.** No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon Golden Oaks Hospice, Inc unless made in writing.

_____ _____

(Signature) (Date)

GOLDEN OAKS HOSPICE

REFERENCE & EMPLOYMENT VERIFICATION

Candidate Name: _____

Name & Title of Person Giving Reference: _____

Company Name: _____ Dates Employed: _____

1. Position: _____ ___ Full-Time ___ Part-Time ___ PRN Pay Rate: _____
2. Job Responsibilities/Overview:

   _____

   _____

   _____
3. What is your relationship to and how long have you known the candidate?

   _____

   _____
4. Describe the candidate's attitude, strengths and weaknesses.

   _____

   _____

   _____
5. What is his/her level of productivity?

   _____

   _____

   _____
6. Reason for leaving employment?

   _____

   _____
7. Would you rehire? ___ Yes ___ No If no, please explain.

   _____

   _____
8. Do you recommend this candidate?

   _____

   _____

Signature: _____ Date: _____

GOLDEN OAKS HOSPICE

REFERENCE & EMPLOYMENT VERIFICATION

Candidate Name: _____

Name & Title of Person Giving Reference: _____

Company Name: _____ Dates Employed: _____

1. Position: _____ ___ Full-Time ___ Part-Time ___ PRN Pay Rate: _____
2. Job Responsibilities/Overview:

   _____

   _____

   _____
3. What is your relationship to and how long have you known the candidate?

   _____

   _____
4. Describe the candidate's attitude, strengths and weaknesses.

   _____

   _____

   _____
5. What is his/her level of productivity?

   _____

   _____

   _____
6. Reason for leaving employment?

   _____

   _____
7. Would you rehire? ___ Yes ___ No If no, please explain.

   _____

   _____
8. Do you recommend this candidate?

   _____

   _____

Signature: _____ Date: _____

GOLDEN OAKS HOSPICE

AUTHORIZATION FOR BACKGROUND INVESTIGATION

I, _____, hereby authorize **Golden Oaks Hospice, Inc.** and/or its agents to make an independent investigation of my background, which may include my character, general reputation, personal characteristics, and mode of living in connection with an application of employment with hospice care.

I authorize and request any present or former employer, school, police department, court records, including those maintained by either public and private organizations, financial institution or other persons having personal knowledge about me to furnish **Golden Oaks Hospice, Inc.** with any and all information in their possession regarding me for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualifications for employment. I am willing that a photocopy of this authorization may be accepted with the same authority as the original, and I specifically waive any written notice from any present or former employer who may provide information based upon this authorization request.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge:

Print Full Name: _____

Print Maiden Name or Other Names Used: _____

Present Address: _____

_____

Date of Birth (for ID purposes only): _____

Social Security Number: _____

Driver's License Number: _____

Golden Oaks Hospice will need to contact you if additional information is needed to process your Background Investigation. Please provide a telephone/cell phone number where we may contact you.

Phone: _____ Cellular: _____

Notice:

Under California Civil Code section 1786.2, a copy of my final report can be requested from the employer upon completion, if this background check is taking place in California. I can request a copy of my background information.

Signature: _____ Date: _____

GOLDEN OAKS HOSPICE

INVITATION TO SELF-IDENTIFY

NOTICE TO EMPLOYEES AND APPLICANTS:

Golden Oaks Hospice, Inc. wishes to comply with the Rehabilitation Act of 1973, as amended, and is giving you the opportunity to identify yourself as a person with a disability under this act. The act prohibits discrimination against persons with a disability in application procedures, hiring, advancement, discharge, compensation, job training, and other terms, conditions, and privileges of employment.

An individual with a disability is one who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment; or is regarded as having such impairment. A physical or mental impairment includes any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special-sense organs; cardiovascular; reproductive; digestive; genitor-urinary; hemic and lymphatic; skin; and endocrine or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disorders. Also included, but not limited, as impairments are: orthopedic problems; visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; heart disease; diabetes; past drug addiction; alcoholism; and AIDS.

In this regard, if you believe you may be covered by this law and wish to be treated accordingly, please identify yourself in confidence by filling out this form. Provision of this information is strictly VOLUNTARY, and refusal to provide it will not subject you to any adverse treatment. The information provided will be kept confidential and will only be used in accordance with federal regulations.

Name: _____ Date: _____

Position Applied For: _____

Is any accommodation necessary for you to proceed through any part of the application/work process: __ Yes __ No

If so, what accommodation do you request? _____

_____

_____
Hospice Representative

GOLDEN OAKS HOSPICE

NEW HIRE PACKET

Included are the following:

1. Consent of Application Information
2. Submission and Reporting of Clinical Notes
3. Disclaimer and Waiver of Liability
4. Job Availability
5. Non-Compete Agreement
6. At Will Employment Statement
7. Automobile Memorandum of Understanding
8. HIPAA Employee Confidentiality Agreement
9. Password Security Statement
10. Harassment Policy Acknowledgement
11. Professional Code of Conduct
12. Elder Abuse Statute Notification
13. Child Abuse Statute Notification
14. Patient's Rights and Responsibilities Receipt (***Please keep pages 28 & 29 in this application***)
15. Universal Precautions
16. Disposal of Biohazard Waste
17. Disposal of Sharp Materials
18. Hepatitis B Vaccine Form
19. Emergency Notification Form
20. Latex Sensitivity Questionnaire
21. Employment Physical Form (if applicable)
22. TB Symptom Survey/Questionnaire (if applicable)
23. Job Description
24. Employment Eligibility Verification (I-9)
25. W4 Form

Follow the instructions, complete all forms and return to Golden Oaks Hospice, Inc as soon as possible.

Please supply current copies of the following documents:

- Driver's License
- Auto Insurance
- Social Security Card
- Professional Licenses
- Current Physical Examination
- Current PPD Results/X-ray (if applicable)
- Professional Liability Insurance
- Training Award Certificates (where applicable)

GOLDEN OAKS HOSPICE

EMPLOYEE INFORMATION

NAME OF EMPLOYEE: _____

MOBILE PHONE: _____ OTHER PHONE: _____

PHYSICAL ADDRESS: _____

_____

_____

EMAIL ADDRESS: _____

CITIES/AREAS WHERE YOU CAN WORK:_____

_____

LANGUAGES SPOKEN: _____

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

CONSENT OF APPLICATION INFORMATION

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

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

GOLDEN OAKS HOSPICE

SUBMISSION AND REPORTING OF CLINICAL NOTES*

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

1. New Assessment & Resumption of Care: 48 hours after the initial visit
2. Clinical Notes and Route Sheets: **No later than Friday of following work week from day care is provided to patient**
3. Recertification: 48 hours after assessment
4. Discharge: 48 hours after discharge
5. Report all findings to Case Manager within 24 hours of assessment/visit

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

Email and Faxes are not permitted unless with the authorization of management

Initial Here: _____

DISCLAIMER AND WAIVER OF LIABILITY

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

I have read and understand this statement and still adhere to the Federal and State rules and regulations and Policies and Procedures of **Golden Oaks Hospice, Inc.**

Initial Here: _____

JOB AVAILABILITY

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

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

Initial Here: _____

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

I acknowledge that all initials are as binding as a signature and that each signature on each page pertains to all sections on that page. I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am no longer employed with **Golden Oaks Hospice, Inc.** I also understand that I may revoke this consent in writing at any time. I certify that the signature below applies to ALL pages of this application.

GOLDEN OAKS HOSPICE

NON-COMPETE AGREEMENT

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

Employees of **Golden Oaks Hospice, Inc.** also agree not to encourage a patient to transfer to a different agency that has previously been, or is, assigned to **Golden Oaks Hospice, Inc.**

Initial Here: _____

AT WILL EMPLOYMENT STATEMENT

I understand and agree that my employment with **Golden Oaks Hospice, Inc.** is on an "at will" basis, and can be terminated by either Hospice or myself at any time and for any reason, with or without cause. I further understand and agree that promises or representations contrary to the foregoing, or given at any time in the future, are not binding on Golden Oaks Hospice unless made in writing and signed by myself and a designated representative of Golden Oaks Hospice. A designated representative is defined to mean the Vice President in my corporations, regions, or department to whom my Human Resources Department reports.

Initial Here: _____

AUTOMOBILE MEMORANDUM OF UNDERSTANDING

This document will represent confirmation of my understanding that transportation of patients or the families of patients of **Golden Oaks Hospice, Inc** is not covered under the liability insurance of **Golden Oaks Hospice, Inc** and is not a covered or accepted service of **Golden Oaks Hospice, Inc**.

I further understand that the third party liability coverage offered by **Golden Oaks Hospice, Inc** will be accessed only after my own automobile/motorcycle liability coverage is exhausted, and will only be available if I am involved in an accident during the normal course of **Golden Oaks Hospice, Inc** business. I also understand that the liability coverage offered by **Golden Oaks Hospice, Inc** covers suits brought against **Golden Oaks Hospice, Inc** not suits brought against me as an individual.

A copy of my automobile/motorcycle insurance card or declaration page is enclosed. I will immediately notify **Golden Oaks Hospice, Inc** of any change in my automobile/motorcycle insurance coverage.

Initial Here: _____

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

I acknowledge that all initials are as binding as a signature and that each signature on each page pertains to all sections on that page. I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am no longer employed with **Golden Oaks Hospice, Inc.** I also understand that I may revoke this consent in writing at any time. I certify that the signature below applies to ALL pages of this application.

GOLDEN OAKS HOSPICE

HIPAA

The Health Insurance Portability and Accountability Act of 1996

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Centers for Medicare and Medicaid Services (CMS) is responsible for implementing various unrelated provision of HIPAA, therefore HIPAA may mean different things to different people.

National standards have been established for electronic health care transactions and national identifiers for providers and health plans. Adopting these standards will improve the efficiency and effectiveness of the national health care system by encouraging the widespread use of electronic data interchange in health care. The Act mandates privacy of patient's medical records and prevents use of medical records by marketers.

Golden Oaks Hospice, Inc. has implemented policies and procedures for the protection of our patients' privacy. Within the office setting, it is mandatory that patients' names, medical conditions or other private information be guarded. Information may not be given to anyone by phone or in writing unless specifically authorized by the patient. There are significant monetary fines for violation of this act. Enforcement officials will make unannounced visits to audit compliance.

Initial Here: _____

Password Security Statement

I, _____, guarantee when I have chosen my password(s) for entry into the **Golden Oaks Hospice, Inc** computer system, I will keep all passwords confidential and not give it/them to any other person or entity. I accept full responsibility of my own password(s).

In addition, I will comply with all guidelines in my HIPPA training regarding patient information on the system and confidentiality.

Initial Here: _____

HARASSMENT POLICY ACKNOWLEDGEMENT

I have read and understood Golden Oaks hospice, Inc. Harassment Policy, which states that harassment of any kind, will not be tolerated in the workplace. I also understand the method of reporting harassment with the company as well as outside the company. I agree to abide by the policy at all times and realize that if I do not, appropriate correction will be taken.

Initial Here: _____

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

I acknowledge that all initials are as binding as a signature and that each signature on each page pertains to all sections on that page. I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am no longer employed with **Golden Oaks Hospice, Inc.** I also understand that I may revoke this consent in writing at any time. I certify that the signature below applies to ALL pages of this application.

GOLDEN OAKS HOSPICE

PROFESSIONAL CODE OF CONUCT

As a healthcare professional and representative of ***Golden Oaks Hospice, Inc.*** *you are to observe the following code of conduct:*

1. You are not to drive in the client's car and they are not to drive or ride in your car. You may, however, accompany the client by cab.
2. No consumption of the client's food or drink.
3. No use of the client's telephone. **For any reason**.
4. No discussion of your personal problems, religious or political beliefs with the client or the client's family.
5. No acceptance of gifts or tips.
6. No friends or relatives brought to the client's home.
7. No consumption of alcoholic beverages or use of medicine or drugs for any purpose other than medical in the client's home or prior to service of delivery.
8. No smoking in the client's home (other than in designated areas).
9. No solicitation or acceptance of money or goods from the client.
10. You may eat the food you bring for meals in the client's home.
11. You may use the client's bathroom facilities.
12. No breach of the client's privacy/confidentiality of records.
13. You will not take an assignment that you know you will not be able to meet with the client at the designated time.
14. You are expected to call at least four (4) hours prior to duty if you are unable to go to an assignment for any reason. In addition, you are also requested to call anytime you are going to be late to an assignment.
15. You will inform the coordinator with any change of hours.
16. **Under NO Circumstances** are you to change any part of the Services provided to the Client. The client or a family member must call in to the office.

NOTE: ANY BREACH OF THESE RULES OF CONDUCT WILL BE GROUNDS FOR, AND MAY RESULT IN IMMEDICATE TERMINATION.

I have read and agree to abide by the foregoing code of conduct.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

GOLDEN OAKS HOSPICE

ELDER ABUSE STATUTE NOTIFICATION

In accordance with State Law, effective January 1, 1995, Section 15659 of the Welfare and Institutions Code of the State of California requires employers of health practitioners and other entities as specified, to inform employees at the time of hire, that they are a mandated reporters of abuse and of their reporting obligations.

In summary, Section 15630 of the Welfare and Institutions Code requires any dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who in his or her professional capacity or within the scope of his or her employment, either has actual knowledge that a dependent adult has been the victim of physical abuse, or observes a physical injury to a dependent adult under circumstances that are consistent with physical abuse, where the dependent adult's statement, or in the case of persons who have developmental disabilities, their statements or other corroborating evidence, indicate that abuse has occurred, shall report the known or suspected instance of physical abuse to the county adult protective services agency, or a local law enforcement agency immediately or as soon as possible by telephone, and shall prepare and send a written report thereof within two working days. The reporting duties under this section are individual, and no supervisor or administrator may impede or inhibit the reporting duties and no person making such a report shall be subject to any sanction for making the report.

I certify that I have read and understand the above statement of the California Welfare & Institutions Code, Section 15630 and that I will comply with its' provisions.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

GOLDEN OAKS HOSPICE

CHILD ABUSE STATUTE NOTIFICATION

Effective January 1, 1985, Section 11166.5 was added to the California Penal Code and creates a requirement to employment practices of hospitals and other entities as specified. As a result of this requirement, at the time of hire and/or as a condition of continued employment, you are required to sign the form below.

Per the California Penal Code, Section 11166, any child care custodian, medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse is required to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

I certify that I have read and understand the above statement of the California Penal Code, Sections 11165.7 and 11166.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

GOLDEN OAKS HOSPICE

Patient's Rights and Responsibilities

I have received a copy of the Patient's Rights and Responsibilities policy. I understand this was developed to encourage awareness of patient rights and responsibilities, to provide guidelines to assist patients making decisions regarding care, and to support active participation in care planning.

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights and responsibilities as described. A patient may designate someone to act as their representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

To assist with fully understanding patient rights and responsibilities, all policies are available to organization personnel, the patient, and his/her representatives as well as other organizations and the interested public.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

GOLDEN OAKS HOSPICE

UNIVERSAL PRECAUTIONS

To Be Used In the Care of All Patients

GLOVES: For touching any patient's blood or body fluids
For handling any soiled items
For performing venipuncture
Change after contact

GOWNS: Worn during any procedure likely to generate splashing of blood or body fluids

MASKS & PROTECTIVE EYE WEAR
Worn during any procedure likely to generate droplets of blood or body fluids

HANDS Wash immediately if contaminated with blood or body fluids
Wash immediately after gloves are removed

To prevent needle-stick injuries, needles should **NOT** be recapped, purposely bent, broken or removed from disposable syringes or otherwise manipulated by hand.

Disposable syringes and needles, scalpel blades and other sharp items should be placed into puncture-resistant containers located as close as practical to the areas in which they were used.

To minimize the need for emergency mouth-to-mouth resuscitation, mouth-pieces, resuscitation bags and other ventilation devices should be available for use in areas where the need for resuscitation is predictable.

I HAVE READ AND UNDERSTAND ALL PRECAUTIONS

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

DISPOSAL OF BIOHAZARD WASTE

I understand that all materials, including IV tubing and needles, contaminated by bio hazardous substances, including cytotoxic agents, shall be disposed of in a safe and legal manner. The patient and his/her family shall be taught safe disposal practices.

I also understand that all biohazardous waste from medication administration equipment shall be double bagged and tagged in waterproof, disposal material and then transported by the contracted infusion therapy pharmacy employees or contracted agents/service to a contracted legal disposal site.

Soiled incontinent articles and wound dressings shall also be double bagged and tagged in waterproof, disposable material and may be disposed of by the patient/family in their household trash.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

DISPOSAL OF SHARP MATERIALS

I understand that hospice clinical staff shall use needleless system or self-capping needles at all times unless the specific device is not manufactured or available for purchase.

Used sharps shall be disposed of in such a manner as to prevent reuse and/or injury. Sharps contaminated with bio-hazardous material shall be contained in a manner to prevent injury and then placed with other bio-hazardous materials for disposal according to Golden Oaks Hospice Inc's. policy.

I understand that this is to prevent the dispersal of potentially injurious materials and to protect public health and safety.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

GOLDEN OAKS HOSPICE

HEPATITIS B VACCINE

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 (HEV) infection. I understand **Golden Oaks Hospice, Inc** will provide the Hepatitis B vaccine at no charge to me. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B, a serious disease, if I am exposed to blood.

❑ **DECLINATION**

I choose to decline the Hepatitis B vaccination at this time. 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.

❑ **ACCEPTANCE**

❑ I choose to be vaccinated for Hepatitis B.

❑ I have already completed the series of the Hepatitis B vaccination.

Year(s) vaccine administered: _____

Initial Here: _____

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date

GOLDEN OAKS HOSPICE

EMERGENCY NOTIFICATION FORM

Employee's Name: _____

(Please Print)

Effective Date: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

Name (Please Print)	Relationship
Street Address	Home Phone
City State Zip	Work/cell/pager

ALTERNATE PERSON TO NOTIFY (OPTIONAL):

Name (Please Print)	Relationship
Street Address	Home Phone
City State Zip	Work/cell/pager

GOLDEN OAKS HOSPICE

LATEX SENSITIVITY QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY

Have you ever experienced or do you currently experience these local (the area that comes into contact with) symptoms with the use of latex gloves, latex balloons, or adhesives?

- ☐ No
- ☐ Yes

If yes, indicate any/all of the following:

- ☐ Swelling
- ☐ Itching
- ☐ Skin redness

Have you ever experienced or do you currently experience these symptoms while using latex gloves, latex balloons, or adhesives?

- ☐ No
- ☐ Yes

If yes, indicate any/all of the following:

- ☐ Swelling
- ☐ Itching
- ☐ Skin redness

Have you ever experienced an unexplained respiratory emergency while undergoing a surgical or medical procedure?

- ☐ No
- ☐ Yes

Are you allergic to bananas, kiwis, avocados, or chestnuts?

- ☐ No
- ☐ Yes

Do you have multiple allergies to foods and/or other plant or animal products?

- ☐ No
- ☐ Yes

Employee's Name: _____

(Please Print)

GOLDEN OAKS HOSPICE

EMPLOYMENT PHYSICAL

*To be used if applicant does not have a current physical exam. Must be completed by physician

Name (Last, First, Initial)	Home Phone:	Other Phone:	
Address:		DOB:	Sex:
Emergency Contact (Last Name, First Name)	Relationship:	Phone:	

Please complete the following PRIOR to your physical:

	Yes	No	Unknown		Yes	No	Unknown
Eye or Ear Infections				Deformities of Bones			
Sinus Trouble				Ruptured Disc in Back			
Frequent Colds				Eczema / Dermatitis			
Asthma				Head Injury			
Pneumonia				Muscle Pain			
Chronic Cough				Arthritis			
Tuberculosis				Change in Activity Level			
Shortness of Breath				Diabetes / Thyroid			
Chest Pains / Cardiac Disease				Allergies			
Low / High Blood Pressure				Recent Weight Loss			
Heartburn				Recent Weight Gain			
Frequent Diarrhea				Depression			
Abdominal Pains				Anxiety or Panic Attacks			
Frequent Headaches / Dizziness				Back Sprains or Surgery			
Deformities of Joints				Swelling of Ankles			

Do you SMOKE? _____ Yes _____ No Do you drink ALCOHOL? _____ Yes _____ No

Do you have hypertension, heart disease, diabetes, or any chronic illness? _____ No _____ Yes, Length of time: _____

Are you taking prescribed or over the counter medications? _____ Yes _____ No
If yes, please list: _____

VACCINATION HISTORY:
Last known TB Skin test? _____ Results: Negative / Positive

If positive, was a Chest X-Ray done? _____ Yes _____ No If yes, results of Chest X-Ray

Last Tetanus Shot? _____

Hepatitis B Vaccination: _____ Yes _____ No If yes, when? _____

Normal	System	Abnormal with comments:
	Head	
	Eyes	
	Ears	
	Nose	
	Mouth	
	Neck	
	Chest	
	Heart	
	Lungs	
	Abdomen	
	Extremities	
	Spine	
	Neuro	
	Skin	

Examining Provider:	Signature:	Date:

GOLDEN OAKS HOSPICE

TB SYMPTOM SURVEY/QUESTIONNAIRE

Employee's Name: _____ Date: _____

HAVE YOU EVER…	Yes	No	
HAD a positive TB skin test?	□	□	
HAD a chest x-ray to rule out active disease?	□	□	If yes, date _____
BEEN exposed to pulmonary TB in the last 1-2 years?	□	□	
HAD treatment for tuberculosis:	□	□	

Type of treatment: _____

INDICATE WHATEVER YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS:

	Yes	No
Frequent cough for no obvious reason?	□	□
Change in cough or coughing up blood?	□	□
Unusual fatigue or tiredness for no obvious reason?	□	□
Fever or Night sweats	□	□
Loss of appetite or weight loss?	□	□

Explain any unanswered yes: _____

I acknowledge my answers are true and correct to the best of my knowledge. Although I may not necessarily have TB disease or be contagious, I take full responsibly to immediately report to my manager any of the early signs and symptoms of TB listed above should they appear. Any "yes" response above may need to be evaluated further by an RN or other healthcare provider. If a previous PPD skin test has been positive, Golden Oaks Hospice will not administer further skin tests, and a chest x-ray may need to be taken. If responses are "no" to all above question, PPD skin test for TB will be administered.

Signature: _____ Date: _____

Reviewed by: _____RN/MD_____Date: _____

INTRADERMAL TB TEST Must be read 2 to 3 days after administration of skin test

Lot Number: _____ Expire Date: _____ PPD Intradermal Site: _____

Placed by: _____RN/MD Read by: _____RN/MD

Date: _____ Date: _____

Time: _____ Time: _____

Results: _____mm induration Circle one: Negative/Positive (5mm or greater)

If Positive, Site must be re-read within 24 hours

_____ mm induration Negative/Positive _____MD

(If PPD skin test is "positive: please send employee to Human Resources for referral for Chest X-Ray)

GOLDEN OAKS HOSPICE

EMPLOYEE'S COPY OF
PATIENT'S RIGHTS/RESPONSIBILITIES

Policy:

It is the policy of GOLDEN OAKS HOSPICE to address and respect patient rights at all times when providing care and services. Patients will be informed of their rights and responsibilities in a language and a manner that they understand.

Procedure:

1) At the time of admission, the hospice professional conducting the admission will present a copy of the patient's "Notice of Rights and Responsibilities" to the patient/surrogate decision maker/ family. The written notice will be reviewed with the patient /family.
2) At the time of admission, the hospice professional conducting the admission will present a copy of the patient's "Notice of Rights and Responsibilities" to the patient/surrogate decision maker/ family. This notice will be reviewed with the patient /family
3) Specific consent for recording, photographing, or filming care, treatment, or services will be obtained as needed, including the right to rescind consent before the recording, film or image is used. The agency will inform the patient of his/her right to request cessation of production of the recording, films or other images. The purpose will be included in writing.
4) The patient/family will be provided with a written copy of the "Notice of Rights and Responsibilities" and signature of the patient's or representative will be obtained to confirm receipt of the notice.
5) The "Patient's Rights and Responsibilities" is as follows:

A PATIENT HAS THE <u>RIGHT</u> TO:

1) To be fully informed of these rights and of all rules and regulations governing patient conduct;
2) To be fully informed, prior to or at the time of admission, of services available in the hospice and of related charges, including any charges for services not covered under Titles XVIII or XIX of the Social Security Act;
3) To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his or her medical treatment, including pain and symptom management, and to refuse to participate in experimental research;
4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal;
5) To be advised of hospices services to be rendered and by what discipline, e.g., licensed nurse, social worker,, counselor, certified aides, and volunteers;
6) To be advised in advance of any change in treatment.
7) To be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third party payment contract.
8) To be treated with consideration, respect, and full recognition of dignity and responsibility, including privacy and in care of personal needs.
9) To not be subjected to verbal, or physical abuse of any kind and to be informed that corporal punishment is prohibited
10) To be informed by GOLDEN OAKS HOSPICE of the provision of the law regarding complaints and procedures for registering complaints confidentially, including, but not limited to, the address and telephone number of the local Department of Public Health.

11) To be informed of the provision of law pertaining to advanced directives, including but not limited to living wills, durable power of attorney for health care, withdrawal or withholding of treatment and/or life support;
12) To be assured the personnel of GOLDEN OAKS HOSPICE are qualified through education and experience to carry out the services for which they responsible.
13) To exercise his/her rights as patient of GOLDEN OAKS HOSPICE.
14) To voice grievances regarding treatment or care that is (fails to be) furnish and the lack of respect for property by anyone who is furnishing services on behalf of GOLDEN OAKS HOSPICE;
15) GOLDEN OAKS HOSPICE will investigate all grievance filed by patient/family or caregiver and document receipt and out outcome of investigation.
16) To not be subjected to discrimination or reprisal for exercising his or her rights.

In addition to the published rights described above, patients have a right to appropriate assessment and management of pain, the right to have their communication needs met as well as rights to confidentiality, privacy and security.

A patient rights set forth in this section may be denied for good cause only by the attending physician and /or hospice medical director and/or hospice physician designee and documented in the patient's clinical record.

A PATIENT HAS THE <u>RESPONSIBILITY</u> TO:

1) Remain under a doctor's care while receiving agency services.
2) Inform GOLDEN OAKS HOSPICE of any advance directives or any changes in advance directives and provide GOLDEN OAKS HOSPICE with a copy;
3) Cooperate with the attending physician, hospice physician , hospice staff and other care-givers;
4) Advice GOLDEN OAKS HOSPICE of any problems or dissatisfaction with patient care;
5) Notify GOLDEN OAKS HOSPICE of address or telephone number changes or when unable to keep appointments;
6) Provide a safe home environment in which care can be given. Conduct such that the patient's or staff welfare or safety is threatened service may be terminated;
7) Obtain medications, supplies, and equipment ordered by the physician if they cannot be obtained or supplied by GOLDEN OAKS HOSPICE;
8) Treat personnel of GOLDEN OAKS HOSPICE with respect and consideration;
9) Sign the required consents and releases for insurance billing and provide insurance and financial information as requested;
10) Accepts consequences for any refusal of treatment or choice of non-compliance.