Application for Employment

PRINT IN BLACK INK OR TYPE. These instructions must be followed exactly. Fill out application form completely. If questions are not applicable, enter "NA." Do not leave questions blank. Be sure to sign when completed. This company is an Equal Opportunity Employer and does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.

Name: _____ Phone: _____

Address: _____ Alt. Phone: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Position Desired: _____ Date available? _____

□ Full-Time □ Part-Time □ PRN/Per Diem Are you willing to work hours other than 8-5? □ Yes □ No

What days are you unable to work? _____

Are you willing to travel? □ Yes □ No If yes, what percent of time? _____

Have you ever been convicted of a felony or subjected to deferred adjudication on a felony charge? □ Yes □ No If your answer is "Yes," explain in concise detail on a separate page, giving dates and nature of the offense, name and location of the court, and disposition of the case(s). A conviction may not disqualify you, but a false statement will.

EDUCATION: (NOTE: Applicants may be required to provide proof of diploma, degree, transcripts, licenses, certifications, and registrations.)
High School Graduate or GED? □ Yes □ No
If yes, name/ location of high school or GED institute: _____

Type of School	Name and Location	Dates Attended	Date Graduated	Degree Type
Undergraduate College or University				
Graduate School				
Technical or Vocational School				

Application for Employment

AN EQUAL OPPORTUNITY EMPLOYER

LICENSE/CERTIFICATION

If a license, certificate, or other authorization is required or related to the position for which you are applying, complete the following:

License/Certification	Date Issues	Date Expires	Issued by:	License #:

SKILLS:

Special Training/Skills/Qualifications: List all job related training or skills you possess and machines or office equipment you can use, such as calculators, printing or graphics equipment, computer equipment, types of software and hardware. (Attach additional page, if necessary.)

_____
_____
_____
_____
_____

Do you speak a language other than English? □ Yes □ No
If yes, what language(s) do you speak? _____
Do you use sign language? □ Yes □ No
Have you ever been employed by this company? □ Yes □ No
Do you have any relatives employed by this company? Name and relationship: _____

MILITARY SERVICE (A copy of a report of separation from the Armed Services may be required.)
Are you a veteran? □ Yes □ No If yes, list type of discharge: _____
Dates of Service (From/To): _____

REFERENCES

Name three persons (not related) who have knowledge of your professional qualifications and whom we have permission to contact. Preferably persons under whom you have worked.

Name	Title/Occupation	Where Employed	Contact

Application for Employment

AN EQUAL OPPORTUNITY EMPLOYER

EMPLOYMENT HISTORY

List All Employment Since Graduation (Present Or Most Recent Position First)

Employer: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Start Date: _____ Starting Pay: _____ End Date: _____ Ending Pay: _____
Position: _____ Supervisor Name: _____
Duties:
_____
_____
_____
_____
_____
Reason for Leaving: _____

Employer: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Start Date: _____ Starting Pay: _____ End Date: _____ Ending Pay: _____
Position: _____ Supervisor Name: _____
Duties:
_____
_____
_____
_____
Reason for Leaving: _____

Employer: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Start Date: _____ Starting Pay: _____ End Date: _____ Ending Pay: _____
Position: _____ Supervisor Name: _____
Duties:
_____
_____
_____
_____
_____
Reason for Leaving: _____

I certify that the information given on this application and in any other supporting documentation, resume, etc. is true and correct. I understand that any false information, willful or negligent misrepresentation; or failure to disclose any requested information will constitute sufficient grounds the employer to terminate my employment without notice. I authorize my previous employers, schools or persons named as reference to give any information regarding my employment together with information they may have regarding me, whether or not it is on their records. I agree that the named company and my previous employers shall not be held liable in any respect if an employment offer is not tendered, is withdrawn or my employment is terminated because of falsity of statements, answers or omissions made by me in this questionnaire. I hereby release said employers, schools or persons from all liability for any damages whatsoever for issuing this information.

Signature: _____ Date: _____

Reference Request

Name: _____ Date: _____

I authorize my previous employer to release any and all information relating to my employment with them to the above company. I further release and hold harmless both parties from any and all liability that may potentially result from the release and/or use of such information. I understand that any information released by my prior employer will be held in strictest confidence, that it will be viewed only by those involved in the hiring decision, and that neither I nor anyone else not so involved will have the right to see the information.

Employee Signature: _____ Date: _____

Previous Employer:

Company Name: _____

Company Contact Name: _____

Company Contact Number: _____

Internal Use Only:

Dates of Employment: _____

Position Held: _____

Other Information Requested/Received:

_____

_____

_____

Witness Signature: _____ Date: _____

Reference Request

Name: _____ Date: _____

I authorize my previous employer to release any and all information relating to my employment with them to the above company. I further release and hold harmless both parties from any and all liability that may potentially result from the release and/or use of such information. I understand that any information released by my prior employer will be held in strictest confidence, that it will be viewed only by those involved in the hiring decision, and that neither I nor anyone else not so involved will have the right to see the information.

Employee Signature: _____ Date: _____

Previous Employer:

Company Name: _____

Company Contact Name: _____

Company Contact Number: _____

Internal Use Only:

Dates of Employment: _____

Position Held: _____

Other Information Requested/Received:

_____

_____

_____

Witness Signature: _____ Date: _____

Authorization For Background Check

Name:_____Date: _____

Please read and sign this form in the space provided below. Your written authorization is necessary for completion of the application process.
I authorize an investigation into my background and qualifications for purposes of evaluating whether I am qualified for the position for which I am applying. I understand they will utilize an outside firm to assist it in checking such information, and I specifically authorize such an investigation by information services and outside entities of the company's choice. I also understand that I may withhold my permission and that in such a case, no investigation will be done, and my application for employment will not be processed further.

- I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past.
- I acknowledge I have been informed and agree to the following checks:
  - A State of Texas criminal history check and
  - Search of the Nurse Aide Registry (NAR) and
  - Search of the Employee Misconduct Registry (EMR)
- I understand that my employment is pending the results of these checks and that I may not have patient contact until all results are concluded.
- I understand that I am not employable if I am listed in the Employee Misconduct Registry or if I have a criminal conviction or offense that bars me from employment with this Agency.
- I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may bar my employment as determined by the hospice.
- I understand that all information obtained by this agency regarding any criminal history will remain confidential.
- I have been informed that agency will also conduct a search of the Nurse Aide Registry (NAR) and the Employee Misconduct Registry (EMR) on an annual basis.

Employee Signature:_____Date: _____

FOR AGENCY USE ONLY:

- ☐ EMR/ NAR checked by using DADS' Employability Status Search website at: https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp
  - ☐ Applicant/employee/Unlicensed Contractor is employable.
  - ☐ Applicant/employee/Unlicensed Contractor is not employable.
- ☐ Criminal History Check completed
  - ☐ Applicant / employee has no offense(s) and is employable.
  - ☐ Applicant/employee has offense(s) which bar employment and is not employable.
  - ☐ Applicant/employee has offense(s) which does not bar employment; offense(s) reviewed and determined to contradict employment and is not employable.
  - ☐ Applicant/employee has offense(s) which does not bar employment; Offense(s) reviewed and determined not to be a contradiction to employment and is employable.

Verified By:_____Date: _____

Health and Safety Code
Title 4 Health Facilities
Subtitle B Licensing of Health Facilities
Chapter 250 Nurse Aide Registry And Criminal History Checks Of Employees and Applicants For Employment In Certain Facilities Serving The Elderly, Persons With Disabilities, Or Persons With Terminal Illnesses
Sec. 250.006. Convictions Barring Employment.
(a) A person for whom the facility or the individual employer is entitled to obtain criminal history record information may not be employed in a facility or by an individual employer if the person has been convicted of an offense listed in this subsection:
(1) an offense under Chapter 19, Penal Code (criminal homicide);

(2) an offense under Chapter 20, Penal Code (kidnapping and unlawful restraint);
(3) an offense under Section 21.02, Penal Code (continuous sexual abuse of young child or children), or Section 21.11, Penal Code (indecency with a child);
(4) an offense under Section 22.011, Penal Code (sexual assault);
(5) an offense under Section 22.02, Penal Code (aggravated assault);
(6) an offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
(7) an offense under Section 22.041, Penal Code (abandoning or endangering child);
(8) an offense under Section 22.08, Penal Code (aiding suicide);
(9) an offense under Section 25.031, Penal Code (agreement to abduct from custody);
(10) an offense under Section 25.08, Penal Code (sale or purchase of a child);
(11) an offense under Section 28.02, Penal Code (arson);
(12) an offense under Section 29.02, Penal Code (robbery);
(13) an offense under Section 29.03, Penal Code (aggravated robbery);
(14) an offense under Section 21.08, Penal Code (indecent exposure);
(15) an offense under Section 21.12, Penal Code (improper relationship between educator and student);
(16) an offense under Section 21.15, Penal Code (improper photography or visual recording);
(17) an offense under Section 22.05, Penal Code (deadly conduct);
(18) an offense under Section 22.021, Penal Code (aggravated sexual assault);
(19) an offense under Section 22.07, Penal Code (terroristic threat);
(20) an offense under Section 32.53, Penal Code (exploitation of a child, elderly individual, or disabled individual);
(21) an offense under Section 33.021, Penal Code (online solicitation of a minor);
(22) an offense under Section 34.02, Penal Code (money laundering);
(23) an offense under Section 35A.02, Penal Code (Medicaid fraud);
(24) an offense under Section 36.06, Penal Code (obstruction or retaliation);
(25) an offense under Section 42.09, Penal Code (cruelty to livestock animals), or under Section 42.092, Penal Code (cruelty to nonlivestock animals); or
(26) a conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.

(b) A person may not be employed in a position the duties of which involve direct contact with a consumer in a facility or may not be employed by an individual employer before the fifth anniversary of the date the person is convicted of:
(1) an offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony;
(2) an offense under Section 30.02, Penal Code (burglary);
(3) an offense under Chapter 31, Penal Code (theft), that is punishable as a felony;
(4) an offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony;
(5) an offense under Section 32.46, Penal Code (securing execution of a document by deception), that is punishable as a Class A misdemeanor or a felony;
(6) an offense under Section 37.12, Penal Code (false identification as peace officer); or
(7) an offense under Section 42.01(a)(7), (8), or (9), Penal Code (disorderly conduct).

(c) In addition to the prohibitions on employment prescribed by Subsections (a) and (b), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:
(1) of an offense under Section 30.02, Penal Code (burglary); or
(2) under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

(d) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

Confidentiality Statement

Name: _____ Date: _____

The company maintains confidentiality of the patient's, personnel and agency records according to the HIPAA Omnibus and HB300 regulations. Due to the nature of employment, each employee will gain, directly or indirectly, sensitive and confidential information on patients, personnel and agency information. This information may only be shared with those persons who, due to their position, have a need to know.

As an employee, I will safeguard the right to privacy of the patient, personnel and agency by judiciously protecting information of a confidential nature.

I have read, understand and agree to abide by the above

Employee Signature: _____

Statement Of Employability

By execution of this document, I acknowledge that I have been informed by this company and agree that said company will conduct a State of Texas criminal history check, search the Nurse Aide Registry (NAR), and search the Employee Misconduct Registry (EMR) per the Texas Administrative Code §93.3, Chapter 250 of the Health and Safety Code, Nurse Aid Registry and Criminal History Checks of Employees and Applicants for Employment in Certain Facilities Serving the Elderly, Persons with Disabilities, Persons with Terminal Illnesses, and Chapter 253, of the Texas Health and Safety Code, Employee Misconduct Registry. I understand that I am not employable if I am listed in the Employee Misconduct Registry or if I have a criminal conviction or offense that bars me from employment with this Agency. I have been informed that the Agency will also conduct a search of the NAR and the EMR on an annual basis.

Background Checks

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the Criminal History Check, and verification on the Nurse Aide Registry and the Employee Misconduct Registry. I understand that I may not have patient contact or access to patient's records until all results are concluded.

CONVICTIONS BARRING EMPLOYMENT Health and Safety Code §250.006

A. A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed below:

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20, Penal Code (kidnapping, unlawful restraint, and smuggling of persons);
- An offense under Chapter 21.02, Penal Code (continuous sexual abuse of young child or children) or Section 21.11, Penal Code (indecency with a child);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- An offense under Section 21.15, Penal Code (improper photography or visual recording);
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.021, Penal Code (aggravated sexual assault) ;
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.05, Penal Code (deadly conduct);
- An offense under Section 22.07, Penal Code (terroristic threat);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.08, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);
- An offense under Section 32.53, Penal Code (exploitation of child, elderly individual, or disabled individual);
- An offense under Section 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering);
- An offense under Section 35A.02, Penal Code (health care fraud);
- An offense under Section 36.06, Penal Code (obstruction or retaliation);
- An offense under Section 42.09, Penal Code (cruelty to livestock animals);
- An offense under Section 42.092, Penal Code (cruelty to nonlivestock animals);
- A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection; or
- An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves.

Statement Of Employability

B. A person may not be employed in a position in which the duties involve direct contact with a patient in a facility before the fifth anniversary of the date the person is convicted of:

- An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or felony);
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft punishable as a felony);
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution punishable as a Class A misdemeanor or felony);
- An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or felony);
- An offense under Section 37.12, Penal Code (false identification as a peace officer); misrepresentation of property; or
- An offense under Section 42.01(a)(7), (8), or (9), Penal Code (disorderly conduct).

C. In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- Of an offense under Section 30.02, Penal Code (burglary); or
- Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

D. In addition to the prohibitions prescribed by Subsections (A), (B) and (C), a nurse aide who is designated in the NAR or the EMR with a finding concerning abuse, neglect, or exploitation or mistreatment of a patient of an agency or a facility, or misappropriation of a patient's property is not employable.

E. I understand that if I have been placed on deferred adjudication community supervision for an offense listed in the section above, and successfully complete the period of deferred adjudication community supervision, and receive a dismissal and discharge in accordance with Article 42A.111, Code of Criminal Procedure, I am not considered convicted of the offense.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Signature of Applicant/Unlicensed Contractor/Employee **Date**

FOR AGENCY USE ONLY:

Texas and Safety Code §250 and §253. Verification of Employability: Employee Misconduct Registry (EMR); Nurse Aide Registry (NAR)

- ☐ **EMR/ NAR checked by using DADS' Employability Status Search website at:** https://emr.dads.state.tx.us/DadsEMRWeb/
- ☐ Applicant/employee/Unlicensed Contractor **is** employable
- ☐ Applicant/employee/Unlicensed Contractor **is not** employable
- ☐ **Criminal History Check completed by one of the following methods: Electronically, disk or by typewritten form submitted to the Department of Public Safety (DPS) for licensed and unlicensed staff that provide direct patient care or have access to patient's records.**
- ☐ Applicant / employee has no offense(s) and **is employable**
- ☐ Applicant/employee has offense(s) which bar employment and **is not employable**
- ☐ Applicant/employee has offense(s) which does not bar employment; offense(s) reviewed and determined to contradict employment and **is not employable**
- ☐ Applicant/employee has offense(s) which does not bar employment; Offense(s) reviewed and determined not to be a contradiction to employment and **is employable**

Verified by Date

Consent To Drug and/or Alcohol Testing

Name: _____ Date: _____

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

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

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

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

I understand that the company will require a drug screen and/or alcohol test under this policy whenever I am involved in an on-the-job accident or injury under circumstances that suggest possible involvement or influence of drugs or alcohol in the accident or injury event, and I agree to submit to any such test.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Hepatitis B Vaccine Consent/Declination

Name: _____ Date: _____

Please check one:

☐ **Hepatitis B Vaccine Consent**

I read the information given to me about Hepatitis B virus and Hepatitis B vaccine and I had the opportunity to ask questions. My questions were answered.

I want to participate in the vaccination program. I understand this includes three injections at prescribed intervals over a 6-month period. I understand that there is no guarantee that I will become immune to Hepatitis B and that I might experience an adverse side effect as the result of the vaccination. Date Given Lot # Administered By Next Date Due

	Date Given	Lot #	Administered By:	Next Due Date:
1st Dose				
2nd Dose				
3rd Dose				

☐ **Hepatitis B Vaccine Declination**

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline the Hepatitis B vaccination at this time.

I understand that by declining this vaccine, I continue to be at risk of acquiring the serious disease Hepatitis B.

If, in the future, I continue to experience occupational exposure to blood or other potentially infectious materials and I wish to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____

Employee Signature Date

_____

Hospice Signature Date

Hepatitis B Vaccine Consent/Declination

Can Hepatitis B be prevented?

Yes. The best way to prevent Hepatitis B is by getting the Hepatitis B vaccine. The Hepatitis B vaccine is safe and effective and is usually given as 3-4 shots over a 6-month period.

What is the Hepatitis B vaccine series?

The Hepatitis B vaccine series is a sequence of shots that stimulate a person's natural immune system to protect against HBV. After the vaccine is given, the body makes antibodies that protect a person against the virus. An antibody is a substance found in the blood that is produced in response to a virus invading the body. These antibodies are then stored in the body and will fight off the infection if a person is exposed to the Hepatitis B virus in the future.

Who should get vaccinated against Hepatitis B?

Hepatitis B vaccination is recommended for:

•Health care and public safety workers at risk for exposure to blood or blood-contaminated body fluids on the job

How is the Hepatitis B vaccine series given?

The Hepatitis B vaccine is usually given as a series of 3 or 4 shots over a 6-month period.

Is the Hepatitis B vaccine series effective?

Yes, the Hepatitis B vaccine is very effective at preventing Hepatitis B virus infection. After receiving all three doses, Hepatitis B vaccine provides greater than 90% protection to infants, children, and adults immunized before being exposed to the virus.

Is the Hepatitis B vaccine safe?

Yes, the Hepatitis B vaccine is safe. Soreness at the injection site is the most common side effect reported. As with any medicine, there are very small risks that a serious problem could occur after getting the vaccine. However, the potential risks associated with Hepatitis B are much greater than the risks the vaccine poses. Since the vaccine became available in 1982, more than 100 million people have received Hepatitis B vaccine in the United States and no serious side effects have been reported.

Is it harmful to have an extra dose of Hepatitis B vaccine or to repeat the entire Hepatitis B vaccine series?

No, getting extra doses of Hepatitis B vaccine is not harmful.

What should be done if Hepatitis B vaccine series was not completed?

Talk to your health professional to resume the vaccine series as soon as possible. The series does not need to be restarted.

Who should not receive the Hepatitis B vaccine?

The Hepatitis B vaccine is not recommended for people who have had serious allergic reactions to a prior dose of Hepatitis B vaccine or to any part of the vaccine. Also, it not recommended for anyone who is allergic to yeast because yeast is used when making the vaccine. Tell your doctor if you have any severe allergies.

Are booster doses of Hepatitis B vaccine necessary?

It depends. A "booster" dose of Hepatitis B vaccine is a dose that increases or extends the effectiveness of the vaccine. Booster doses are not recommended for persons with normal immune status who have been fully vaccinated.

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only

DECLINATION FORM FOR SEASONAL INFLUENZA VACCINE

Name (printed):_____ 3-4 ID or SSN:_____

Facility: _____ Department:_____

This facility has recommended that I receive influenza vaccination in order to protect myself and the patients I serve.

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. [In California, influenza usually begins circulating in early January and continues through February or March.]
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the 2019-2020 season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form. I am declining due to the following reasons (check all that apply):

- ☐ I believe I will get influenza if I get the vaccine.
- ☐ I do not like needles.
- ☐ My philosophical or religious beliefs prohibit vaccination.
- ☐ I have an allergy or medical contraindication to receiving the vaccine.
- ☐ Other reason – please tell us. _____

- I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.
- I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.
- I have read and fully understand the information on this declination form.

_____ _____

Signature Date

TB Fact Sheet

The following criteria is utilized to identify if an employee has potential TB. This criteria is also utilized to determine if an employee needs another chest x-ray. This information is also presented in training.

Detection of employees who may have active TB are based on the following criteria:

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB disease in the lungs may cause symptoms such as:

1. A bad cough that lasts 3 weeks or longer
2. Pain in the chest
3. Coughing up blood or sputum (phlegm from deep inside the lungs)

Other symptoms of TB disease are:

1. Weakness or fatigue
2. Weight loss
3. No appetite
4. Chills
5. Fever
6. Sweating at night

Groups with a higher prevalence of TB infection:

1. Medically underserved populations
2. Homeless individuals
3. Current or past prison inmates
4. Alcoholics
5. Injecting drug users
6. Elderly
7. Foreign-born persons from Asia, Africa, the Caribbean and Latin America
8. Contacts to individuals with TB
9. Groups with a greater risk to progress from latent TB infection to active disease
10. Individuals with HIV infection, silicosis, S/P gastrectomy or jejuno-ileal bypass surgery, greater than 10 lb. Below normal body weight, chronic renal failure, diabetes mellitus, immunosuppressed due to medication, and those with some malignancies.
11. Individuals who have been infected within the past 2 years and individuals with fibrotic lung disease on chest x-ray.

I have reviewed the signs and symptoms of TB. I am not experiencing symptoms of TB. I understand if I experience any of the above symptoms I am to report to management immediately.

Name: _____ Date: _____

Reviewed by Agency Administrative Staff: _____ Date: _____

Health Screening – Tuberculosis (TB)

Name:_____ Date:_____

DOB: _____

All personnel (including volunteers and contracted) are required to complete a Health Screening with a healthcare professional (RN, MD, NP) before commencement of employment and annually thereafter.

Please answer all of the following questions by checking the appropriate box.

	Yes	No	Date
Have you ever had a TB skin test?			
Have you been exposed to anyone with active TB?			
Have you recently lived or traveled out of the country where TB is common? (Latin America, Caribbean, Africa, Asia, Eastern Europe, Russia)			
Have you ever had a positive TB test?			
Have you ever taken anti-tuberculosis medication?			
Do you currently have any of the following symptoms?			
Cough for > 3 weeks?			
Night sweats?			
Unexplained weight loss?			
Fever/chills?			

Personnel:

Signature:_____ Date:_____

Healthcare Professional:

Signature:_____ Date: _____

If you have any of the symptoms above, you will be required to have one of the following tests performed, as appropriate to history, prior to patient contact:

A. 2 step Mantoux

B. Single TB blood test

C. Chest X-ray

I am at least 18 years of age and agree to be tested for Mycobacterium tuberculosis.

Print Name: _____

Signature:_____ Date: _____

The results will be filed in a separate medical file kept confidential and as part of the Personnel Record.

TB Skin Test (TBT)

Name:_____Date:_____

I am at least 18 years of age and agree to a TB Skin Test (TBT).

Print Name: _____

Signature:_____Date:_____

Tuberculin skin testing (TST) is the standard method for screening for tuberculosis (TB) infection. Because the immune system loses its ability to respond to the tuberculin injection during a TB infection, individuals infected with TB may show a false negative result with the initial TST. To avoid misinterpreting a previous infection that didn't show at initial testing with a current infection, many institutes frequently apply a two-step TB testing. The two-step TST is common among health care workers.

Instructions

A. Step #1: Inject 0.1 ml of tuberculin purified protein derivative (PPD) into the inner surface of the forearm.

B. 48 hours to 72 hours after initial injection, read the test by measuring the test area induration (swelling, redness, raised or hardened area).

C. Step #2: When skin test #1 reads negative, 7 days after the initial TST, inject 0.1 ml of PPD.

D. 48 to 72 hours after the second TST, read the test.

A second test is not required if there is a documented TST result from any time during the previous 12 months.

A negative two-step TB test indicates no current or previous TB infection.

A positive two-step test indicates infection and additional evaluation to rule out current TB infection is performed.

Step #1:	Step #2:
• Date Administered:_____Time:_____ • Lot Number:_____ • Administered by: _____ • Right Forearm:_____Left Forearm: _____ • Date Read:_____Time:_____ • Results: Negative_____Positive _____ • Read by :_____RN	• Date Administered:_____Time:_____ • Lot Number:_____ • Administered by: _____ • Right Forearm:_____Left Forearm: _____ • Date Read:_____Time:_____ • Results: Negative_____Positive _____ • Read by :_____RN

See Reading Results, if needed.

Obtain second opinion from an RN or MD if results are not clear or question the results.

TB Skin Test (TBT)

Reading Results:

An induration of 5 or more millimeters is considered positive in

-HIV-infected persons

-A recent contact of a person with TB disease

-Persons with fibrotic changes on chest radiograph consistent with prior TB

-Patients with organ transplants

-Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF-a antagonists)

An induration of 10 or more millimeters is considered positive in

-Recent immigrants (< 5 years) from high-prevalence countries

-Injection drug users

-Residents and employees of high-risk congregate settings

-Mycobacteriology laboratory personnel

-Persons with clinical conditions that place them at high risk

-Children < 4 years of age

-Infants, children, and adolescents exposed to adults in high-risk categories

An induration of 15 or more millimeters is considered positive in any person, including persons with no known risk factors for TB. However, targeted skin testing programs should only be conducted among high-risk groups.

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. (This is not a consent form, but serves as information for the applicant.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by this agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee (optional)

_____
Date

_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ _____ initial

Purpose of CCH: _____

Empl ___ Vol/Contractor ___ _____ initial

Date Printed:_____ _____ initial

Destroyed Date: _____ _____ initial

Retain in your files

Rev. 09/2015

Signature Authentication

To authenticate entries into written medical records:

Printed Name: _____ Date: _____

Signature: _____

Title: _____
Initials: _____

If signature is illegible, you will need to print your name next to your signature on every entry of written medical records.

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:

ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C

1	2	3

Employer Information

1. Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports.

2. State Employer ID Number (Optional):

3. Employer Name:

4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):

5. Employer City (if US):

6. State (if US):

7. ZIP Code (if US): –

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):

12. Employer FAX (Optional):

13. New Hire Contact Person (Optional):

Employee Information

14. Social Security Number (SSN):

15. Date of Hire (MM/DD/YYYY):

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US): –

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

27. Employee DOB (MM/DD/YYYY) (Optional):

28. Employee's Salary (Dollars and Cents) (Optional):

29. Salary Frequency (Check One ONLY) (Optional):

☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

INSTRUCTIONS FOR COMPLETING THE TEXAS EMPLOYER NEW HIRE REPORTING FORM

The purpose of the Texas New Hire Reporting Form is to allow employers to fulfill new hire reporting requirements. You may enter your employer information and photocopy a supply and then enter employee information on the copies.

REPORTING OF NEW HIRES IS REQUIRED:

All required items (numbers 1, 3, 4, 5, 6, 7, 14, 15, 16, 17, 18, 19, 20, 21, 22) on this form must be completed.

Box 1: Federal Employer ID Number (FEIN). Provide the 9-digit employer identification number that the federal government assigns to the employer. This is the same number used for federal tax reporting. Please use the same FEIN that appears on quarterly wage reports.

Box 2: State Employer ID Number (Optional). Identification number assigned to the employer by the Texas Workforce Commission.

Box 3: Employer Name. The employer name as listed on the employee's W4 form. Please do not provide more than one employer name (for example, "ABC, Inc DBA. John Doe Paint and Body Shop" is not correct).

Box 4: Employer Address. Please indicate the address where the Income Withholding Orders should be sent. Do not provide more than one address (for example, P.O. Box 123, 1313 Mockingbird Lane is not correct).

Box 8: Employer Province/Region (if foreign). Provide this information if the employer address is not in the United States.

Box 9: Employer Country (if foreign). Provide the two letter country abbreviation if the employer address is not in the United States.

Box 10: Postal Code (if foreign). Provide the postal code if the employer address is not in the United States.

Box 13: New Hire Contact Person (Optional). Providing the name of a contact staff person will facilitate communication between the employer and the Texas Employer New Hire Reporting Program.

Box 15: Date of Hire. List the date in month, day and year order. Use four digits for the year (for example, 2001). This should be the first day that services are performed for wages by an individual. If you are reporting a rehire (where a new W-4 is prepared) use the return date, not the original date of hire.

Box 23: Employee Province/Region (if foreign). Provide this information if the employee does not reside in the United States.

Box 24: Employee Country (if foreign). Provide the two letter country abbreviation if the employee address is not in the United States.

Box 25: Postal Code (if foreign). Provide the postal code if the employee address is not in the United States.

Box 26: State Where Employee was Hired. Use the abbreviation recognized by the U.S. Postal Service for the state in which the employee was hired.

Box 27: Employee DOB (Date of Birth) (Optional). List the date in month, day and year order. Use four digits for the year (for example, 1985).

Box 28: Employee Salary (Optional). Enter employee's exact wages in dollars and cents. This should correspond to the salary pay frequency indicated in Box 29.

Box 29: Salary (Check One ONLY) (Optional). Check the appropriate box relating to the employee's salary pay frequency. Check " Bi-weekly" if the salary is based on 26 pay periods. Check "Semi-monthly" if the salary is based on 24 pay periods. Check "Annually" if salary payment is a one-time distribution.

SUBMISSION OF NEW HIRE REPORTS. The Texas Employer New Hire Reporting Program offers a variety of methods that employers can use to submit new hire reports. For further information on which method may be best for you, call 1-800-850-6442. Employers are encouraged to keep photocopies or electronic records of all reports submitted. When the form is completed, send it to the Texas Employer New Hire Reporting Program using one of the following means:

- **FAX:** 1-800-732-5015
- **U.S. Mail:**

ENHR Operations Center
P.O. Box 149224
Austin, TX 78714-9224

- **Telephone Submissions:** 1-800-850-6442
- **Internet Submissions: www.employer.texasattorneygeneral.gov**

Employers must provide all of the required information within 20 calendar days of the employee's first day of work to be in compliance. State law provides a penalty of $25 for each employee an employer knowingly fails to report, and a penalty of $500 for conspiring with an employee to 1) fail to file a report or 2) submit a false or incomplete report.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

Multiply the number of other dependents by $500 . . . . ► $ _____

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

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

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

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

1. Expect to work only part of the year;

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

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

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

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

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

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

☐ **New Hire** ☐ **Change** ☐ **Re-hire** ☐ **Termination** ☐ **1099/Contractor**

Social Security Number_____Employee # _____

Name: Last_____First:_____MI_____

Address: _____

City:_____State:_____ZIP: _____

Telephone #:_____ Date of Birth: _____

Gender: _____ Race: _____ Marital Status: _____

Department:_____Status: ☐ Full Time ☐ Part time ☐ PRN ☐ Contract

Hire Date:_____Re-hire Date:_____Term Date: _____

Pay Rate Information

Pay Frequency: ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

☐ Direct Deposit (see attached form) ☐ Live Pay Check

PRN Rate: $_____ Annual Salary: $_____

Hourly Rate: $_____ Pay Overtime: Yes No **(If Salaried**)

Auto Allowance: $_____ Phone Allowance: $_____

First Pay Amount if Prorated: $_____

Tax Information

W-4 Filing Status: ☐ Single or Married filing separately ☐ Married filing jointly ☐ Head of Household

Insurance / PTO Information

Insurance: ☐ Start Date:_____☐ Pre-Tax Amount:_____☐ Post Tax Amount: _____

PTO: ☐ Start Date:_____☐ Total Days per Year / Accrual Per Pay Period:_____/_____

Deduction Information

Deduction_____Amount_____per _____

Deduction_____Amount_____per _____

For Office Use Only:

Hospice Representative: _____ Date Completed: _____

Delta Hospice LLC/ Alliance United Hospice Care LLC
850 Central Parkway East, Suite-105, Plano, TX 75074, Ph:972-424-4001, Fx: 888-977-3576

Non-Competition Provisions for Transferring Patients.

At all times during the Term of this Agreement, full time Employees may not be associated with or employed by any other hospice agency. Considerations will be made and approved by Company for PRN employees on individual basis.

Further, at no time will Employee, either during employment or after leaving the Company for employment elsewhere for a period of six (6) months, attempt to transfer any of Company's patients or other employees to another hospice agency directly or indirectly. If at any time during the Term of this Agreement or after termination of this agreement Employee does attempt to transfer any of Company's patients or employees to another agency (including a period of six (6) months after employment has ended), Employee will compensate Company in the sum of Twenty Thousand ($20,000.00) Dollars per patient or other employee of Company for each Such incident.

Signature:_____ Date:_____

Name:_____

PT/INR MONITORING
COMPETENCY TEST

T	F	1.	Verify physician's order.
T	F	2.	Let the test strips come to room temperature.
T	F	3.	The patient's doctor told him why the procedure is being done so no patient teaching is necessary for this now common monitoring procedure.
T	F	4.	Instruct the patient to wash his/her hands with soap and warm water before doing the finger stick.
T	F	5.	Hold the meter in your hand while applying the sample to protect the meter from falling off the table.
T	F	6.	The under pad of the left index finger is the only viable site for the PT/INR finger stick.
T	F	7.	Errors in PT/INR readings may result if the test is not done immediately following the finger stick, the first drop of blood is not used, or if more blood is added to the target area of the test strip.
T	F	8.	Make sure the code number on the test strip container and the code number on the code chip match.
T	F	9.	Test strips can be stored in the refrigerator indefinitely.
T	F	10.	The lancet should be disposed of in a sharps container and the test strip should be disposed of in the trash.

NAME: _____ DATE: _____

Test scored by: _____ Score: _____
(Passing score above 80%)

If score below 80%, the nurse should not be allowed to perform this procedure and should review Agency's competency requirements. Retake the competency test. Results should be maintained in the nurse's personnel file.

PT/INR MONITORING
ANSWER SHEET

1. T
2. T
3. F
4. T
5. F
6. F
7. T
8. T
9. F
10. F

License Verification

Employee:_____**Social Security Number**_____

Discipline:_____ **License number:**_____

Hire date:_____

Date	Valid /Exp. Date	Name of Verifier	Person Verifying

NURSING VENIPUNCTURE COMPETENCY TEST

Employee name: _____ Date: _____

Please do not mark answers on this test, use the answer gird provided. A copy of your corrected answer grid will be returned to you. A score of 85% is required. You will be provided further training and asked to retake the test if needed.

1. Select the most appropriate methods to fill a vein.
   a. Hydration, gravity, cold soak to site, tap vein
   b. Tourniquet, warm compress, pump fist
   c. Open hand, warm compress

2. When should you wash your hands when performing a venipuncture?
   a. Before you apply gloves and stick
   b. Before you apply gloves for stick and after completed and gloves removed

3. When are gloves required for venipuncture?
   a. When the blood test is for HIV confirmation
   b. If the patient is suspected of HIV or hepatitis
   c. For every venipuncture, no matter the test or patient

4. What gauge needle is used on the typical medical patient for a chemistry profile?
   a. 14-16
   b. 20-22
   c. Always 18

5. How full are you supposed to fill the tube with blood?
   a. 1/4" below the stopper
   b. To the colored line on the side of the tube
   c. How much ever blood is sucked in by the vacutainer

6. You have an order to perform a digoxin level on Mrs. Smith tomorrow, what is the best thing you can tell her?
   a. Call Mrs. Smith and see what time she usually takes her digoxin and then schedule your visit before that dose.
   b. Tell her to hold dose until you arrive.
   c. Let her know it is OK to eat breakfast.

7. When you draw blood for a digoxin level, which tube do you use?
   a. Purple top
   b. Red tube with gel in the bottom
   c. Blue top
   d. Red tube without gel

8. When you take an order for lab it should say pt. name, lab requested and date due. What else should you check before making the visit?
   a. Location of the lab if you are delivering specimen; any special requisition to be used; what color tube is needed.
   b. If insurance is paying, what labs are covered on the insurance plan.
   c. Adequate supply of vacutainer needles, vacutainer holder, tourniquet, gloves, extra tubes of needed color
   d. a and c
   e. a, b and c

9. What color top tube is used for protime?
   a. Purple
   b. Blue
   c. Red
   d. Gray

10. What color top tube is used for CBC?
   a. Purple
   b. Blue
   c. Red
   d. Gray

11. What is the best thing to tell a patient who is scheduled to have a fasting blood sugar tomorrow am?
   a. I will be drawing your blood at 7 am
   b. I will be drawing your blood at 7 am, remain fasting until I arrive.
   c. I would like to draw your blood before breakfast, what time do you eat? Schedule visit 30 mins prior to that time. Inform pt. not to eat or drink anything before your arrival.

12. The doctor asks you to check a 2 hour post prandial blood sugar. What does that mean?
   a. Check BS 2 hrs after breakfast
   b. Check BS 2 hrs before lunch
   c. Check BS 2 hrs after exercise
   d. Check BS 2 hrs before bedtime

13. You have an order for a chemistry profile on Mr. Jones tomorrow. What is required?
   a. Fasting
   b. Non-fasting

14. In hospice you should always get your patient schedule the day before the visit. Why?
    a. It helps you to organize the coming day.
    b. You may have labs due in the morning.
    c. You have time to review patient charts and prepare yourself for patient care.
    d. You may have a death that prevents you to prepare in the morning.
    e. All of the above.

15. You have performed a wound culture, how is it transported to the lab?
    a. In igloo with ice to keep the culture refrigerated
    b. In igloo at room temp so as not to stop growth of bacteria

16. When performing a venipuncture how do you insert the needle into the vein?
    a. Bevel up
    b. Bevel down

17. Where are venipuncture needles placed after the stick?
    a. In a biohazard container which you brought in with you, then store it in your trunk
    b. In any can in the patient kitchen trash
    c. Carry needles to your car and place in biohazard container in your trunk

18. In Hospice, when you go into the home to do a venipuncture, what else should you do?
    a. Ask if the patient is in pain.
    b. Assessment of the patient.
    c. Ask if any patient/family needs are present.
    d. All of the above.

19. What documentation is required in your note on the day of a venipuncture?
    a. Name of the test
    b. How many sticks were required to obtain specimen
    c. What was the VP site and how was stick tolerated by patient
    d. What was the gauge of the needle
    e. All of the above

20. You just drew blood on a pt. who is taking Coumadin, how long should you hold pressure to the site to minimize bleeding?
    a. 1-2 mins. b. 3-4 mins c. 5-10 mins

NURSING VENIPUNCTURE COMPETENCY ANSWER GRID

"Graders" - Place the employees answer grid on top of your answer grid and hold it up to the light for quick grading...

1.	a	**B**	c	d	e
2.	a	**B**	c	d	e
3.	a	b	**C**	d	e
4.	a	**B**	c	d	e
5.	a	**B**	c	d	e
6.	**A**	b	c	d	e
7.	a	b	c	**D**	e
8.	a	b	c	d	**E**
9.	a	**B**	c	d	e
10.	**A**	b	c	d	e
11.	a	b	**C**	d	e
12.	**A**	b	c	d	e
13.	**A**	b	c	d	e
14.	a	b	c	d	**E**
15.	a	**B**	c	d	e
16.	**A**	b	c	d	e
17.	**A**	b	c	d	e
18.	a	b	c	D	e
19.	a	b	c	d	E
20.	a	**B**	c	d	e

NURSING VENIPUNCTURE COMPETENCY ANSWER GRID

Employee Name: _____ Date: _____

1.	a	b	c	d	e
2.	a	b	c	d	e
3.	a	b	c	d	e
4.	a	b	c	d	e
5.	a	b	c	d	e
6.	a	b	c	d	e
7.	a	b	c	d	e
8.	a	b	c	d	e
9.	a	b	c	d	e
10.	a	b	c	d	e
11.	a	b	c	d	e
12.	a	b	c	d	e
13.	a	b	c	d	e
14.	a	b	c	d	e
15.	a	b	c	d	e
16.	a	b	c	d	e
17.	a	b	c	d	e
18.	a	b	c	d	e
19.	a	b	c	d	e
20.	a	b	c	d	e

PULSE OXIMETER MONITORING

T	F	1.	Verify physician's order.
T	F	2.	Inspect the power cord (if applicable) and probe cable for frayed or exposed wires.
T	F	3.	The patient knows why the procedure is being done so no patient teaching is necessary for this common monitoring procedure.
T	F	4.	Instruct the patient to wash his/her hands with soap and water before placing the pulse oximeter.
T	F	5.	Remove patient's nail polish, if used, and clean site with alcohol prep pad.
T	F	6.	The left index finger is the only viable site for monitoring pulse oximetry.
T	F	7.	Errors in pulse oximeter readings may result from improper probe placement, hypothermia, and low light transmissions.
T	F	8.	Observe the pulse rate on the oximeter and correlate it with the manually measured rate.
T	F	9.	Normal resting oxygen saturation is usually greater than 90%.
T	F	10.	A non-disposable probe does not have to be disinfected because it is being used for the same patient each time.

NAME: _____ DATE: _____

Test scored by: _____ Score: _____
(Passing score above 80%)

If score below 80%, the nurse should not be allowed to perform this procedure and should review Agency's competency requirements. Retake the competency test. Results should be maintained in the nurse's personnel file.

PULSE OXIMETER MONITORING
ANSWER SHEET

1. T
2. T
3. F
4. T
5. T
6. F
7. T
8. T
9. T
10. F

CONFIDENTIALITY OF PATIENT/CLIENT INFORMATION

I plan to utilize electronic documentation of patient care.

I will ensure confidentiality and security of patient information by password protecting the device or program utilized.

I agree to change the password at least quarterly or following a breach of security.

I will not provide my password to anyone.

I will use an electronic signature, if acceptable to payor source. Authentication will be available if requested by the Agency.

I have been informed of the Agency's Confidentiality Policy and Safeguarding of Medical Records Policy and I agree to abide by these policies.

_____

Printed Name

_____

Signature

_____

Date

HOSPICE AIDE
COMPETENCY EVALUATION
Written Exam

Aide Name: _____ **Date:** _____

Score: Section 1: 2: 3: 4: 5: 6: 7:

I. Observation, Reporting, and Documentation of Patient Care and Status

1. Mr. Jones pulse rate is usually 64-70. When you take it today it is 52. You should:

a. Wait 30 minutes and recheck it.
b. Tell the patient to go to the doctor.
c. Call the nurse or supervisor immediately.

2. Mr. Smith tells you he feels as if he is going to vomit after taking his new medicine the doctor ordered so he is not taking it. You should:

a. Tell his wife to make him take it.
b. Tell him to take it with 7-Up.
c. Tell him you will call the supervisor about what he should do.
d. Tell him he must take it if he wants to get well.

3. While bathing the patient the hospice aide has an opportunity to:

a. Talk about your personal life.
b. Think about your personal life.
c. Visit with the family.
d. Observe the skin condition, mobility and movement of the patient.

4. When reporting a change in your patient's pulse, temperature or respiration, you need to specify all of the following <u>except</u>:

a. Method of measuring body temperature (oral, rectal, axillary).
b. The exact time the temperature, pulse and respirations were taken.
c. Any other complaints the patient may be expressing (pain, stress, etc.).
d. Why you were late getting to the patient's home.

5. When reporting or recording information it is important to:

a. Report and record exactly how you feel about the situation.
b. Report and record exactly what you see.
c. Report and record what the family feels is wrong.
d. Report and record what the nurse feel is wrong.

II. Basic Infection Control Procedures and Standard Precautions

1. Good hand washing technique is important because:

a. It prevents the spread of germs.
b. It is required by the health department.
c. Its good for the patients morale.

2. The perineal area is washed:

a. From front to back
b. From back to front.
c. It doesn't matter.

3. Wearing disposable gloves or other personal protective equipment while giving personal care:

a. Means your patient has an incurable disease.
b. Protects both you and the patient from the spread of germs.
c. Is never necessary unless the patient has aids.

4. When handling dirty linens and clothing it is best to:

a. Put the dirty linens and clothing on the floor.
b. Shake linens and clothing before washing them.
c. Place dirty linens and clothing in a clothes hamper or plastic bag until they can be washed.

5. When considering the hospice aide's role in reducing the spread of germs, the hospice aide would do all of the following but:

a. Cover nose and mouth when sneezing or coughing.
b. Go to work even when you are ill.
c. Wash hands after handling soiled items such as linens, clothing, garbage, etc.
d. To protect yourself, clean and cover cuts and breaks in your skin.

III. Basic Elements in Body Functining and Changes Reported to RN/Supervisor

1. A five (5) pound weight gain in two days:

a. Is normal and nothing to be worried about.
b. Shows that the patient has been eating too many sweets.
c. Should be reported to the nurse.

2. Mrs. Smith's catheter bag contains a very large amount of dark red urine. You should:

a. Encourage her to drink more fluids.
b. Empty the bag.
c. Call your supervising nurse as soon as possible.

3. A red spot over the patient's hip joint:

a. Might develop into a bedsore.
b. Is a normal sign of old age.
c. Should be treated with a heat lamp.

4. When observing the patient's bowel habits, the following should be reported to the nurse immediately:

a. Symptoms of pain, abdominal swelling, or cramping.
b. Patient not passing gas.
c. Bowel movements occurring every other day.

5. Ms. Whit, who lives alone, is usually talkative during her bath. Today she says very little, appears anxious and worried and has difficulty speaking. When would you report Ms. Whit's change of condition to your supervisor?

a. At the next case conference.
b. At the end of the day.
c. As soon as possible after making the observation.

IV. Maintenance of a Clean, Safe and Healthy Environment

1. Before transferring a patient from the bed to a wheelchair, it is always necessary to:

a. Put a pillow in the seat.
b. Put a blanket over the seat and back.
c. Lock the wheelchair brakes.
d. Unlock the wheelchair brakes.

2. Prior to assisting the patient into the tub or shower, as a safety factor, you should check for:

a. A rubber mat for the tub or shower.
b. Lotion for his/her skin.
c. Comfortable water temperature.
d. Both a. & c.

3. Regardless of the type of bath given to the elderly, the temperature of the water is important because:

a. You can not get them clean unless it is hot enough.
b. You have to follow the procedure manual.
c. Elderly skin is more delicate and burns easily.
d. We have to keep the family happy.

4. Wrinkles in the patient's bed linens may cause:

a. No problems.
b. The linens to wear out.
c. Contractures.
d. Bedsores.

5. Which one of the following statements is <u>not</u> true:

a. Puddles of water or other liquids should be mopped up immediately to avoid falls.
b. Always be sure electrical cords are not lying in open walk areas.
c. If someone in a house uses a cane or a walker, it is a good idea to cushion the floor by using lots of throw rugs.
d. Cleaning supplies and other dangerous substances should be kept in a safe, secure cabinet or area.

V. Recognizing Emergencies and Knowledge of Instituting Emergency Procedures

1. Mr. Jones lives alone and never goes out of the house. When you arrive at his home, the door is locked and although it is in the middle of the day, you can see the lights turned on in the living room. When you knock, you can hear a low moan coming from somewhere in the house, you should:

a. Come back later.
b. Get to the nearest telephone and call your hospice agency.
c. Break a window and climb in.
d. Keep knocking until he opens the door.

2. Fire safety instruction is important because:

a. The supervisor says it is.
b. The patient will think you are great.
c. It prepares you to know proper emergency action in case of fire.
d. It will look good on your visit record.

3. Upon arriving at your patient's home, she tells you that she spilled boiling water on her hand while trying to cook. You should:

a. Cover the area with Vaseline.
b. Apply cool water to the area if there is no break in the skin and notify the supervisor.
c. Scold the patient for being in the kitchen.

4. Your patient, who is awake and alert, begins to complain of heaviness in the chest and nausea. You should:

a. Run to the neighbors for help.
b. Begin CPR.
c. Call your supervisor immediately and follow the instructions given the by the supervisor.
d. Give him some heart medicine you know he used to take for chest pain.

5. If your patient falls while you are in the home, you should <u>not</u> do which of the following:

a. If excessive bleeding occurs, apply a pressure dressing with a clean cloth or sterile gauze.
b. Move the patient to the bed to make him more comfortable.
c. Watch for symptoms of shock - cold and clammy skin, weakness, nausea, etc.
d. Call you supervisor immediately.

VI. Physical, Emotional and Developmental Needs - Respect for the Patient, Privacy and Property

1. Mr. Dodd is eating lunch when you arrive at his home. Your assignment is to take his vital signs and assist him in and out of the bathtub. Which of the following answers is correct?

a. Tell him to finish his lunch later because you have three more patients to see today.
b. Allow him to finish his lunch, then do the bath and take his vitals signs last.
c. Allow him to finish his lunch, rest for at least ten (10) minutes take the vital signs and then do the bath.

2. When performing any procedure in which a body part is exposed, keep the patient covered with a blanket as much as possible.

a. This is important because the patient has the right to dignity and privacy.
b. It is not necessary to do this because it is easier to give care without having blankets get in the way.
c. It is better to just turn up the heat to keep the patient warm.

3. A patient, Miss Green, tells you she is very upset with you and demands you to tell her the supervisor's name so she can call and report you. The correct action is:

a. Tell her you are doing the best you can.
b. Leave her home and go to the next patient.
c. Refuse to see her again.
d. Give her the supervisor's name and phone number.

4. Your patient asks you what his diagnosis is and if he is going to die. You should:

a. Ignore the question.
b. Tell him that you do not know the answer, but that you will have your nursing supervisor come talk to him.
c. Tell him to call his doctor.

5. When caring for a patient who is from another culture than yours, remember that:

a. The patient lives in Missouri now and should change their way to conform to Missouri culture.
b. The patient's response to grief and pain should be the same as yours.
c. Family habits and religious practices will affect the way the patient responds to the care you provide.

VII. Adequate Nutrition and Fluid Intake

1. Elderly patients may not eat a well-balanced diet due to:

a. Loss of the ability to taste food well.
b. Weakness and fatigue.
c. All of the above.

2. Fiber or roughage in the diet:

a. Has no effect on the digestive tract.
b. Helps food move through the digestive tract.
c. Helps people to chew food better.
d. Add lots of cholesterol to the diet.

3. Very good sources of protein are:

a. Beans, peanut butter and eggs.
b. Green salads and cooked greens.
c. Potatoes and noodles.
d. Apples and oranges.

4. Which one of the following statements is correct:

a. Always feed a patient - never let him feed himself.
b. All food served to the patient should be lukewarm.
c. Before serving the meal, it is important to be sure the patient is clean and comfortable.

5. When the plan of care requires you to increase fluids, this food would not be encouraged:

a. Milkshakes.
b. Gelatin.
c. Potato chips
d. Broth.

Scored By: _____

Score by section. No more than one question may be missed per section.

HOSPICE AIDE
SKILLS COMPETENCY CHECKLIST
Determined by direct observation of the Aide

Aide Name: _____ **Date:** _____

Task	Date	Satisfactory	Unsatisfactory	RN Initials
I. Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff				
II. Reading and recording Temperature, Pulse, Respiration				
A. Temperature [only one type required] **- Oral** **- Rectal** **- Axillary**				
B. Pulse [only one required] **- Radial** **- Apical** **- Other_____**				
C. Respirations				
Appropriate and safe techniques in performing personal hygiene and grooming tasks that include:				
III. Bed Bath **Comments:**				
IV. Bath [Note: All are required] **A. Sponge** **B. Tub** **C. Shower** **Comments:**		A B C	A B C	
V. Blood Pressure				

HOSPICE AIDE
SKILLS COMPETENCY CHECKLIST
Determined by direct observation of the Aide

VI. Shampoo (all are required) **A. Sink** **B. Tub** **C. Bed** **Comments:**		A B C	A B C	
VII. Nail and Skin Care (verbalizes skin changes to report) **Comments:**				
VIII. Oral Hygiene **Comments:**				
IX. Toileting and Elimination **Comments:**				
X. Safe Transfer Techniques and Ambulation **Comments:**				
XI. Normal Range of Motion and Positioning **Comments:**				
XII. Other Optional Skills (as permitted under state law). The Agency is responsible for training hospice aides, as needed, for skills not covered in the basic checklist, and verifying competency, Example: shaving, trimming of beards, etc. The Hospice Aide will not be assigned these tasks until successful demonstration of competency.				

Each of the tasks above must be observed in its entirety to confirm the competence of the Hospice aide.

RN Name: _____ Date: _____

Final Score: _____ Out of eleven (11) required tasks have been successfully completed.

Date: _____ Signature of RN: _____

The competency evaluation must be performed by a Registered Nurse in consultation with other skilled professionals, as appropriate.

WRITTEN EXAM KEY

Four [4] of the five [5] questions in each section must be answered correctly to pass the written exam.

Section I

1. **c**
2. **c**
3. **d**
4. **d**
5. **b**

Section II

1. **a**
2. **a**
3. **b**
4. **c**
5. **b**

Section III

1. **c**
2. **c**
3. **a**
4. **a**
5. **c**

Section IV

1. **c**
2. **d**
3. **c**
4. **d**
5. **c**

Section V

1. **b**
2. **c**
3. **b**
4. **c**
5. **b**

Section VI

1. **c**
2. **a**
3. **d**
4. **b**
5. **c**

Section VII

1. **c**
2. **b**
3. **a**
4. **c**
5. **c**

Personnel/Volunteer File Checklist

Name: _____ **Date:** _____

Section I

___ Completed, signed Application for Employment form

___ Documentation of employment Reference Checks (at least two attempted)

___ Texas Employer New Hire Reporting Form

Section II

___ Signed Job Description for each position held

___ Skills Competency Checklist (per regs or policy).

___ Written exams (HA, others per policy)

___ Signed Orientation Checklist

___ Employee Acknowledgment

___ Statement of Employability to include results of Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR) for all unlicensed direct care staff (including Chaplain) as well as documentation that Criminal History Check was completed on-line; OIG Exclusion List check as required

___ W-4 tax withholding form (Search the internet for W4 Forms to download the most current form)

___ Confidentiality/Conflict of Interest Statement

___ Compliance Pledge

___ Miscellaneous

Section III

___ Documentation/copy of current License, Registration/Certification, or Competency (ST license, MSW - Masters Degree & license)

___ Verification of current License/Certification (as required by State regulation)

___ Current CPR, (if required)

___ Current Drivers License

___ Current Automobile Liability

Name: _____ **Date:** _____

Section IV

___ In service Records

___ Performance evaluations (at least annually or per policy), counseling forms, commendations

Health File/I-9 Checklist

All health files may be maintained in a sealed envelope in the personnel file or in a separate file/binder in a secure location.

___ TB clearance (if required, according to agency policy)

___ Hepatitis B vaccination consent/declination

___ Hepatitis B vaccination tracking form

Other forms if applicable

___ HBV/HIV exposure and exposure follow up

___ Workers compensation forms and related documents

___ Medical Leave of Absence forms and related documents

___ Medical information related to accommodation

___ Miscellaneous documentation of illness

I-9 Form should not be in the personnel file, but kept in a separate file folder/binder in a secure location. (Search the internet for I9 Forms to download the most current form)

Criminal Background History Check Form and health information should not be filed as part of the personnel file, but should be kept in a separate file folders/binders in a secure location.

ORIENTATION CHECKLIST FOR CONTRACT STAFF

1. Introduction
- HIPAA/Confidentiality
- Safety
- Emergency Preparedness
- Compliance Program

2. Exposure Control/Standard Precautions
- Standard Precautions, OSHA, Hazardous Waste, Infection Control

3. Human Resource Policies
- Non-discrimination Policy
- Illegal Remuneration
- Fraud and Abuse

4. General Policies & Procedures
- Patient Supplies
- Patient Durable Medical Equipment
- Hospice Agency Paperwork
- Schedules/Time frames

5. Clinical
- Agency Policies & Procedures
- Patient Care Responsibilities
- Abuse, Neglect Exploitation & Reporting
- Coordination of care
- Hospice philosophy
- Patient Rights

Confidentiality: Due to the nature of our work, each contract staff will gain, directly or indirectly, sensitive and confidential information on clients/patients and staff members. The health care professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If in doubt as to whether or not certain information may be shared, s/he should consult with their supervisor.

I acknowledge that I have read, understand and will comply with all applicable agency policies.

_____ _____

Contract Staff Signature Date

Contract Staff Personnel File Checklist

Contract Staff Name: _____ Date: _____

- Compliance Program, to include Confidentiality Conflict of Interest form and Compliance Pledge
- Contractor Services Agreement/Contract (annual review if required by policy or accreditation)
- Orientation Checklist
- License and License verification
- Competency Skills Checklist as appropriate
- Validation of professional liability insurance
- Criminal Background check, Employee Misconduct Registry/Nurse Aide Registry
- OIG check as required
- Hepatitis B consent/declination
- TB (per agency policy)
- Validation of current flu season vaccination/declination if required

_____

_____

_____

Note: The results of the Criminal Background History Check and health information should not be filed as part of the personnel file, but should be kept in a separate file folder/binder in a secure location.

CONFIDENTIALITY/CONFLICT OF INTEREST DISCLOSURE STATEMENT

CONFIDENTIALITY/NON-DISCLOSURE OF COMPANY OR PATIENT/CLIENT INFORMATION:

Access to any confidential or proprietary information will be limited to the minimum required for the performance of duties as relates to each individual's job. Any confidential information created, received, maintained, used, disclosed, accessed, or transmitted in the performance of job duties will be maintained and protected from unauthorized disclosure.

The Health Information Portability and Accountability Act (HIPAA) ensures the patient/client's right to privacy of Protected Health Information to be maintained at all times. Any information related to the care of patients/clients through this Agency will be held as confidential. All information, written or verbal, will be disclosed only to appropriate health care personnel, appropriate staff, those with a "need to know basis", or to individuals the patient/client requests.

CONFLICT OF INTEREST DISCLOSURE STATEMENT:

I acknowledge I have read the policy and procedure regarding conflict of interest and the procedure for disclosure. I understand that if I have an outside relationship that is personal, professional, or otherwise, with a patient/client, vendor, or potential business associate, I must disclose the nature of that relationship to my supervisor, or Administrator as soon as the relationship is established. I also understand that I forfeit any voting privileges, decision making capacity, and input from any activities associated with said relationship.

❑ I have no conflict of interest to report

I,_____ as a staff member, or member of the Governing Body or Interdisciplinary Group, am providing the following disclosure as potential conflict of interest:

_____

_____

_____

_____ _____ _____

Name (Please Print) Signature Date

The reported conflict of interest was reviewed by the Governing Body with the following decision(s) made:

_____

_____

_____

_____ _____

Signature of Governing Body Member(s) Date

COMPLIANCE PLEDGE

(Completed On Hire and Annually)

The undersigned is a current Governing Body member, Interdisciplinary Group (IDG) member, owner, officer, director, or person who performs billing or coding functions on behalf of the Agency or an employee of the Agency. In that capacity, the undersigned hereby affirms that:

I have received the Agency Standards of Conduct, have had an opportunity to have questions regarding the Standards of Conduct answered, and agree to conduct myself in accordance with same in all dealings with or on behalf of the Agency;

I have completed the Compliance Training and Education Program as required by the Agency Compliance Program;

I am not aware of any actual or potential unreported activity by any person or entity acting for or in conjunction with the Agency which is known or believed by me to be in violation of any applicable federal or state law, rule or regulation;

I understand the importance of compliance with applicable laws, rules and regulations to the Agency and to the government and third-party payers;

I understand that all Agency representatives are expected to report any suspected violations of these laws, regulations, or rules to their supervisor or the Compliance Officer. I understand that I must also report any suspected violations of the policies or the standards and procedures of the program, and that I may anonymously report any suspected violations through the Compliance Drop box or the Hotline # _____;

I understand that conduct in accordance with the Agency Compliance Program will be a condition of my continued relationship with the Agency. I understand that failure to comply with the program may subject me to sanctions or discipline, including but not limited to termination of employment, and/or privileges; and

I am not currently and have not been subject to any criminal charge or conviction involving any government business nor any conviction, exclusion action, disciplinary action, debarment or proposed debarment, or loss or limitation of licensure, privilege or employment as a result of any alleged violation of applicable state or federal law, rule or regulation.

Signed this _____ day of _____, 20_____.

_____
Signature

_____
Printed Name

_____
Title or Job Description