STEWARD
Home Health Agency Inc.

8607 Imperial Hwy Suite # 203, Downey, California. 90242
Tel: (562) 869-6723 **Fax:** (562) 869-9468

Employment Application

Applicant Information			
Last Name	First	M.I.	Date
Street Address			Appt./Unit#
City		State	ZIP
Phone	E-mail Address		
Date Available	SS#	Desired Salary $	
Position Applied For			
Are you a Citizen of the U.S.? Yes [ ] No [ ] If no, are you authorized to work in the U.S? Yes [ ] No [ ]			
Type of employment desired: Part time [ ] Full time [ ] Other:			
Have you ever been convicted of a felony? Yes [ ] No [ ] If yes, explain:			

Education			
High School	Address		
From: To:	Did you graduate? Yes [ ] No [ ]	Degree	
College	Address		
From: To:	Did you graduate? Yes [ ] No [ ]	Degree	
Other	Address		
From: To:	Did you graduate? Yes [ ] No [ ]	Degree	

References	
Please list three professional references.	
Full Name	Address
Company	Phone ( )
Full Name	Relationship
Company	Phone ( )
Address	
References Checked: ☐ Yes ☐ No	**By; Name:**
Date:	**Signature:**

Previous Employment

Company	Phone ( )	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From: To:	Reason for Leaving	
May we contact your previous supervisor for a reference? Yes [ ] No [ ]		
Company	Phone ( )	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From: To:	Reason for Leaving	
May we contact your previous supervisor for a reference? Yes [ ] No [ ]		
Company	Phone ( )	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From: To:	Reason for Leaving	
May we contact your previous supervisor for a reference? Yes [ ] No [ ]		

Military Service

Branch	From: To:
Rank at Discharge	Type of Discharge
If other than honorable, explain	

Disclaimer and Signature

I certify that many answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature	Date

APPLICANT'S STATEMENT OF PERSONAL FACTS

I certify that the answers I provide in the Employment Application documents are true and complete to the best of my knowledge. I authorize investigation of all statement contained in my application for employment as may be necessary in arriving at an employment decision. This application for employment shall be considered active for a period of time not to exceed 45 days. I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this Agency is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge the Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by the Agency's President and/or CEO.

In the event of employment, I understand that false or misleading information given by me in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Employer as indicated in the Employee Handbook or contained in a document which has been made available to me.

_____

Applicant Name

_____ _____

Applicant Signature Date

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize **STEWARD HOME HEALTH AGENCY INC** its staff, its affiliates, and its agents to request information from, and consult with, former employees, educational institutions, local, state, and federal law enforcement agencies, and individuals with whom I have associated AND others who may have information regarding my competence, character and qualifications, and any and all other source deemed appropriate by **STEWARD HOME HEALTH AGENCY INC**

I hereby release **STEWARD HOME HEALTH AGENCY INC** its staff, its affiliates and agents from any and all liability for their acts performed in the investigation, consideration, and evaluation of my credentials and qualifications, and further release from any liability all individuals and organizations who provide information concerning my competence, character, other qualifications, and other applicable background information for my employment consideration.

I understand that nothing in this authorization or in the employment application is intended to create a promise of employment or any contractual rights. I further understand that any misrepresentation of facts and falsification regarding my employment history, academic attainments, or qualifications, or other background information may disqualify me from further consideration as a candidate for employment with **STEWARD HOME HEALTH AGENCY INC** and, if employed, shall be grounds for dismissal.

I am willing that a photocopy of facsimile transmittal of this authorization be accepted with the same authority as the original, and I specifically waive written notice of any information provided by a present or previous employer.

PLEASE PRINT

Name: _____ Social Security No: _____

Other Name(s) used by you _____

Do you authorize STEWARD to contact your previous Employer? [ ] Yes [ ] No

Signature: _____ Date: _____

For Personnel Use Only

Position Applied For: _____

Remarks: _____

CONFIDENTIALITY STATEMENT OF INFORMATION

If you accept employment with the Agency, you have obligated yourself to refrain from discussing any patient's condition or office personnel matters with anyone outside the agency, unless expressly authorized to do so. You will not pass on medical information to clients and visitors unless you have been instructed to do so by your supervisor. All information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with your family. Your job as an employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings. Information about clients, or the agency, is not to be provided to media.

Disclosure of confidential information gained through your employment by the Agency will be considered an act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient's illness, family, financial condition or personal peculiarities is strictly confidential. When a patient's history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information to which you gain access in the course of your work, concerning another person – whether a patient or an employee - is also considered confidential and may not become the topic of conversation with others.

I have read and understood the above statement and agree to abide by these policies. I understand that a breach of policy may result in disciplinary action, including legal proceedings, and possible dismissal from employment.

Applicant Name: _____ Date: _____

Applicant Signature: _____

Witness Name: _____ Date: _____

Witness Signature: _____

COMPLIANCE FORM

Medicare and Medicaid patients, their care, diagnosis, and billing, represent "public" funding mediums and as such must be treated with utmost attention, accuracy, honesty, and integrity. Accordingly, Steward Home health Agency Inc (the Agency) adheres to the following policy:

a. The Agency seeks to maintain **up-to-date** knowledge about federal and state law, and federal, state and private payer health care program requirements.

b. The Agency **educates** its employees and keeps them up-to-date about federal and state laws, and federal, state and private payer health care program requirements.

c. The Agency **complies** with all federal and state law, and federal, state and private payer health care program requirements to the best of its ability.

d. The Agency **audit**s its Compliance, **makes corrections** where needed, and puts into place additional checks and programs as needed in order to further comply with federal and state law, and federal, state and private payer health care program requirements.

I have or will read, within 7 days from the commencement of my employment, the policies and procedures contained in the Agency's Policies and Procedures Volumes 1–13. I understand, and agree, to comply with the Agency's policies and procedures – which, I have been advised, are consistent with Medicare Conditions of Participation and Title 22 Regulations. I will advise the Compliance Officer if I believe there is activity within the Agency that is not in compliance with the Agency's policies and procedures.

_____ _____

Applicant/Employee Signature Administrator Signature

Date: _____ Date: _____

LEGAL AND ETHICAL RESPONSIBILITY

STEWARD HOME HEALTH AGENCY INC acknowledges both legal and ethical responsibility to protect the privacy of patients and employees. Consequently, the indiscriminate or unauthorized review, use, OR disclosure of personnel information, medical or otherwise, regarding any patient or employee, is expressly prohibited.

Except when required in the regular course of business, the discussion of use, transmission, or narration in any form, of any patient information which is obtained in the regular course of your business or the scope of your employment, is strictly forbidden.

Those individuals who also have access to employee information must respect and treat the confidentiality of such information in the same manner as that of patient information.

Any violation of this policy shall constitute grounds for severe disciplinary action, including possible termination of the offending employee.

I have read and understand the significance of this policy and I agree to abide by it.

_____ _____

Employee's Name Date

_____

Employee's Signature

_____ _____

Witness Name Date

_____

Witness Signature

FRAUD AND ABUSE LAWS OF THE MEDICARE ACT

To aid STEWARD HOME HEALTH AGENCY INC in the attainment of its mission of providing quality health care to the public on the home care setting, certain standards of conduct have been developed and approved by the Board of Directors and the agency's leadership. It is therefore expected that all employees and contracted individuals will thoroughly understand and conduct themselves according to the tenants stated below:

The Medicare statutes prohibit the following:

1. Submission of false claims for the purpose of obtaining payments or benefits. Omission of information for this purpose is also prohibited.

2. The provision of false information or material misrepresentation of facts to obtain and maintain certification as a Medicare participation home health agency.

3. Conversion of any payment from the programs other than for use of the person on whose behalf the payment was made.

4. Solicitation, receipt, offer or payment of any remuneration (kickbacks, bribes, rebates) in return for referral of Medicare patients or in return for recommending or arranging for the purchase, lease, or rendering of Medicare related services. This prohibition is known as the Anti-kickback Statute (42.U.S.C. 132a -7b).

5. Submitting a claim for services that were never rendered to the beneficiary or that the home health agency knew were not necessary for the beneficiary.

6. Submitting a claim for services that were actually rendered and were medically necessary but providing false information to substantiate the claim.

7. Receiving Medicare benefits that are rightfully due to another home health agency.

(CONTINUED)

8. Submitting duplicate bills, such as submitting two claims to Medicare for the same service or one claim to Medicare and another claim to the beneficiary for the same service.

9. Submitting claims for services provided by practitioners who have been excluded from participation in the programs or who are unlicensed.

10. Submitting claims at higher prices for Medicare and Medicaid patients than for other patients.

The type of disciplinary action which may be taken in response to violation of this code of conduct will be determined on an individual basis to include but not limited to the following: reporting of the incident to licensing agencies, oral warning, written warning, suspension of employment without pay, demotion, probation or termination. Violations of the Medicare Fraud and Abuse Laws may result in fines up to $25,000 and 5 years imprisonment.

I have read and agree to comply with the above Fraud and Abuse Laws of the Medicare Act.

_____ _____

Employee's Signature / Title Date

_____ _____

Witness' Signature / Title Date

EMPLOYEE REFERENCE VERIFICATION

I, _____ have applied for employment with Steward Home Health Agency Inc.(the Agency).
I authorize the Agency to collect any information concerning my qualifications and past performance.
Further, I hereby release the company or person completing the form from any liability in supplying the requested information

_____ _____
Signature Date

REFERENCE INFORMATION

Name of Applicant:	**SS#:**	**Phone No:**
Company:		**Company No:**
Company Address:		**Contact Person:**

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY.

Position held: _____ Dates Employed From: _____ To: _____
Reason(s) for leaving: _____
Would you rehire? Yes_____ No _____ If No, Explain:
_____
Employment was verified: __(via telephone) __ (via fax) ___ (via email)

Please check the appropriate rating:

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Quality of Work			
Dependability			
Cooperation			

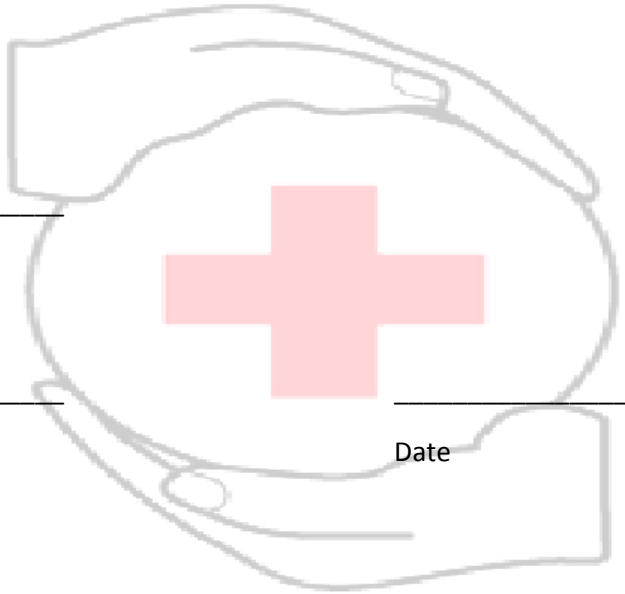
Additional Comments: _____

_____

_____ _____ _____
Signature Title Date

ACCEPTANCE OF EMPLOYMENT

I HAVE BEEN OFFERED, AND ACCEPTED, EMPLOYMENT WITH **STEWARD HOME HEALTH AGENCY INC** AS _____, AND WILL BE COMPENSATED AT THE RATE OF $_____/HR. I WILL ADHERE TO, AND COMPLY WITH, THE TERMS AND CONDITIONS OF EMPLOYMENT AS INDICATED IN THE EMPLOYEE HANDBOOK, MY EMPLOYMENT AGREEMENT, AND VOLUMES 1-13 OF THE AGENCY'S POLICIES AND PROCEDURES, AS APPLICABLE. MY EMPLOYMENT BECOMES EFFECTIVE ON _____ ON AN "AT WILL" BASIS, WHICH MEANS THAT THE EMPLOYEE MAY RESIGN AT ANY TIME, AND THE EMPLOYER MAY DISCHARGE THE EMPLOYEE AT ANY TIME WITH OR WITHOUT CAUSE.



_____

Employee Name (Print)

_____ _____

Employee Signature Date

ORIENTATION CHECKLIST

EMPLOYEE: _____ POSITION: _____

SUBJECT	EMPLOYEE'S INITIAL
Agency Mission and Goals	
Organizational Chart	
Job Description	
Brief Overview of Regulatory Agencies	
Federal Regulations (Medicare Conditions of Participation)	
State Regulations (Title 22)	
Legal and Ethical Documents	
Patient's Rights and Responsibilities	
Confidentiality / Ethics	
Agency Policies and Procedures	
HIPAA Policies and Procedures and HIPAA Forms	
Administrative Policies and Procedures	
Fraud and Abuse	
Infection Control	
Agency Forms – Personnel	
Agency Forms – Medical Records	
Access to Medical Records	
Submission of Visit Notes and Other Required Forms	
Confidentiality and Disclosure of Medical Records	
Contents of Medical Records	
Employee Health	
Safety management	
Hepatitis B Vaccine	
Exposure Control Plan	
Body Mechanics	
Quality Management / Utilization Review	
Human Resources Policies and Procedures	
Employee Handbook	
Environmental Safety	
Advance Directives	
Handling of Hazardous Materials	
Disaster Plan	
Grievance Procedure: Patient / Employee	
Personal Safety / Security	
Performance Evaluation	
Dress Code	
Wages / Salary	
Termination of Employment	
Employee Disciplinary Measures	
Employee Name Tags	
Introduction to Office Personnel	
Introduction to Administrative Department	
Introduction to Medical Records Department	

I certify that I have received orientation and training covering the above subjects:

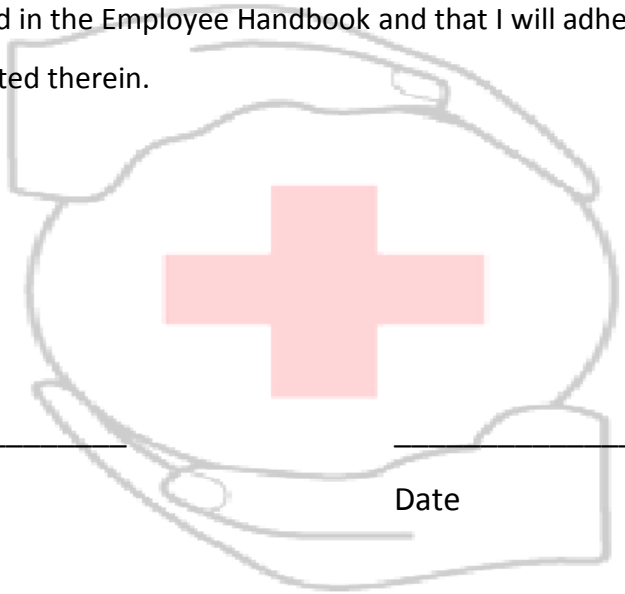
Employee's Signature: _____ **Date:** _____

Trainer's Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE HANDBOOK

This is to acknowledge that I have received a copy of the **STEWARD HOME HEALTH AGENCY INC. EMPLOYEE HANDBOOK** and understand that it sets forth terms and conditions of my employment as well as rights, duties, responsibilities and obligations during my employment with the company.

I further understand and agree that it is my responsibility and obligation to read and familiarize myself with the provisions contained in the Employee Handbook and that I will adhere to, and abide by, the conditions of employment cited therein.



_____ _____

Employee Signature Date

_____ _____

SHHAI Representative Date

Emergency Contact Information

Employee's
Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: **( )** _____ Alternate Phone: **( )** _____

E-mail Address: _____

Social Security Number or Government ID: _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone: **( )** _____

Contact's
Full Name _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: **( )** _____ Alternate Phone: **( )** _____

Relationship: _____

Contact's
Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: **( )** _____ Alternate Phone: **( )** _____

Relationship: _____

Your Allergies or Other Relevant Information:

_____

LICENSE VERIFICATION

Name: _____ Date: _____

License Type: _____

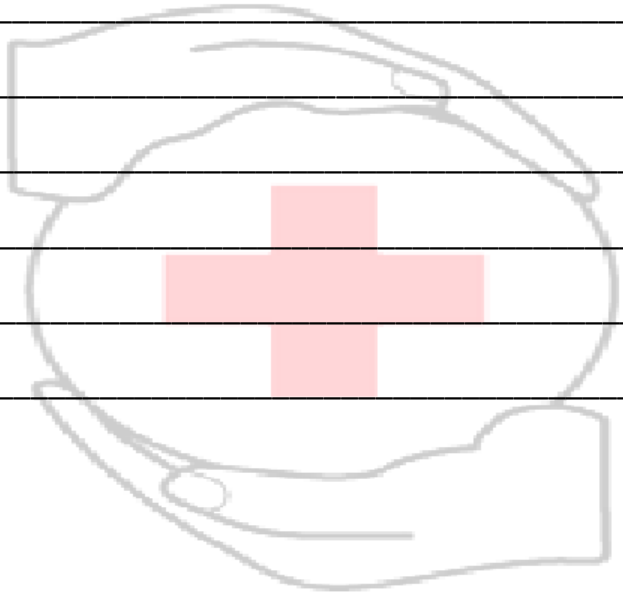
License Number: _____

Issued Date: _____

Expiration Date: _____

Verification Information: _____

County Issued: _____



Verified by: _____

Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING OF POLICIES

1. I acknowledge receipt and understanding of the following:
   A. Employee Handbook
   B. Job Description
   C. Child Abuse and Neglect Reporting Policy and Procedure (if a Clinician)
   D. Elder and Dependent Adult Abuse Reporting Policy and Procedure (If a Clinician)
   E. Confidentiality Policy.

2. I understand that, in accordance with **STEWARD HOME HEALTH AGENCY, INC.** standards and State and Federal regulations, it is my responsibility to provide this Agency copies of my current license, CPR certificate, P.E, and other job related materials, as required.

3. I will submit all required documents to this agency within ten (10) business days from today's date.

I understand that failure to complete submission of required documents and/or materials will prevent me from being hired.

_____ _____

Employee Name SHHAI Representative

_____ _____

Employee Signature/ Date SHHAI Signature/ Date

CHILD and ELDER/ DEPENDENT ADULT

ABUSE ACKNOWLEGEMENT FORM

A. CHILD ABUSE REPORTING

California Penal Code Section 11166.5 requires that all "child custodians, medical Practitioners, and non-medical practitioners" who commence employment on or after January 1, 1985, be provided with the following statement and that the statement be signed by the employee as a perquisite to employment, and retained in his/her personnel records:

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

Definitions

Child Care Custodian- a teacher, administrative officer, supervisor of child, welfare and attendance or certified pupil, personnel employee of any public/private school, and administrator of a public private day camp; a licensee, or an administrator, or an employee of a community care facility licensed to care for children; head start teacher, a licensing worker or licensing worker or licensing evaluator; public assistance worker; employee worker, employee of a child care institution including but not limited to foster parents, group home personnel of residential care facilities; a social worker or probation officer.

Medical Practitioner- a physician, surgeon, psychiatrist, dentist, psychologist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, or any person who is currently licensed under Division 2, commencing with section 500, of the Business and Professions Code; any Emergency Medical Technician I or II paramedic or other person certified pursuant to Division 2.5 commencing pursuant to Section 1797, of the Health and Safety Code, or a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.

Non-medical Practitioner- a State or Country public health employee who treats a minor for any condition; paramedic; marriage/family/child counselor or a religious practitioner who diagnosis or examines or treats children.

B. **ELDER/DEPENDENT ADULT ABUSE REPORTING**

California Welfare and Institutions Code Section 15632, requires all "care custodians" and "health practitioners" who become employees after January 1, 1986, be provided with the following statement and that the statement be signed by the employee as a prerequisite of employment, and retained in his/her personnel records:

"Section 15630 of the Welfare and Institutions Code requires any elder or dependent adult care custodian, health practitioner, or employee of a Country adult protective services agency, or a local law enforcement agency, who in his/her professional capacity or within the scope of his/her employment, either has observed an incident that reasonably appears to be physical abuse has observed a physical injury where the nature of which, and its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred, or is told by elder or dependent adult that he/she has experienced behavior constituting physical abuse, shall report the known or suspected instance either to the long-term care facility or the Country adult protective services agency, or a local law enforcements agency when the abuse is alleged to have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report thereof within thirty six (36) hours."

Definitions

Care Custodian – an administrator or an employee, except persons who do not work directly with elder or dependent adults, as part of their official duties, including members of support and maintenance staff, of any of the following public/private facilities which provide for elders or dependent adults.

1. 24 – Hour health facilities as defined in Sections 1250, 1250.2, & 1250.3 of the Health and Safety Code.
2. Clinic, home health agencies, adult day health care centers, sheltered workshops, camps, respite care centers, and foster homes.
3. Secondary schools which serve 18-22 year old dependent adults; and post secondary institutions which are dependent adults.
4. Community care facilities, and elderly residential care facilities, as defined by Section 1502 and 1569.2 respectively, of the Health and Safety Code.
5. Regional centers for persons with developmental disabilities. State Department of Social Services, and State Department of Health Services licensing divisions.
6. State Department of Social Services, and State Department of Health Services licensing divisions.
7. County welfare departments.
8. Offices of the long-term care ombudsmen, patients rights advocates, public conservations and public guardians.

(CONTINUED)

9. Any other protective or public assistance agency which provides health or social services to elders or dependent adults.

Health Practitioners - a physician, surgeon, psychologist, resident, intern, dental hygienist, podiatrist, chiropractor, licensed nurse, licensed clinical social worker, marriage/family/child counselor, or any person who is currently licensed under Division 2, commencing with Section 500, of the Business and Professions Code; any Emergency Medical technician I or II paramedic or other person certified pursuant to Division 2.5, commencing with Section 1797, of the Health and Safety Code, or a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, or an unlicensed marriage/family/child counselor intern registered under Sections 4980.44 of the Business and Professions Code, state or county public health of social service employee, who treats an elder or dependent adult for any conditions; a coroner, or a religious practitioner who diagnoses/examines/treats elders or dependents adults.

Elder/Dependent Adult - includes any person aged 18 or over.

I have read, understood, and will abide by, the policy described above.

_____ _____

Employee Name (Print) Signature

_____

Date

HEPATITIS B VIRUS CONSENT / DECLINATION

BLOOD BORNE PATHOGENS

I have been informed of the symptoms and modes of transmission of the blood borne pathogens, including Hepatitis B virus [HBV]. I know the facility's infection control program and understand the procedure to follow if an exposure incident occurs.

I understand that the hepatitis B vaccine is available, at no cost, to employees whose job involve the risk of directly contacting blood or other potentially infectious material. I understand that vaccinations shall be given according to recommendations for standard medical practice in the community.

HEPATITIS B VACCINE DECLINATION

Appendix a Section 1910.1030

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus [HBV] infection. I have been given-the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to myself. However, I am declining the Hepatitis B Vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____

Employee Name (Print)

_____ _____

Employee Signature Date

HEPATITIS B VACCINE QUESTIONNAIRE

Please answer the following questions regarding your medical history in reference to Hepatitis B Vaccine. This information will be part of your personnel file. Please contact the office or inform your supervisor in writing should any of the information change in the future.

Should you have any doubt about the answers to any of these questions, please contact your physician before answering them.

1. Have you ever completed a Hepatitis B vaccination series? Yes_____ No _____
2. Has antibody testing revealed you are immune to Hepatitis B? Yes_____ No _____
3. Is the vaccine contraindicated for medical reasons? Yes_____ No _____

I have received a copy of the Hepatitis B Virus Consent/Declination and the Vaccine Declination Forms and have read them.

LAST: _____ FIRST: _____ M.I. _____

SIGNATURE: _____ DATE: _____

TUBERCULOSIS EXPOSURE QUESTIONNAIRE

HISTORY:

Pre-employment PPD Date _____ Results _____ Type _____
Previous PPD Date _____ Results _____ Type _____
Current PPD Date _____ Results _____ Type _____

Known exposure to active TB at work? (Date and circumstances):
_____
_____

Known exposure to active TB at other sites? (From relatives, home, or other employment / list specifications):
_____
_____

History of BCG administration?: _____ Birth Country _____

Years in U.S.A.?: _____

Recent Travel? (Since last PPD):
_____

Symptoms?:

Cough [ ] Yes [ ] No Night Sweats [ ] Yes [ ] No
Weight Loss [ ] Yes [ ] No Undue Fatigue [ ] Yes [ ] No

Chest X-ray results?:
_____
_____

Treatment:
_____
_____
_____
_____
_____

Applicant Name: _____ Date: _____

EMPLOYEE HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Sex: _____ S M W D S: _____

Last First MI

Address: _____ Telephone: _____

Position applied for: _____ Employment Date: _____

Family Physician: _____

Date & Reason for last visit: _____

Family History: Nervous or Mental Illness _____ Diabetes: _____ TB _____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING DISEASE OF? (check "Yes" or "No" box)

Yes	No		Yes	No		Yes	No	
		BRAIN			GENETIALS			CHRONIC CONSIPATION
		EYES			DIZZINESS			BLOOD IN URINE
		EARS			HEADACHES			SWOLLEN ANKLES
		NOSE			DEAFNESS			HIGH BLOOD PRESSURE
		THROAT			RUNNING EARS			JAUNDICE
		HEART			FREQUENT SORE THROAT			HERNIA(Rupture)
		LUNGS			FREQUENT COLDS			STOMACH ULCERS
		STOMACH			FAINTING SPELLS			PNEUMONIA
		INTESTINES			CHEST PAINS			PLEURISY
		LIVER			SHORTNESS OF BREATH			KIDNEY STONES
		SPLEEN			CHRONIC COUGH			PILES
		GALL BLADDER			COUGHING UP BLOOD			FITS OF CONVULSIONS
		KIDNEYS			PALPIPATIONS			TUBERCULOSIS
		BLADDER			ALLERGIES			BRONCHITIS
		BONE			POOR APPETITE			NEPHRITIS
		JOINTS			CHRONIC APPETITE			MALARIA
		BACK (Spine)			RECURRENT NAUSEA			RHEUMATIC FEVER
		SKIN			RECURRENT VOMITING			PARALYSIS
		LYMPH NODES			VOMITING BLOOD			CANCER OR TUMORS
		ASTHMA			HAY FEVER			DIABETES

EMPLOYEE PHYSICAL EXAMINATION

(To be completed by the examining physician)

_____Sex: (M) (F) Marital Status: (S) (M) (D) (Sep)

APPLICANT/EMPLOYEE NAME

Past Medical History:_____

Inquiries: (Request proof of any prior injuries to back, back pain, back problems. Record dates, nature and extent of specific problems)

Family Medical History:_____

CLINICAL EVALUATION	NORMAL	ABNORMAL
Head/Face/Neck/Scalp		
Mouth/Throat		
Eyes - General		
Ears - General		
Lungs & Chest		
Heart		
Vascular System		
Abdomen & Viscera		
Upper/Lower Extremities		

Age_____Ht_____Wt_____

Pulse_____ BP _____/_____

RR_____T_____Repeat_____

Other Findings_____

_____

_____

_____

1. **Does your physical examination of the applicant/employee reveal any physical limitations with respects to:**

Back (Spine): yes_____ no_____ Bending: yes_____no_____ Lifting: yes_____ no_____

**** If yes to any of the above, please describe limitations below.****

(CONTINUED)

2. **Has the applicant/employee had a TB Skin Test:** yes____ no____ Date:_____

Result: positive___ negative___ don't know___ If (+) P*lease indicate size/measurements*:↑ 2 mm ↑ 5 mm ↑ 8 mm ↑ 12 mm

STATEMENT BY EXAMINING PHYSICIAN:

_____NO LIMITATIONS HAVE BEEN FOUND. *Free from health conditions which would interfere with the ability to perform duties*.

_____VERIFIED FREE FROM SYMPTOMS OF INFECTIOUS DISEASE.

THE FOLLOWING LIMITATIONS WERE FOUND:

_____

PHYSICIAN NAME/SIGNATURE:_____

ADDRESS/PHONE NUMBER: _____

CHECKLIST – INDEPENDENT CONTRACTOR FILE

CONTRACTOR: _____ **DATE OF CONTRACT**: _____

POSITION: _____ **DEPARTMENT:** _____

==========

I.	**CREDENTIALS**	**DATE EXPIRED**	**RENEWAL DATE**	**N/A**
I.	Independent Contractor Agreement	_____	_____	_____
	Staff Agreement	_____	_____	_____
II.	Copies of Required Documents			
	A. Professional License License Verification Print-Out Department of Consumer Affairs	_____	_____	_____
	B. Drivers License (DMV)	_____	_____	_____
	C. Car Insurance	_____	_____	_____
	D. Proof of Liability Insurance	_____	_____	_____
	E. Business License	_____	_____	_____
	F. CPR Card	_____	_____	_____

(CONTINUED)

G.	Criminal Background Check	_____	_____	_____
H.	Proof of Citizenship / Permanent Resident Card / Work Permit	_____	_____	_____
	Immigration Form-I9	_____	_____	_____
	Social Security Card / FTIN	_____	_____	_____
	IRS Form-W9	_____	_____	_____
I.	Physical Exam			
	1. C X R every 2 years	_____	_____	_____
	(CONFIDENTIAL ENVELOPE)			
	2. PPD	_____	_____	_____
J.	Hepatitis B Acceptance / Declination	_____	_____	_____
K.	Hepatitis B Vaccine Questionnaire	_____	_____	_____
L.	Tuberculosis Exposure Questionnaire	_____	_____	_____