

SECTION 1

PERSONNEL FOLDER CONTENT

PART ONE

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JOB DESCRIPTION
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EMPLOYMENT VERIFICATION
CRIMINAL HISTORY CHECK
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PERSONNEL EVALUATIONS



PART TWO

(ADDITIONAL PERSONNEL DOCUMENTS)

PART THREE

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SECTION 2

PERSONNEL FOLDER CONTENT



TEXAS DRIVER'S LICENSE/ ID
RN LICENSE
CAN CERTIFICATION/HHA/CNA CARD
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PROOF OF AUTOMOBILE INSURANCE

SECTION 3

PERSONNEL FOLDER CONTENT



PART ONE

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PART TWO

ORIENTATIONS
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CERTIFICATE OF EDUCATION HOURS

SECTION 4

PERSONNEL FOLDER CONTENT



Authorized Personnel Only

TB/ CHEST X-RAY
AIDS/ HEP DOCUMENTS
ALL ADDITIONAL MEDICAL RECORDS

INFUSION XPERTS PLLC
Application for Employment

It is this facility's policy to provide equal employment opportunities without regard to race, color, religion, sex, national origin, age or disability.

Applicant Name: _____ Date of Birth: _____

Present Address: _____

Phone: _____ Social Security Number: _____

Are you at least 18 yrs old? ☐ Yes ☐ No Position Applying For: _____

☐ Full Time ☐ Part Time ☐ Per Visit ☐ Pool Shift: ☐ Day ☐ Night ☐ Evening ☐ Weekends

Salary Requirements: _____ Date Available: _____

If you are not a US Citizen have you the legal right to remain permanently in the US? ☐ Yes ☐ No

Do you have adequate means of transportation to get to work on time each day and when called in on short notice during normal working hours? ☐ Yes ☐ No

Have you been convicted of a crime (excluding misdemeanors and traffic offenses) and/or released from confinement following a conviction for any criminal offense within the past 7 years? ☐ Yes ☐ No If Yes, please give date, place and nature of each such conviction. _____

Are you presently charged with any violation of the law other than traffic violation? ☐ Yes ☐ No If Yes please give date, place and nature of each such conviction. _____

Educational History

| Type of School | Name and Location of School | Circle Last Year Attended | Graduated | Degree |
|----------------|-----------------------------|---------------------------|-----------|--------|
| High School | | 9 10 11 12 | | |
| College | | 1 2 3 4 | | |
| Other | | From: To: | | |

List professional licenses you possess. Indicate type of license, number and state _____

List any membership in professional organizations, honors or activities which you feel would enhance your application, excluding those that would indicate race, color, religion, sex, national origin or disability. _____

List languages spoken other than English: _____

List other skills applicable to the position for which you are applying, including computer experience, typing speed, etc: _____

In case of an emergency notify: _____ Phone: _____

Name: _____

Work History

Attach an additional sheet listing other work experience pertinent to the position for which you are applying if the space below is insufficient.

| | | | |
|---|--|---------------------|--|
| Company Name | Complete Address | Phone Number | Supervisor's Name |
| Date Started: Date Left: | Type of Business: Salary: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Per Visit | Reason for Leaving: | Ok to Contact Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Describe your job title, responsibilities, and accomplishments. | | | |
| Company Name | Complete Address | Phone Number | Supervisor's Name |
| Date Started: Date Left: | Type of Business: Salary: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Per Visit | Reason for Leaving: | Ok to Contact Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Describe your job title, responsibilities, and accomplishments. | | | |
| Company Name | Complete Address | Phone Number | Supervisor's Name |
| Date Started: Date Left: | Type of Business: Salary: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Per Visit | Reason for Leaving: | Ok to Contact Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Describe your job title, responsibilities, and accomplishments. | | | |
| Company Name | Complete Address | Phone Number | Supervisor's Name |
| Date Started: Date Left: | Type of Business: Salary: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Per Visit | Reason for Leaving: | Ok to Contact Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Describe your job title, responsibilities, and accomplishments. | | | |

Name: _____

| Personal References | | |
|---------------------|-------|--------------|
| Name | Phone | Relationship |
| 1. | | |
| 2. | | |

Please review and sign

In making application for employment:

- I certify that the information in this application is true and complete for all practical purposes. It may be verified by the facility or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the facility or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate discharge without recourse.
- I understand that an investigative report may be made by a consumer reporting agency to include as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I understand that I will receive notice that such report has been requested, and that I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.
- I understand and agree that I am offered employment will be for no definite term and that either I, or the facility will have the right to terminate the employment relationship at any time, with or without cause, and specific as to all material terms and is signed by me and the Administrator of the facility.
- I understand, if I am an unlicensed person who has direct patient contact, that the agency will perform a criminal history check per State Regulations.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant Signature: _____

Date: _____

| | | | | |
|------------------------|---------------------------------------|--|------------------------------------|---|
| FOR OFFICE USE ONLY | <input type="checkbox"/> Interview(s) | <input type="checkbox"/> References Checked | If Hired: Position: Start Date: | Salary: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Per Visit |
|------------------------|---------------------------------------|--|------------------------------------|---|

Pre-Employment Interview:

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____, have been notified that a Computerized Criminal History (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints and pay a fee of \$9.95 to the fingerprinting services company, L1 Enrollment Services.

Once this process is completed and the agency receives the date from DPS, the information on my fingerprint criminal history record may be discussed with me.

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

Signature of Applicant or Employee

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: _____

Hire _____ Not Hired _____ _____ initial

Date Printed: _____ _____ initial

Destroyed Date: _____ _____ initial

Retain in your files

INFUSION XPERTS PLLC

Statement of Employability

By execution of this document, I _____, hereby acknowledge that I have been informed by **INFUSION XPERTS PLLC** that a criminal history check will be performed on my name. I have informed this agency of all names (i.e. maiden name aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary or interim pending the results of the criminal history check.

I hereby profess that I have not been convicted of any of the following crimes which are a permanent automatic bar to employment by this agency:

- An offense under Section 19, Penal Code (criminal homicide);
- An offense under Section 20, Penal Code (kidnapping and false imprisonment);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.11, Penal Code (indecent with a child);
- 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 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering); and
- An offense under Section 35A.02, Penal Code (Medicaid fraud); and
- An offense under Section 42.09, Penal Code (cruelty to animals); or
- A conviction under the laws of another state, federal law, or Uniform Code of Military Justice for an offense containing the elements that are substantially similar to the elements of an offense listed above.

I also profess that I have not been convicted of any of the following crimes within the past 5 years (applicable only those hired on or after September 1, 2007 unless otherwise noted):

- An offense under Section 22.01, Penal Code (assault punishable as a Class A Misdemeanor or felony) [applicable to those hired on or after September 1, 2003];
- An offense under Section 30.02, Penal Code (burglary) [applicable to those hired on or after September 1, 2003];

- An offense under Chapter 31, Penal Code (theft punishable as a felony) [applicable to those hired on or after September 1, 2001]
- 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) [applicable to those hired on or after September 1, 2003]
- An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or felony) [applicable to those hired on or after September 1, 2003];
- An offense under Section 37.12, Penal Code (false identification as peace officer); or
- An offense under Section 42.01 (a)(7), (8), or (9), Penal Code (disorderly conduct).

I understand that I have been placed on deferred adjudication community supervision for an offense listed above, successfully completed the period of deferred adjudication community supervision, and received a dismissal and discharge according to Section 5 (c), Article 42.12, 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 also 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

Printed Name

Date

INFUSION XPERTS PLLC

STAFF EVALUATION

Staff Person's Name: _____ Date of Evaluation: _____

☐ Annual ☐ 3 Month ☐ 6 Month ☐ Probation ☐ Other: _____

Strengths: _____

Growth Areas: _____

Comments on Client Care: _____

Comments on Documentation: _____

Comments on Clinical Skills: _____

Comments on Infection Control, Safety: _____

General Comments/ Recommendations: _____

Evaluator: _____ Date: _____

INFUSION XPERTS PLLC

SUBJECT: SECURITY INSPECTIONS AND POSSESSION OF PROHIBITED ARTICLES

NUMBER: 330

POLICY STATEMENT

- **INFUSION XPERTS PLLC** wishes to maintain a work environment free of illegal drugs, alcohol, firearms, weapons, explosives, or other improper materials. To this end, **INFUSION XPERTS PLLC** prohibits the possession, transfer, sale, or use of such materials on its premises. **INFUSION XPERTS PLLC** requires the cooperation of all employees in administering this policy.
- Desks and other storage areas may be provided for the convenience of employees, but remain the sole property of **INFUSION XPERTS PLLC**. Accordingly, they, as well as containers or articles found in them, can be inspected by any representative of **INFUSION XPERTS PLLC** at any time, either with or without prior notice. Containers are subject to search whether or not they are locked.
- Additionally, employees may be asked to submit to a search of any vehicle brought onto **INFUSION XPERTS PLLC** or **INFUSION XPERTS PLLC** clients' premises.
- Any employee who wishes to avoid inspections of any articles or materials should not bring such items onto **INFUSION XPERTS PLLC** or **INFUSION XPERTS PLLC** clients' premises.
- Refusal to consent to a search or inspection will result in disciplinary action, up to and including discharge. The possession, transfer, sale, or use of the aforementioned prohibited materials, as set out in this policy will also result in disciplinary action, up to and including discharge.

PURPOSE:

- To provide a safe working environment for employees.

PROCEDURE:

- Upon hiring, the new employee will be informed of the policy and given a copy of the policy.
- The disciplinary procedure will be utilized for any violations of the policy. Suspension without pay and/or immediate termination may be utilized.

Name of Employee

Date

Signature of Employee

INFUSION XPERTS PLLC

AN EQUAL OPPORTUNITY EMPLOYER

It is the policy of **INFUSION XPERTS PLLC** to provide employment opportunities without regard to race, religion, sex, national origin, age, handicap, or veteran status.

PROFILE

Name: _____
Address: _____
Phone: _____ Fax: _____
Mobile: _____ Alt #: _____

ALTERNATE CONTACT INFORMATION

Name: _____
Address: _____
Phone: _____ Fax: _____
Mobile: _____ Alt #: _____

EMPLOYEES ORIENTATION

| | Initial | Date |
|--|---------|-------|
| MISSION STATEMENT, PHILOSOPHY, OBJECTIVE | _____ | _____ |
| WELCOME LETTER | _____ | _____ |
| CERTIFICATION & CONTRACT AGREEMENT | _____ | _____ |
| BUSINESS CARDS | _____ | _____ |
| COMPANY HANDBOOK | _____ | _____ |
| RULES OF CONDUCT | _____ | _____ |
| CONFIDENTIALITY AGREEMENT | _____ | _____ |
| SCOPE OF SERVICES | _____ | _____ |
| COMMUNICATION W/ CLIENT POLICY | _____ | _____ |
| NON-COMPETE POLICY | _____ | _____ |
| SUBSTANCE ABUSE POLICY | _____ | _____ |

ABUSE NEGLECT & EXPLOITATION ACKNOWLEDGEMENT

I, _____, acknowledge reading and understanding the policy and procedure of **INFUSION XPERTS PLLC**, regarding Abuse, Neglect, and Exploitation and agree to comply with and be bound by, the policy.

INVOLUNTARY TERMINATION POLICY

POLICY:

All termination will be done by the Administration based on recommendations from supervisor.

PURPOSE:

To maintain compliance with agency policies

PROCEDURE:

- 1) Disciplinary policy must be followed
- 2) All violators and reprimands with employee must be documented in employee file.
- 3) Employee file and documentation must be submitted to the Administrator.
- 4) Attachment must be completed and submitted to the Administrator.

SUBSTANCE AND ABUSE POLICY NOTIFICATION

POLICY:

INFUSION XPERTS PLLC does not drug test its employees: however, the agency prohibits employees to possess, distribute and/or use alcoholic beverages or controlled substances, including inhalants while on premises of property controlled by **INFUSION XPERTS PLLC**, or while in the course of conducting company business or engaged in any company sponsored activity. Further, it shall be prohibited for any client or visitor to possess, distribute and/or alcoholic beverages or controlled substances while on the premises of the property controlled by **INFUSION XPERTS PLLC**.

PROCEDURE:

Any employee who has knowledge of person violating the policy must report it to his/her supervisor immediately. Based on reasonable cause, the company may conduct searches or inspections of an employee person or personal effect.

The Substance Use and Abuse Policy and Procedure above has been presented and explained to me. I hereby acknowledge that I, _____ (print employee's name) understand and agree to comply with the Substance Use and Abuse Policy.

SAFETY POLICY

I, _____, have successfully & thoroughly read the Department Safety Manual and/or general information on safety. I am aware that **INFUSION XPERTS PLLC**, policy requires annual retaining on all new policies/revisions related to the Department Safety Manual.

Employee Signature

Date

Orientation/Safety Coordinator Signature

Date

GROUNDS FOR IMMEDIATE TERMINATION

- 1) Forgery or falsification of any document (i.e., license, health card, charting, etc.)
- 2) Working under the influence of drugs and alcohol.
- 3) Forgery of timesheets.
- 4) Violation of Code of Ethics.
- 5) Theft or property from patient, co-worker, or company
- 6) Unsatisfactory job performance.
- 7) Neglect of person (client) property or injury of patient.
- 8) Accepting money.
- 9) Disclosing any information concerning a patient condition, treatment, personal affairs, or records to anyone other than authorized users.
- 10) Carrying a weapon.
- 11) Abuse of service time or property.
- 12) Insubordination
- 13) Arrest or conviction of felony, drug possession
- 14) Misrepresentation of the service
- 15) Discussion of fellow employees with possession.
- 16) Failure to satisfy poor job performance within reasonable time frame.
- 17) Malpractice
- 18) Performance outside of job description
- 19) Solicitation of employment to patients by employee.

This list is not all-inclusive, **INFUSION XPERTS PLLC**, reserves the right of immediate dismissal for any reasonable cause.

EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedures manuals are available and that it is my responsibility to read, and understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure and Abuse, Neglect, and Exploitation and agree to comply with and be bound by the Policy.

I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force of any vehicle I use for the conduction of Agency business during the term of my employment. The agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and State and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time-sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meetings and in-service training. Home Health Aides are required to have 12 hours of in-service training annually.

I understand that I must submit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided.

I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis, information concerning child abuse, mental health, drug or alcohol abuse is protected under law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individuals written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of client/employment confidentiality is subject to civil and criminal penalties.

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

To insure the Agency is in compliance with the HIPAA regulations and to ensure the protection to Protected Health Information (PHI) and the prevention of unauthorized use the Agency will authorize those persons allowed having access to PHI. The Agency must be what is minimally necessary to perform/ carry out the job duty/ function.

By signing this agreement, I agree to comply with the Agency's policies and procedures pertaining to PHI. Failure to do so will result in progressive disciplinary action including termination as applicable.

EMPLOYEE SIGNATURE IDENTIFICATION FOR CLINICAL RECORDS

Employee Name: _____

Print Name: _____

Script Signature: _____

Print Initials: _____ Script Initials: _____

The above information is strictly for the use of the Clinical Record Department and will be maintained ion that department.

REQUIRED DOCUMENTS

The agency requires copies of the following documents prior to providing patient assignment.

Driver's License

Social Security Card

Proof of Auto Insurance

Skilled Licensure

Certification (In-service Records)

Additional Documents to complete Not Limited to:

I-9, W-4, W-9

AVAILABILITY

Week Days Preferences

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------|--------|---------|-----------|----------|--------|----------|
| | | | | | | |

☐ Part-Time ☐ Full-Time ☐ Days ☐ Evenings ☐ Nights

EMPLOYMENT HISTORY

IMPORTANT! LIST IN CONSECUTIVE ORDER ALL EMPLOYMENT YOUR PRESENT OR MOST RECENT EMPLOYER. ALL SECTIONS MUST BE COMPLETED. ADDITIONAL EMPLOYMENT MAY BE LISTED ON SEPARATE PAGE(S) IF NECESSARY. **MUST HAVE TWO (2) GOOD REFERENCES**
PRESENT OR MOST RECENT EMPLOYER

| | | | | | |
|---|--|--|--|---------------|----|
| FULL NAME OF COMPANY | | | TELEPHONE | EMPLOYED FROM | TO |
| STREET ADDRESS STATE ZIP CODE | | | BEGINNING SALARY ENDING SALARY | | |
| NAME & TITLE OF SUPERVISOR | | | DEPARTMENT TITLE OF YOUR POSITION | | |
| REASON FOR LEAVING | | | | | |

PREVIOUS EMPLOYER

| | | | | | |
|---|--|--|--|---------------|----|
| FULL NAME OF COMPANY | | | TELEPHONE | EMPLOYED FROM | TO |
| STREET ADDRESS STATE ZIP CODE | | | BEGINNING SALARY ENDING SALARY | | |
| NAME & TITLE OF SUPERVISOR | | | DEPARTMENT TITLE OF YOUR POSITION | | |
| REASON FOR LEAVING | | | | | |

OTHER EMPLOYMENT

LIST PART-TIME EMPLOYMENT WHILE IN SCHOOL, INCLUDING COMPANY NAME(S) ADDRESSES, DATES OF EMPLOYMENT:

HAVE YOU EVER BEEN SUSPENDED, PLACED ON PROBATION, ASKED TO RESIGN, DISCHARGED OR TERMINATED? _____

IF YES, PLEASE EXPLAIN: _____

SKILLS

Indicate Experience in Years or Months for Each Area: (✓)

| TITLE | YEARS/MTHS | TITLE | YEARS/MTHS | TITLE | YEARS/MTHS |
|--|------------|--|------------|---|------------|
| <input type="checkbox"/> ACCOUNTING _____ | | <input type="checkbox"/> BILLING _____ | | <input type="checkbox"/> MEDIA RELATION _____ | |
| <input type="checkbox"/> BOOKKEEPING _____ | | <input type="checkbox"/> IC D-9 CODING _____ | | <input type="checkbox"/> ADVERTISING _____ | |
| <input type="checkbox"/> PAYROLL _____ | | <input type="checkbox"/> MARKETING _____ | | <input type="checkbox"/> MANAGEMENT _____ | |

List All Other Skill You Have That May Be of Value to The Company Such as Programming, Etc.

Computer Skills ☐ Yes ☐ No ☐ Hardware ☐ Software WPM _____

Indicate Short-Term Goal(s) _____

Indicate Long-Term Goal(s) _____

Describe Your Ideal/Dream Job _____

PERSONAL INFORMATION

| | | | |
|--|-------|---|--|
| Last Name | First | Initial | Social Security # |
| Street Address | | | Home Telephone# |
| City, State, Zip | | | Cellular/Alternate # |
| Referred By | | | Indicate Title (✓) <input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> Aide <input type="checkbox"/> Other (indicate) |
| Are you legally able to be Employed in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Do you have a Criminal History? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, Explain |

GENERAL INFORMATION

Position of Interest _____ Desired Salary _____ Possible Start Date _____

HOW DID YOU HEAR ABOUT COMPANY? _____ ADVERTISEMENT (specify): _____

PLACEMENT FIRM (firm name): _____ OTHER: _____

ARE YOU WILLING TO WORK ANY SHIFT, INCLUDING NIGHTS AND WEEKENDS? ☐ YES ☐ NO

HAVE YOU EVER BEEN EMPLOYED BY THE COMPANY? _____ IF SO, WHEN? _____ POSITION _____

ARE ANY RELATIVES, INCLUDING IN-LAWS, EMPLOYED AT THE COMPANY? _____

IF YES, GIVE NAME, REALTIONSHIP, POSITION AND LOCATION: _____

HAVE YOU EVER PREVIOUSLY APPLIED FOR EMPLOYMENT AT THE COMPANY? _____ IF SO WHEN? (MO.) _____ (YR.) _____

EDUCATION INFORMATION

| SCHOOLS/ ED INSTITUTIONS | YEARS ATTENDED | GRADUATED | INDICATE ONE | MAJOR STUDIES |
|-----------------------------|----------------|--|------------------------------------|---------------|
| HIGH SCHOOL | | <input type="checkbox"/> YES <input type="checkbox"/> NO | CERTIFICATION DIPLOMA DEGREE | |
| COLLEGE/UNIVERSITY | | <input type="checkbox"/> YES <input type="checkbox"/> NO | CERTIFICATION DIPLOMA DEGREE | |
| VOCATIONAL, BUSINESS, OTHER | | <input type="checkbox"/> YES <input type="checkbox"/> NO | CERTIFICATION DIPLOMA DEGREE | |

LIST ANY SCHOLARSHIPS, ACADEMIC HONORS, AWARDS OR SPECIAL ACHIEVEMENTS:

I HEREBY CERTIFY that my answers to the foregoing questions are true and complete and that I have not knowingly withheld any facts, circumstances or other information, which would, if disclosed, affect my application. I further understand that any false or misleading statement or omission of pertinent information will result in the rejection of my application, or in dismissal if discovered subsequent to my employment.

I HEREBY AFFIRM that by execution of the application, I acknowledge that the Company has disclosed to me that a Criminal History check, including information as to my character, general reputation, personal characteristics, and mode of living may be made; and that I, upon written request to the Company made within a reasonable time after the date of this application, may obtain a complete and accurate disclosure of the nature and scope of the investigation requested.

I HEREBY AUTHORIZE the Company to request, and **I ALSO AUTHORIZE AND REQUEST** each former employer, school attended, and each person, firm, or corporation given as references above, to furnish at any time, any information which may be sought concerning me and my work habits, character or skill, and any other data required, whether in connection with this application on for purposes of complying with surety company requirements or otherwise.

I HEREBY AFFIRM that by submitting this application I agree to submit to medical evaluations and/or examinations, including tests for the presence of illegal drugs or alcohol, prior to and during employment, within a tie period prescribed by the Company and as often as directed during employment.

I UNDERSTAND that should I be given employment, such employment shall be for an indefinite period of time and may be terminated, at will, at any time, for any reason, by me or by the Company without notice or without liability whatsoever, except for unpaid wages or salary earned by the date of termination. I further understand that only **INFUSION XPERTS PLLC** has the authority to enter into any agreement for employment for a specified period of time or to make any agreement contrary to this at will standard and that any such agreement must be in writing.

I UNDERSTAND that if I am employed, this application, the Company's Terms of Employment, and Policy and Procedures will govern the terms and conditions of my employment, as amended from time to time by the agency.

The Company operates under the principles of affording equal employment opportunity through affirmative action for qualified handicapped individuals, qualified veterans of the Vietnam era and qualified disabled veterans.

All applicants who believe they to be members of one or more of these groups, and who wish to identify themselves as such for the purpose of affirmative action consideration are invited to do so.

Submission of this information is voluntary and refusal to provide it will not subject you to discharge or disciplinary treatment. Information obtained concerning individuals shall be kept confidential, except t hat (1) supervisors and managers may be informed regarding disabled veterans and handicapped individuals, as necessary, (2) first aid and safety personnel may be informed, when and to the extent appropriate, if the condition might require emergency treatment, and (3) governmental officials investigating compliance will be informed.

I wish to volunteer the following information (check one) _____ I do not qualify
I do qualify under the following: _____ Handicapped
_____ Vietnam Era Veteran
_____ Disabled Veteran

Signature

Date

Thank you for completing this application. It will remain under consideration for six months. It will not be necessary for you to reapply during this six-month period. Your interest in **INFUSION XPERTS PLLC** is appreciated.

INFUSION XPERTS PLLC
REFERENCE CHECK
PHONE: (832) 369 – 6811 FAX: (713) 981 – 1811

Applicant Name

SS#

Company: _____

Contact: _____

Employment Dates: _____

Eligible For Rehire? ☐ YES ☐ NO

Position Held: _____

Salary: _____

Terminated/ Separation due to _____

Please indicated below with a (v)

Quality of work ☐ Exceptional ☐ Satisfactory ☐ Poor

Attitude ☐ Exceptional ☐ Satisfactory ☐ Poor

Attendance ☐ Exceptional ☐ Satisfactory ☐ Poor

Completed By

Date

INFUSION XPERTS PLLC to Complete Below this Line

Method of Verification: ☐ Telephone ☐ Fax ☐ Mail

Verified By

Title

Date

INFUSION XPERTS PLLC
REFERENCE CHECK
PHONE: (832) 369 – 6811 FAX: (713) 981 – 1811

Applicant Name

SS#

Company: _____

Contact: _____

Employment Dates: _____

Eligible For Rehire? ☐ YES ☐ NO

Position Held: _____

Salary: _____

Terminated/ Separation due to _____

Please indicated below with a (v)

Quality of work ☐ Exceptional ☐ Satisfactory ☐ Poor

Attitude ☐ Exceptional ☐ Satisfactory ☐ Poor

Attendance ☐ Exceptional ☐ Satisfactory ☐ Poor

Completed By

Date

INFUSION XPERTS PLLC to Complete Below this Line

Method of Verification: ☐ Telephone ☐ Fax ☐ Mail

Verified By

Title

Date

INFUSION XPERTS PLLC

SUBJECT: EMPLOYEE SAFETY

NUMBER: 513

POLICY STATEMENT

During orientation and at least annually, thereafter, staff members will be instructed on the appropriate safety measures to be used during home visits.

- When making home visits, staff members will not carry valuables or large sums of money on their persons or into client homes. Any necessary personal identification will be locked in the trunk of the automobile, if possible or carried in a belt pack.
- Staff members will not go unescorted into areas where there are known drug trafficking or other known or suspected unsafe areas.
- Staff members should request escort service for visits on which they feel unsafe. The supervisor will arrange for a buddy systems or other escort as appropriate.
- Staff members will not carry concealed weapons. However, they may carry pepper sprays or other deterrents as desired.
- Staff members will carry maps and have clear directions for locations of home visits.
- Staff members will carry medical supplies out of visual sight, such as in the trunk of the automobile.
- Staff will lock their vehicle during home visits to maintain security of supplies and confidentiality of client information.
- Staff will request that clients and family members keep dangerous animals chained during home visits if animals are not adequately restrained or if the patient refuses to do so, a home visit will not be made.
- Home visits will not be made to patients' homes where there are weapons in sight; if the client and/or a family member threaten staff or are verbally abusive; or if the staff member feels unsafe.
- When making on-call visits after dark, staff members will notify the answering service, a supervisor, or a family member of their presence and expected return.
- Staff members wear **INFUSION XPERTS PLLC** identification and appropriate attire for all home visits.

PURPOSE:

- To provide guidelines to staff members for their safety while making home visits.

PROCEDURE:

- Safety measures for use by staff members are presented during the general orientation for each new employee.
- Specific safety measures for a particular branch are included in that branch's orientation.
- Annual in-services are offered for all staff members.
- Occasional articles regarding safety policies and procedure are included in the employee newsletter.

Name of Employee

Date

Signature of Employee

INFUSION XPERTS PLLC

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI)

It is both the agency and employees' responsibility to ensure that every patient's health information is protected at all time. By signing below you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health Information (PHI) will be provided to you upon hire.

I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for sue and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rules and Regulations.

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employee with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in an enclosed envelop when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it's conducted in a private area.
- Patient Protected Health Information will be returned to the agency upon acknowledgment of the patient being discharged.

I pledge to make every effort to keep patient's PHI protected at all times.

Employee Name

Date

Employee Signature

INFUSION XPERTS PLLC

ORIENTATION DOCUMENTATION ON HIPAA COMPLIANCE

It is the policy of this agency to ensure that every employee understands that guidelines of contact with Protected Health Information. This agency strictly enforces rules and regulations of HIPAA. Signing this form indicates that you have been oriented on HIPAA per the agency's policy.

Employee Name

Date

Employee Signature

INFUSION XPERTS PLLC

SUBJECT: NON-DISCRIMINATION POLICY

NUMBER: 325

POLICY STATEMENT

INFUSION XPERTS PLLC will comply and incorporate the non-discrimination protocol onto its policies and procedures.

PURPOSE:

- To ensure **INFUSION XPERTS PLLC** policy statement meets the DADS requirements.
- To ensure compliance with the U.S. Department of Health & Human Services Requirements.
- **INFUSION XPERTS PLLC** will comply with The Department of Aging & Disability Services for development and the implementation of a nondiscrimination policy statement.
- **INFUSION XPERTS PLLC** will implement The Department of Aging & Disability Services requirements as outlined.

NON-DISCRIMINATION POLICY

- In accordance with Title VI of the Civil Rights Act of 1964 and the implementation of the regulations, **(Name of the agency)** will not, directly or through contractual arrangements, discriminate on basis of race, color, or national origin in its admissions or its provision of services and benefits, including assignments or transfers or referrals to or from **INFUSION XPERTS PLLC**. Staff privileges are granted without regard to race, color, or national origin.
- In accordance with section 504 of the rehabilitation Act of 1973 and the implementation of these regulations, **INFUSION XPERTS PLLC** will not, directly or indirectly through any contractual arrangements, discriminate on the basis of disability in admissions, access treatment or employment, Director of Nursing, has been designated as the coordinator for the implementation of this policy.
- In accordance with the Age Discrimination Act of 1975 and its implementing regulation, **INFUSION XPERTS PLLC** will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services, unless age is factor necessary to normal operations or the achievement of any statutory objective.
- In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact **INFUSION XPERTS PLLC's** administrator, _____, at _____.
- A copy of **INFUSION XPERTS PLLC** nondiscrimination policy is posted in its facility for visitors and clients to view.
- **INFUSION XPERTS PLLC's** nondiscrimination policy is printed in the company admission booklet and is routinely distributed to patients, referral sources and the community.
- A copy of **INFUSION XPERTS PLLC's** nondiscrimination statement is available upon request.
- **INFUSION XPERTS PLLC** posts its nondiscrimination policy in all company brochures and advertisements.

Date: _____

Name of Employee: _____

Signature of Employee: _____

Title: _____

INFUSION XPERTS PLLC

HEPATITIS B VIRUS (HBV) VACCINATION CONSENT FORM/ STATUS RECORD

INITIAL EACH APPLICABLE STATEMENT:

- ☐ I understand that the nature of my job makes it reasonably anticipated that I may have percutaneous, mucous membrane or non-intact skin exposure to blood or other potentially infectious body fluids in the course of my work. Therefore, I am entitled to receive the HBV vaccine series at no cost to me, at a reasonable time and place, and during work hours. I understand that taking the HBV vaccine will reduce the risk of developing serious liver disease as a result of occupational exposure to HBV.
- ☐ I understand that my decision to accept or decline HBV vaccine will not affect my employment or any benefits available to me through my employment.
- ☐ I elect to receive the HBV vaccination series provided to me by Name of Agency I understand that by receiving the vaccine series I have a 90 percent assurance of immunity against the virus.
- ☐ I have received training on the risk of infection with HBV on the job and have given the opportunity to be vaccinated with HBV vaccine. However, I decline HBV vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring HBV, a serious disease. If in the future I continue to be at risk of occupational exposure to blood or other potentially infectious body fluids, and I want to be vaccinated with HBV vaccine I can receive the vaccine at no charge to me.
- ☐ I have previously received the complete 3-dose series of HBV vaccine. My third injection of vaccine was on _____.
- ☐ Antibody testing (anti-HBs or anti-HBc) has revealed that I am immune to HBV.
- ☐ The HBV vaccine is contraindicated for medical reasons as evidenced by the attached statement from my physician.
- ☐ Antibody testing (anti-HBs) after the primary series of HBV vaccine and at least one booster indicates that I am a non-responder to HBV vaccine.

Employee Signature

Date

Witness Signature

Date

INFUSION XPERTS PLLC

Name of Employee _____ had a chest xray

Date _____ Negative _____ Positive for TB

Have you had any symptoms of:

- _____ Excessive sneeze or cough
- _____ Excessive sweat
- _____ Excessive chills
- _____ Excessive fever
- _____ Excessive loss of weight
- _____ Excessive pain in the chest
- _____ Weakness or fatigue
- _____ No appetite
- _____ Coughing blood or green sputum

Employee Signature

Date

Supervisor Signature

Date

INFUSION XPERTS PLLC

ANNUAL AFFIRMATION OF COMPLIANCE AND DISCLOSURE STATEMENT

I have received and carefully read the Conflict of Interest Policy for trustees, employees, consultants, vendors and volunteers of **INFUSION XPERTS PLLC** and have considered not only the literal expression of the policy, but also its intent. By signing this affirmation of compliance, I hereby affirm that I understand and agree to comply with the Conflict of Interest Policy.

Except as otherwise indicated in the Disclosure Statement and attachments, if any, below, I hereby state that I do not, to the best of my knowledge, have any conflict of interest that may be seen as competing with the interests of the **INFUSION XPERTS PLLC**, nor does any family member or business associate have such an actual or potential conflict of interest.

If any situation should arise in the future which I think may involve me in a conflict of interest, I will promptly and fully disclose the circumstances to the Chairman of the Board of Trustees or to the Administrator of **INFUSION XPERTS PLLC** as applicable.

I further certify that the information set forth in the Disclosure Statement and attachments, if any, is true and correct to the best of my knowledge, information and belief.

Name (Please Print)

Signature

Date