PERSONNEL FILE SECTIONS

EMPLOYEE Personnel File

Name_____ Date of Hire _____

Position Held_____

	Car Insurance Expiration	**Driver's License** Expiration	**Hire/Annual Competency Evaluation**	**90 Day Performance Evaluation**	**1 Year Performance Evaluation**	**Professional's License Expiration**	**CPR Expiration Date**	**Background Check**	**Misconduct**
Compliance Date									
Compliance Date									
Compliance Date									
Compliance Date									
Compliance Date									
Compliance Date									
Compliance Date									
Compliance Date									
Compliance Date									

PERSONNEL FILE SECTIONS

SECTION 1

- **EMPLOYMENT APPLICATION**
- **RESUME**
- **INTERVIEW REVIEW**
- **TWO REFERENCES**
- **NEW HIRE FORM**

SECTION 2

- **LICENSE COPY/VERIFICATION**
- **DIPLOMA/DEGREE TRANSCRIPT**
- **SOCIAL SECURITY CARD**
- **CPR CARD**
- **DRIVER'S LICENSE**
- **AUTO INSURANCE**

SECTION 3

- **ORIENTATION CHECKLIST**
- **JOB ACCEPTANCE STATEMENT**
- **JOB DESCRIPTION**
- **EMPLOYEE EMERGENCY CONTACT FORM**
- **PERFORMANCE EVALUATION**
- **SKILLS COMPETENCY EVALUATIONS**
- **CORPORATE COMPLIANCE STATEMENT**
- **COUNSELING/DISCIPLINARY ACTIONS**

SECTION 4

- **INSERVICES (HIPAA, Blood borne Pathogens, Medical Device Reporting, Infection Control, TB-Respiratory Disorders)**
- **CEUS (HIV/AIDS for HHA/CNA; 2 hour CEU on Alzheimer's disease for all direct care givers)**
- **CLASS CERTIFICATES**

SECTION 5

- **CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION**
- **FIELD PRACTICES STATEMENT**
- **CONFIDENTIALITY STATEMENT**
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- **PROTECTIVE EQUIPMENT STATEMENT**
- **EXIT INTERVIEW**

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SECTION 7

- **ANYTHING HEALTH RELATED**
- **IMMUNIZATIONS**
- **HEPATITIS DECLINATION/ACCEPTANCE**
- **CRIMINAL HISTORY CHECK/FORMS**
- **OTHER CONFIDENTIAL INFORMATION**

SEPARATE FILE

- **ALL I – 9s / ALPHABETIZED IN ONE FOLDER**

SECTION 1

- ☐ **EMPLOYMENT APPLICATION**
- ☐ **RESUME**
- ☐ **INTERVIEW REVIEW**
- ☐ **2 REFERENCES**

APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural origin or handicap. All information provided herein will be kept confidential.

PERSONAL

Last Name	**First**	**Middle**	**Date**
Street Address			**Home Phone**
City, State, Zip Code			**Business Phone**
S.S. #			**Date of Birth**

Emergency contact (person not living with you)_____

Have you ever applied for employment with this Agency? _____Yes _____ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____ No

How did you learn of our organization? ____ Newspaper Ad ____Agency employee _____Other

Are you willing to work: _____Evenings? _____Weekends?

Position applying for: _____

EDUCATION:

School Name	Location of School	Course of Study	Years of	Degree/ Study
Diploma College:				
Vo-Tech or Trade:				
High School:				
Other:				

Employment:
--List the last five years employment history, starting with the most recent employer.

1. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

2. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

3. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____

APPLICATION FOR EMPLOYMENT

Was your last name different from your present name during the above listed jobs?
Yes_____ No_____

If Yes, what was your name? _____

Are you currently employed? Yes _____ No _____

Do you have reliable transportation? Yes _____No _____

PROFESSIONAL REFERENCES
Persons who can furnish information about job performance

1. Name: _____Telephone:_____
Fax: _____
Address: _____

2. Name: _____Telephone:_____
Fax: _____
Address: _____

3. Name: _____Telephone:_____
Fax: _____
Address: _____

GENERAL

Have you ever been convicted of a crime in the past 5 years, barring employment in a Home Care and community support Agency? Yes _____No _____
Conviction will not necessarily disqualify an applicant from employment.
If yes, describe in full: _____
_____
_____
_____

Are you capable of performing the job set forth in the job description? Yes__No__

If you answered No, which job requirement can you not meet? _____
_____
_____
_____
_____

APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience**.**

_____

_____

_____

_____

_____

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL

I Authorize complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to the Agency.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time**.**

DATE: _____ **SIGNATURE** _____

INTERVIEW REVIEW

Applicant Name: ._____Date_____

Days and Hours available M Tu W Th F Sa Su

Review:

Personality:	friendly	average	quiet
Verbal skills:	excellent	average	poor
Communicates:	clear	somewhat clear	not very clear
Flexibility:	very flexible	somewhat	not flexible
Skill level:	higher skilled	moderately skilled	lower skilled
Appearance:	professional	semi-professional	not professional
Good Candidate for employment:		yes no	

Overall Interview: _____

_____ _____

Interviewer Date

APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ To: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities: _____

_____

Reason for Leaving: _____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

Reference check performed by_____

APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ To: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities: _____

_____

Reason for Leaving: _____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

Reference check performed by_____

SECTION 2

- ☐ **LICENSE COPY/VERIFICATION**
- ☐ **DIPLOMA/DEGREE TRANSCRIPT**
- ☐ **SOCIAL SECURITY CARD**
- ☐ **CPR CARD**
- ☐ **DRIVER'S LICENSE**
- ☐
- ☐ **AUTO INSURANCE**

SECTION 3

- ☐ **ORIENTATION CHECKLIST**
- ☐ **JOB ACCEPTANCE STATEMENT**
- ☐ **JOB DESCRIPTIONS**
- ☐ **EMPLOYEE EMERGENCY CONTACT**
- ☐ **PERFORMANCE EVALUATION - 90 DAYS**
  with field observation
- ☐ **PERFORMANCE EVALUATION - ANNUAL**
  with field observation
- ☐ **SKILLS COMPETENCY**
- ☐ **CORPORATE COMPLIANCE STATEMENT**
- ☐ **COUNSELING/DISCIPLINARY ACTIONS**
- ☐
- ☐ **FLORIDA NEW HIRE FORM**

ORIENTATION

The following orientation will be used for all full-time, part-time and per-diem workers.

Topic	Initials
Agency Mission, Vision and Plan	
Types of Care Provided by the Agency	
Policies and Procedures	
Personnel Policies and Job Descriptions	
Client Rights and Grievance Policy	
Ethics and Confidentiality of Patient Information	
HIPAA Compliance	
Supervision and Evaluation	
Home Safety (Bathroom, Electrical, Environment, Fire and Hazards)	
Safety Issues in the Home (Including Security and Guns in the Home)	
Emergency Preparedness Plan/Actions to Take in the Event of Disaster	
Actions to Take in Unsafe Situations	
Infection Control in the Home/Standard Precautions	
Patient Care Responsibilities	
Understanding and coping with Alzheimer's Disease and Dementia	
Identifying and Reporting Abuse, Neglect and Exploitation	
Client Bill of Rights	
Fraud and Abuse	
Personnel and Client Grievance Policy	
False Claims, False Statements and Whistle blowing	
Community Resources	
Quality Assurance	
Documentation - Record Keeping including OASIS	
Hazardous Device Reporting	
Reviewed, understands and signed job description	
ID Badge issued	

Print Name_____ Title_____

Signature_____ Date_____

Supervising staff signature _____date_____

JOB ACCEPTANCE STATEMENT

I have read, understand and agree to the terms specified in this job description for the position I presently hold. A copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Employee Signature_____ Date_____

Florida New Hire Reporting Form

Send completed forms to:
Florida New Hire Reporting Center
PO Box 6500
Tallahassee, FL 32314-6500
Fax: (850) 656-0528 or toll-free fax 1 (888) 854-4762

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

Federal Employer ID Number (FEIN) *(Please use the same FEIN that appears on your quarterly wage reports you submit to the State):*

Florida Employer Unemployment Compensation

Employer Name:

Employer Address:

Employer City: Employer State: Zip Code (5 digit):

Employer Phone: Extension: Employer Fax:

EMPLOYEE INFORMATION

Employee Social Security Number (SSN):

Employee First Name: Middle Initial:

Employee Last Name:

Employee Address:

Employee City: Employee State: Zip Code (5 digit):

Date of Hire: Date of Birth:

Reports must be submitted within 20 days of date of hire or rehire

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

Employee Emergency Contact Information

Employee Name:_____

Current Address:_____

Home Phone:_____ Cell Phone:_____

Next of kin:_____ Phone:_____

Relationship:_____ Address:_____

_____

*In case of emergency, please contact:

Name:_____ Phone:

Relationship:_____ Address:_____

_____

*Please notify this Agency immediately if any of the emergency contact information changes.

SKILLS COMPETENCY TESTING

PURPOSE

To ensure that staff members that perform functions involving specific patient/client care tasks are competent in those areas and maintain proficiency; the Agency will define the requirements for competency based on clinical standards of practice and organizational policy and evaluate the level of staff skill.

POLICY

The patterns and trends used to identify staff learning needs are acted on by offering in-service education, training and other methods related to the identified learning needs

PROCEDURE

1. Hiring

a. The Human Resources Department will conduct all initial interviews, reference checks, licensure validation and screen the most qualified applicants and schedule interview times with the appropriate management staff. Final employment is contingent upon satisfactory references, conformance with health requirements, and validation of current applicable license and/or certification.

b. Evaluation of competencies commences when an individual is hired and continues throughout employment. This process is carried out for all staff including RNs, LPNs, Medical Social Workers (MSW), Physical Therapists (PT), Occupational Therapists (OT) and Speech Therapists (ST).

2. Orientation

a. All new hires are subject to a probationary period during which initial competencies are verified, prior to assuming an independent caseload. Staff participating in specialty programs will meet the skills and competency requirements established for those programs.

3. Methods of Determining Competence and Skill Level

a. Clinical skills must be observed by a manager or designee, who based on his/her clinical and managerial knowledge, experience, and history of competence and proficiency, is qualified to evaluate skill proficiency.

b. Simulated testing stations/lab settings may be used to determine ability to perform a skill if it is determined that in this instance a mannequin and live person are equivalent.

c. Learning and training are distinct from proficiency. The Agency will need to determine if a clinician is skilled after one observed experience. The choice of lab setting vs. observing a skill performed in the home must be driven by the type of skill.

d. A skill which is cognitive can be evaluated through written exam and oral presentation. Any skill which is technical must be observed.

e. Contract employees must also have competencies and skills verified. This must follow Agency policy and may be done within the organizational process. The contract agency assumes responsibility for this process and must outline the method

and responsibility. The Agency will monitor the process for compliance.

4. Competency Validation Schedule

a. All core competencies will be completed as follows:

(1) By the end of the orientation period

(2) Once yearly at the time of the annual performance appraisal

(3) When introducing a new procedure, technique or equipment

(4) As a result of new program development, performance improvement activities, regulatory requirements, and changes in patient/client care needs.

5. Competencies Not Met

a. If a clinician is observed and evaluated not to be proficient or competent in a skill, an action plan with defined time parameters, and a schedule set for re-observation will be implemented.

b. Staff members that are unable to meet competency requirements are not permitted to perform those tasks until they can demonstrate competency.

6. Performance Appraisals/Competency Requirements

a. All core and specialty competency requirements must be successfully completed in order to receive a satisfactory performance appraisal and rating.

7. Competency Expectations

a. New clinicians will be assessed for basic skills with core competencies as part of orientation. Newly trained or probationary Home Health Aides receive, at a minimum, on-site, joint supervisory every two weeks during the initial eight weeks of employment. When Home Health Aide services are contracted, this is the responsibility of the contracting agency.

b. Skills verification will be performed by a clinical manager or designee who has been determined to have proficiency in the area.

c. Staff will receive the education and training necessary to successful become skilled in any new techniques, skills, or procedures introduced to the Agency.

d. Staff members that are unable to meet the requirements of core competencies are not permitted to perform those tasks until they can demonstrate competence.

e. Data is collected continuously, aggregated and analyzed for patterns and trends as part of the performance improvement program.

SKILLS CORE COMPETENCY CHECKLIST FOR REGISTERED NURSES

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PEER PROFESSIONAL COMPETENCY				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
Pulmonary Assessment					
Cardiac Assessment					
Teaching Disease Process					
Diet Teaching					
Medication Teaching					
Wound Care					
Venipuncture/Lab Draws					
Foley Catheter – Urethral					
Foley Catheter – Supra pubic					
Using Universal Precautions					
Proper Hand Washing					
Proper Bag Technique					
IV Therapy (if applicable					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

SKILLS CORE COMPETENCY CHECKLIST FOR LICENSED PRACTICAL/VOCATIONAL NURSES

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PEER PROFESSIONAL				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
Medication Teaching					
Diet Teaching					
Teaching Disease Process					
Wound Care					
Foley Catheter – Urethral					
Using Universal Precautions					
Proper Hand Washing					
Proper Bag Technique					
Venipuncture/Lab Draws (if applicable)					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

CORE COMPETENCY SKILLS CHECKLIST FOR MEDICAL.SOCIAL WORKERS

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PEER PROFESSIONAL				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
Emotional					
Mental					
Social					
Financial					
Environmental					
Support System					
Problems/Impediment to effective treatment/care					
Problem Solving Techniques					
Assessment of Depression					
Counseling Technique					
Assistance Given re: Community Resources					
Follow up Plan					
Appropriate number of visits projected to resolve identified problems					
Overall interventions					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

CORE COMPETENCY SKILLS CHECKLIST FOR PHYSICAL THERAPISTS

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PEER PROFESSIONAL				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
History: Prior level of function					
ROM Assessment					
Gait Assessment & Training					
Safety Precaution Assessment					
Pain Assessment					
Equipment in Home					
Proper use of Body Mechanics					
Muscle Strength Testing					
Bed Mobility Skill					
Transfer Skill					
Balance					
Home Program Teaching					
ADL Assessment					
Energy Conservation Techniques					
Universal Precautions					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

CORE COMPETENCY SKILLS CHECKLIST FOR PHYSICAL THERAPIST AIDE

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PROFESSIONAL PHYSICAL THERAPIST				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
ROM Instruction					
Gait Training					
Safety Precaution Instruction					
Pain Assessment					
Equipment in Home					
Proper use of Body Mechanics					
Muscle Strength Testing					
Bed Mobility Skill					
Transfer Skill					
Balance					
Home Program Teaching					
ADL Instruction					
Energy Conservation Techniques					
Universal Precautions					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

CORE COMPETENCY SKILLS CHECKLIST FOR OCCUPATIONAL THERAPISTS

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PEER PROFESSIONAL				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
Independent Assessment					
History: Prior Level of Function					
ADL Technique					
Bathroom Skill Assessment					
Home Safety Instruction					
Equipment Needs					
Cognitive Training					
Coordination Training					
Muscle Stretching					
Joint ROM					
Balance Training					
Pain Assessment					
Energy Conservation Technique					
Home Exercise Program					
Transfer Technique					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

CORE COMPETENCY SKILLS CHECKLIST FOR OCCUPATIONAL THERAPIST AIDE

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PROFESSIONAL OCCUPATIONAL THERAPIST				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
ADL Technique					
Bathroom Skill Instruction					
Home Safety Instruction					
Equipment Needs					
Cognitive Training					
Coordination Training					
Muscle Stretching					
Joint ROM					
Balance Training					
Pain Assessment					
Energy Conservation Technique					
Home Exercise Program Instruction					
Transfer Technique					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

CORE COMPETENCY SKILLS CHECKLIST FOR SPEECH THERAPISTS

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PEER PROFESSIONAL				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
Speech Intelligibility Assessment					
History: Prior Level of Speech					
Visual/Reading Comprehension					
Auditory Comprehension					
Articulation					
Voice (Phonation					
Verbal Expression					
Memory					
Language/Fluency					
Cognitive Retraining					
Reasoning					
Or muscle Stretching					
Breathing Patterns					
Swallowing Assessment					
Non-verbal Communication					
Home Exercise Program					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

CORE COMPETENCY SKILLS CHECKLIST FOR SPEECH THERAPIST AIDE

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY PROFESSIONAL SPEECH THERAPIST				AREAS NEEDING IMPROVEMENT. EMPLOYEE MAY NOT PERFORM UNTIL GIVEN UPDATE/INSTRUCTION
Assessment	**E**	**G**	**F**	**P**	
Visual/Reading Comprehension					
Auditory Comprehension					
Articulation					
Voice (Phonation					
Verbal Expression					
Memory					
Language/Fluency					
Cognitive Retraining					
Reasoning					
Or muscle Stretching					
Breathing Patterns					
Swallowing Instruction					
Non-verbal Communication					
Home Exercise Program Instruction					

Name	**Signature**	**Date**
Evaluator	**Signature**	**Date**
Comments:		

Home Health Aide Competency Checklist

For each task observe the HHA's technique with a patient	Evaluate the Task	Satisfactory	Unsatisfactory	For tasks rated unsatisfactory retrain & reevaluate. Note date of satisfactory rating
Reading &recording temp. pulse & respiration				
Personal hygiene and grooming, including: bed bath; sponge, tub or shower bath, shampoo--sink, tub, or bed; nail , skin care; oral hygiene; toileting and elimination				
Safe transfer techniques and ambulation				
Normal range of motion and positioning				
Communication skills				
Observation, reporting & documentation of patient status & the care/service provided				
Basic infection control process				
Elements of body function and changes in body function that must be reported to a supervisor				
Maintenance of a safe clean healthy environment				
Recognizing emergencies and knowledge of emergency procedures				
Physical, emotional and developmental needs of and ways to work with patients incl. respect for the patient and his/her privacy and property				
Adequate nutrition and fluid intake				
Any other task that the Agency may choose to have the Home Health Aide perform				
Home Exercise Program				
I certify that I am a licensed Registered Nurse and have determined that _____ has successfully passed this checklist.				
SIGNATURE		**TITLE**		**DATE**
FACILITY NAME		**ADDRESS**		

Attendant Competency Checklist

For each task observe the HHA's technique with a patient	Evaluate the Task	Satisfactory	Unsatisfactory	For tasks rated unsatisfactory retrain & reevaluate. Note date of satisfactory rating
Communication skills				
Observation, reporting & documentation of patient status & the care/service provided				
Basic infection control process				
Elements of body function and changes in body function that must be reported to a supervisor				
Maintenance of a safe clean healthy environment				
Recognizing emergencies and knowledge of emergency procedures				
Physical, emotional and developmental needs of and ways to work with patients incl. respect for the patient and his/her privacy and property				
Adequate nutrition and fluid intake				

I certify that I am the Agency Administrator/Manager and have determined that _____ has successfully passed this checklist.

SIGNATURE	**TITLE**	**DATE**
FACILITY NAME	**ADDRESS**	

Comments:

COMPLIANCE STATEMENT

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contract basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding
As you know, our Home Care Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature and date:

EMPLOYEE COUNSELING REPORT

Employee: _____

Date: _____ / _____ / _____

Job Classification: _____

Reason For Conference/Report
Commendation
Work Performance
Infraction of Policy
Other (Specify): _____

Type of Communication:
Telephone
Office Conference
Field Conference

Events leading to conference session:

_____
_____
_____
_____

Handling of event/session:

_____
_____
_____
_____

Recommendation to Employee:

_____
_____
_____
_____

Employee Comments:

_____
_____
_____
_____

Signature of Employee _____
Date: _____ / _____ / _____

Signature of Counselor _____
Date: _____ / _____ / _____

SECTION 4

- **INSERVICES**

  (Required: HIPAA, Blood borne Pathogens, Medical Device Reporting, Infection Control, TB-Respiratory Disorders)

- **CEUS**

- **CLASS CERTIFICATES**

EMPLOYEE INSERVICE LOG

DATE	EMPLOYEE NAME	SIGNATURE	INSERVICE	CEU HOURS

SECTION 5

- **CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION**
- **FIELD PRACTICES STATEMENT**
- **CONFIDENTIALITY STATEMENT**
- **POLICIES AND PROCEDURES STATEMENT**
- **PROTECTIVE EQUIPMENT STATEMENT**
- **EXIT INTERVIEW**

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both the Agency's and the employee's responsibility to ensure that every patient's health information is protected at all times. 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 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 use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Employee: _____ Date: _____

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment 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 a protected travel chart when traveling.

- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.

- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Employee_____ Date: _____

FIELD EMPLOYEE STANDARDS AND PROCEDURES

Welcome! This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/client/family. This includes personal hygiene, jewelry, hair and makeup.

2. Please do not smoke in the presence of a patient/client.

3. Always wear your ID Badge. Licensed personnel must always carry their current nursing license and CPR care while on assignment.

4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR PATIENT DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!

5. If you have any problem, incident or accident on the job, do not discuss it with the patient/client, but call the Agency immediately.

6. If the patient/client asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.

7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.

8. UNDER NO CIRCUMSTANCES are you to ask for, or accept any money from your patient/client or take home property that belongs to the patient client.

9. There shall not be any involvement with the patient/client's financial affairs (i.e. check writing).

10. You are expected to honor the confidentiality of any patient/ client information which is obtained in the regular course of your employment.

11. No personal telephone calls should be made or received by you while on assignment.

12. Please do not discuss your pay or any other personal affairs with the patient/client/family.

13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient/client contact us.

14. It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule. If the patient/client is unable to sign your note, a family member or responsible party may sign.

15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

16. Never leave your patient/client unattended.

Employee Signature_____Date_____

CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

The Agency requires that the Employee avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee agrees to refrain from prohibited competition with the Agency and to maintain the confidentiality of information regarding employees, clients and the Agency business.

The Employee will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any client or entity to discontinue any relationship with the Agency, solicit any client of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee is required to return all of the Agency's property including keys, client records, forms, manual, beeper, etc. to the Agency and will not retain copies. Failure to return a key will result in a $25.00 charge and failure to return a beeper will result in a $50.00 charge deducted from the paycheck.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency. Employee will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

_____ _____

Employee Date

REQUIRED HIPAA CONFIDENTIALY AGREEMENT

EMPLOYEE CONFIDENTIALITY AGREEMENT of PATIENT HEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS

For good consideration and as an inducement for _____(employer) to employ _____(employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any patient health information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain.

The Employee agrees to not copy and to return all such Agency supplied Information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____.

_____

Agency

_____

Employee

EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, 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 on Abuse, Neglect and Exploitation and agree to Comply with and am 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 on 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 meeting and inservice training. Home health aides are required to have 12 hours of inservice training annually.

I understand that I must remit 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 specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's 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/ employee confidentiality is subject to civil and criminal penalties.

If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will.

Employee Signature_____ Date_____

PERSONAL PROTECTIVE EQUIPMENT FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- **Barrier Safety Goggles**
- **CPR Shield Face Barrier**
- **Fluid Resistant Gown**
- **Gloves**
- **Sharps Container**
- **Biohazard Bag**
- **Fitted respirator / 3m8511 n95 5-10479 (Purchased from uline 800-295-5510)**

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Signature/Title_____ **Date**_____

EXIT INTERVIEW

YOUR COMMENTS ARE IMPORTANT TO US. PLEASE COMPLETE THE QUESTIONS ON THIS FORM. YOUR ANSWERS WILL BE USED TO DEVELOP RECOMMENDATIONS FOR IMPROVEMENT. PLEASE BE CANDID WITH US.

NAME:_____ TITLE_____

DATE OF HIRE:_____ DATE OF RESIGNATION_____

1; MOST IMPORTANT REASON FOR LEAVING_____

2. WAS THE INFORMATION GIVEN TO YOU ABOUT YOUR JOB CONCERNING HOURS, SALARY, AND JOB DUTIES AN ACCURATE REFLECTION OF WHAT YOU FOUND ON THE JOB?_____

3. WERE YOU ADEQUATELY PREPARED TO PERFORM YOUR JOB? IF NOT, WHAT COULD HAVE BEEN DONE TO HELP YOU PERFORM MORE EFFECTIVELY?_____

4. WHAT DID YOU LIKE BEST ABOUT WORKING FOR THE AGENCY?_____

5. WHAT DID YOU LIKE LEAST ABOUT WORKING FOR THE AGENCY?

6 DID YOU RECEIVE SUFFICIENT INFORMATION ABOUT YOUR PERFORMANCE?

SECTION 6

- **PAYROLL FORMS**

- **MISCELLANEOUS**

SECTION 7

- **SEPARATE HEALTH RECORD FOR FIELD STAFF ONLY (Sealed envelope marked confidential)**

- **IMMUNIZATIONS**

- **TB QUESTIONAIRE**

- **HEPATITIS VACCINE**

- **CRIMINAL HISTORY CHECK/FORMS**

- **OTHER CONFIDENTIAL INFORMATION**

HEALTH STATEMENT

Applicant Name: _____Date_____

I, _____ hereby attest that the state of my health is such that it will enable me to perform the duties of a health care professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

AIDS	Anthrax	Chickenpox	Cholera
Diphtheria	Encephalitis	Hepatitis, Types A, B and C	Influenza
Leprosy (Hansen's Disease)	Leptospirosis	Malaria	Measles (Rubeola)
Meningitis	Mononucleosis	Mumps	Whooping Cough
Plague	Poliomyelitis	Psittacosis (Ornithosis)	Rabies
Rocky Mountain Spotted Fever	Rubella (German Measles)	Shigellosis	Smallpox
Tetanus	Tularemia	Tuberculosis	Typhoid Fever

TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____

Print Name

		YES	NO
1.	Have you ever had a positive TB skin test or history of TB infection? If the answer is YES, please answer the following:	____	____
2.	Have you ever had the BCG vaccine?	____	____
3.	Do you have prolonged or recurrent fever?	____	____
4.	Have you recently lost weight?	____	____
5.	Do you have a chronic cough?	____	____
6.	Do you cough up blood?	____	____
7.	Do you have sweating at night?	____	____
8.	Do you have any of the following risk factors which may substantially increase the risk of tuberculosis?		

____ a. Silicosis (Lung Disease)

____ b. Gastrectomy

____ c. Intestinal Bypass

____ d. Weight 10% or more below ideal body weight?

____ e. Chronic Renal Disease

____ f. Diabetes Mellitus

____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy

____ h. Hematologic Disorder 1.e. leukemia or lymphoma

____ i. Exposure to HIV or AIDS

____ j. Other malignancies

_____ _____

Employee Signature Date

HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

☐ request that I receive the Hepatitis vaccine

☐ refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the 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 vaccine series at no charge to me.

☐ provide written proof of immunity (attach)

☐ provide written proof of previous vaccination (attach)

☐ provide written proof of medical contraindication (attach)

Signature: _____ Date: _____

CRIMINAL HISTORY CHECK

POLICY:

It is the policy of this Agency that direct care staff members have a criminal history check in his/her personnel file prior to home visits. The criminal history check is kept in a separate folder marked confidential. The employee may start orientation and but may not make home visits prior to the results of the check being returned.

PURPOSE:

To provide the highest ethical, moral standard in the Agency employees

PROCEDURE:

1. Prior to an offer of employment to direct care staff a level 2 background screening will be conducted to determine whether the prospective employee has a criminal conviction or has committed certain conduct including abuse, neglect or mistreatment of a consumer of an agency or a facility licensed under the Health and Safety Code, or misappropriation of a consumer's property, will bar him/her from employment with the Agency. The request for a criminal history record must be made within 72 hours or employment. Background screenings must be renewed every five years.

2. Current field employees who have had a level 1 screening must have a level 2 screening at the time of screening renewal (every five years). All field employees must have met this requirement at five years, and it is expected that all field employees will have the level 2 testing no later than July 31, 2015.

3. All unlicensed employees hired on or after September 1, 2009 must have their employability checked through the Nurse Aide Registry (NAR) and the Employee Misconduct Registry (EMR) at least annually if they have face-to-face client contact. The toll free telephone option is no longer available.

4. The AHCA, Background Screening Unit offers direct access electronic screening capabilities to all active licensed or certified health care providers. This service enables providers to search criminal history screening results by Social Security Number of potential employees screened through the Agency and the Department of Health. A user code is necessary for entry into this system and will be assigned when an agency receives it initial license

Each provider wishing to access the system must complete and return a User Agreement. You may access the User Agreement at: http://ahca.myflorida.com/MCHO/Long Term Care/Background Screening/logon.shtml.

Once you have printed the "User Agreement," the system will require the selection of a password. To prevent a lapse in service, you should mail the User Agreement immediately. The system will not allow access after 30 days if the User Agreement has not been received by BGS. If you have questions regarding the web site, you may contact the Background Screening Unit at (850) 410-3400.

4. It is at the discretion of the administration to make the decision regarding criminal history checks on non-direct care employees.

5. Any employee whose criminal history is being checked has the right to be informed prior to obtaining the history.

6. The employee is subject to immediate termination if:

a. The Agency determines, as a result of a criminal history check, that a person has been convicted of an offense listed by the state as one which is terminable.

b. The Agency becomes informed of a person's 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 under State Code.

c. A person is listed as unemployable due to findings of abuse, neglect or mistreatment of a consumer of any agency or facility licensed under Health and Safety Code or misappropriation of a consumer's property

d. If it is determined that a person is listed as unemployable due to a finding that the person has committed an act that constitutes reportable conduct as described in the State Code.

7. The criminal history records and the information they contain may not be released or otherwise disclosed to any person or entity other than the subject of the information except on court order or with the written consent of the person being investigated. If the Agency has reason to believe that an employee has abused, exploited or neglected a client of the Agency, the Agency must report the information upon discovery to:

The Florida Home Health Hotline at 1-888-419-3456

The Florida Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873)

The Florida Child Abuse Hotline at 1-800-792-5200

8. A person convicted of an offense listed below may not be employed in a position which involves direct contact with a client. This includes criminal homicide, kidnapping and false imprisonment, indecency with a child, aggravated assault, injury to a child, elderly individual, or disabled individual, abandoning or endangering children, aiding suicide, agreement to abduct from custody, sale or purchase of a child, arson robbery, or aggravated robbery.

9. The Criminal History Check is filed in a separate folder marked confidential.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AFFIDAVIT OF COMPLIANCE WIT Background Screening Requirements

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

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

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

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

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

I hereby attest to meeting the requirements for employment and that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S

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

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

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

(d) Section 782.04, relating to murder.

(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, relating to vehicular homicide.

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

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

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

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

(k) Section 787.01, relating to kidnapping.

(l) Section 787.02, relating to false imprisonment.

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

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

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

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

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

(r) Section 794.011, relating to sexual battery.

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

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

(u) Chapter 796, relating to prostitution.

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

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

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

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

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

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

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

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

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

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

(gg) Section 826.04, relating to incest.

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

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

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

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

(ll) Section 843.01, relating to resisting arrest with violence.
(mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

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

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

(pp) Chapter 847, relating to obscene literature.

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

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

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

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

(uu) Section 944.40, relating to escape.

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

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

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

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

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

Criminal offenses found in section 408.809(4), F.S
(a) Any authorizing statutes, if the offense was a felony.

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(b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (g) Section 817.234, relating to false and fraudulent insurance claims. (h) Section 817.505, relating to patient brokering. (i) Section 817.568, relating to criminal use of personal identification information. (j) Section 817.60, relating to obtaining a credit card through fraudulent means.	(k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (l) Section 831.01, relating to forgery. (m) Section 831.02, relating to uttering forged instruments. (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (p) Section 831.30, relating to fraud in obtaining medicinal drugs. (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

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

Purpose of Prior Screening:_____
Screened conducted by: _____Date of Prior Screening:

- ☐ Agency for Health Care Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Children and Family Services
- ☐ Department of Financial Services

Affidavit

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

_____ _____ _____
Employee/Contractor Signature Title Date

SEPARATE FILE

ALL I – 9s

ALPHABETIZED IN ONE FOLDER