INFINITY
HOME HEALTHCARE

Required Documents for hiring/orientation process

Skilled Clinicians ***(check clinician type)***

	SN		LPN		MSW		CNA		PT		PTA		OT		COTA		SLP

- ☐ Copy of Active State License/ Approved School Certificate
- ☐ Copy of current CPR Card
- ☐ Copy of current TB Skin Test/Chest X-ray
- ☐ Copy of current flu vaccine (if applicable)
- ☐ Copy of current auto insurance
- ☐ Copy of current Driver's License
- ☐ Copy of SSN Card or Passport
- ☐ Copy of current Permanent Resident Card/ work permit (if applicable)

Equal Employment Opportunity: While many employers are required by federal law to have an Affirmative Action Program, all employers are required to provide equal employment opportunity and may ask your national origin, race and sex for planning and reporting purposes only. This information is optional and failure to provide it will have no effect on your application for employment. **We are an Equal Opportunity Employer and fully subscribe to the principles of Equal Employment Opportunity. Applicants and/or employees are considered for hire, promotion and job status, without regard to race, color, religion, creed, sex, marital status, national origin, and age, physical or mental disability.**

Employment Application

Position Applying For: ☐ RN ☐LPN ☐PT ☐PTA ☐OT ☐OTA ☐SLP ☐CNA ☐HHA ☐PCA OTHER: _____

Position Type: ☐ Full Time ☐ Part time ☐ PRN (work available basis)

Date of Application: _____ **Hired Date:** _____

Personal Information

NAME: _____
Last First Initial

ADDRESS: _____
street City State ZIP Code

PHONE NUMBERS: Home: _____ Cell: _____

Email: _____

Social Security No: _____ **Date of Birth:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Caucasian ☐ Asian ☐ Hispanic ☐ African American ☐ Other _____

Languages Spoken: 1. _____2. _____3. _____

- If you are applying for a position and are **under the age of 18, please check here** ☐
- Are you prevented from lawfully becoming employed in this country because of Visa or Immigration status?
  ☐ Yes ☐ No
  - How did you learn about job opening? ☐ website ☐ friend/client ☐ other: _____
- Are you currently employed? ☐ Yes ☐ No
- May we contact your present and past employer(s)? ☐ Yes ☐ No
- Are you currently on lay-off status and subject to recall? ☐ Yes ☐ No
- Are you able to travel if required? ☐ Yes ☐ No
- Will you work with a client that smokes? ☐ Yes ☐ No
- Will you work with a client that has pets? ☐ Yes ☐ No

Date available for work: _____

- Shifts available to work: ☐ Days ☐ Evenings ☐ Nights ☐ Weekends

Areas of Coverage

- Loudoun County:
  ☐Leesburg ☐Sterling ☐Herndon ☐Ashburn ☐Purceville ☐Middleburg ☐Aldie ☐South Riding
  Other:_____
- Fauquier County:
  ☐Warrenton ☐Marshall ☐Calverton ☐Midland ☐The Plains ☐ Upperville ☐ Belvoir
  _____
- Fairfax County:
  ☐ Clifton ☐ Fairfax Station ☐ Vienna ☐ Mclean ☐ Merrifield ☐ Falls Church ☐ Alexandria ☐ Annandale ☐ Arlington ☐Lorton ☐ Springfield ☐Burke ☐ Fort Belvoir ☐ Chantilly ☐ Centreville ☐ Reston
  _____
- Prince William County:
  ☐ Manassas ☐ Haymarket ☐ Dumfries ☐ Bristow ☐ Occoquan ☐ Quantico ☐ Woodbridge
  _____
- Stafford County:
  ☐ Stafford ☐ Falmouth ☐ Aquia Harbor ☐ Gateway Other: _____
- Fredericksburg County:
  ☐ Fredericksburg City ☐ Caroline ☐ King George ☐ Spotsylvania Other: _____

Education & Training

Circle last grade completed - Grade 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 Bachelors____ Masters _____Doctorate ____

(High School, College, Business, Trade or Other)	Location	Dates Attended	Courses Taken or Major/Minor	Diploma/Degree Received? Yes/No Date Received
				Yes/No Date Rec'd
				Yes/No Date Rec'd
				Yes/No Date Rec'd

Skills and Qualifications

Describe any job-related training received in the United States Military or other. _____

_____

RN Skills (please Check all that apply)
☐ Admissions ☐ Case Management ☐ IV infusion/PICC line management

RN/LPN Skills (please Check all that apply)
☐ Medicaid Supervisory Visits ☐ Ventilator experience ☐ Tracheostomy Care/change ☐ GT/JT feeding/care/change
☐ Burn ☐ Hoyer lift ☐ Pediatrics ☐ Cardiac after care ☐ Diabetes care/teaching ☐ Bowel/bladder training

CNA/HHA/PCA Skills (please Check all that apply)

Care Experience: □ Dementia/Alzheimer's □ HIV/AIDS □ Stroke □ Children with Autism/developmental delay

Transfers: □ Bed to wheelchair □ wheelchair to bed □ Transfer board □ Hoyer Lift
□ Meal Preparation (cooking) □ Foley care □ GT Care

Other: _____

Professional Licenses:

Applicants applying for positions that require a Professional license must have a current Commonwealth of Virginia license, unless otherwise noted on position description. Please attach a copy with your application.

Type of License	License number	Expiration Date & State	Granted by (Licensing Board)

Nonprofessional Licenses or Certificates, including a valid Driver's License (List below)

Type of License	License number	Expiration Date & State	Granted by (Licensing Board)

Employment History

Starting with your PRESENT or MOST RECENT EMPLOYER list in consecutive order ALL EMPLOYMENT for at least the past three employers.

EMPLOYER NAME & ADDRESS:	Position title/duties, skills	Start date:	End date:
		Reason for Leaving:	
PAY $	Supervisor: Phone:		
EMPLOYER NAME & ADDRESS:	Position title/duties, skills	Start date:	End date:
		Reason for Leaving:	
PAY $	Supervisor: Phone:		
EMPLOYER NAME & ADDRESS:	Position title/duties, skills	Start date:	End date:

		Reason for Leaving:
PAY $	Supervisor: Phone:	

Employment Reference Authorization and Release of Information

I authorize Infinity Home Healthcare and/or its agents to contact any former employers, educational institutions, and certifying and/or licensing entities listed on this application for the purposes of employment and if hired, promotion.
I further agree to release this practice, and those previous employers or institutions which provide references regarding my work and academic practices, from all liability regarding this verification process.

A photocopy of this authorization and waiver shall be considered as legally valid as the original and may be sent to former employers as a statement of my intent to hold them harmless for the results of references given.

I certify that I have truthfully and accurately completed the employment application and that I have read and do understand this statement of authorization, release and waiver **Applicants Initial/Date: _____**

Emergency Contact

Name: _____ Daytime phone: _____

Address: _____ Relationship: _____

Fair Credit Reporting Act Disclosure and Authorization Statement

In connection with my application and or/continued employment, I understand that an investigative consumer report may be requested that will include information as to my character, work habits, performance and experience, along with reason for termination with past employment. I understand that as directed by Infinity Home Healthcare policy and consistent with the job described, you may be requesting information from public and private sources about my: COURT RECORDS, DRIVING RECORDS, WORKERS' COMPENSATION INJURIES, EDUCATION, CREDENTIALS, CREDIT AND/OR REFERENCES.

Medical and Workers' Compensation information will only be requested in compliance with the Federal Americans with Disabilities Act and /or any other applicable state laws. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my perspective employer from a consumer-reporting agency. If so, I will be notified and given the name and address of the agency or the Source that provided the information.

I acknowledge that a facsimile or photographic copy shall be valid as the original. This release is valid for most federal, state and county agencies.

Your personal information is used and required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purpose. I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, reference or insurance company contacted by an agent of Infinity Home Healthcare to furnish the information described. I hereby release True Care Home Healthcare, and all persons, agencies, and entities providing information or reports about me from all liability arising from the request for, or release of, any of the mentioned information or reports. **Applicants Initial/Date: _____**

Non-Compete Statement

<u>If hired, I</u> agree not to accept employment (whether temporary or permanent, full-time or part-time) from or on behalf of any person who is or was a client of Infinity Home Healthcare. This restriction shall apply only to employment for the provision of services like those offered by the Agency and shall be in effect for a period of one year following termination of employment. In the event of a breach of this restrictive covenant the employee shall pay to the Agency (or have his/her new employer pay on his/her behalf) liquidated damages in the nature of a placement fee in the amount of $2,500.

Applicants Initial/Date: _____

At-Will Employment Statement

Your employment with Infinity Home Healthcare is a voluntary one and is subject to termination by you or Infinity Home Healthcare at will, with or without cause, and with or without notice, at any time. Nothing in Infinity Home Healthcare policies shall be interpreted to conflict with or to eliminate or modify in any way the employment-at-will status of Infinity Home Healthcare employees. This policy of employment-at-will may not be modified by any officer or employee and shall not be modified in any publication or document. The only exception to this policy is a written employment agreement approved at the discretion of the President or the Board of Directors, whichever is applicable. These personnel policies are not intended to be a contract of employment or a legal document.

Applicants Initial/Date: _____

HIPAA Privacy Rule Employee Confidentiality Statement & Acknowledgement

I have read and understand Infinity Home Healthcare policies regarding the privacy of individually identifiable protected health information (PHI), as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the state of Virginia. In addition, I acknowledge that I have received training in policies concerning PHI use, disclosure, storage and destruction as required by HIPAA.

In consideration of my employment or compensation from, I hereby agree that I will not at any time – either during my employment or association with or after my employment or association ends – use, access or disclose PHI to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities, as set forth in privacy policy and procedures or as permitted under HIPAA. I understand that this obligation extends to any PHI that I may require during the course of my employment or association with Infinity Home Healthcare, whether in oral, written or electronic form and regardless of the manner in which access was obtained.

I understand and acknowledge my responsibility to apply Infinity Home Healthcare policies and procedures during my employment or association. I also understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including termination of employment or association with Infinity Home Healthcare and the imposition of civil penalties and criminal penalties under applicable federal and state law, as well as professional disciplinary action as appropriate.

I understand that this obligation will survive the termination of my employment or end of my association with Infinity Home Healthcare, regardless of the reason of such termination. **Applicants Initial/Date: _____**

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 acknowledgment 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.

I agree to protect all Electronic Medical Records including passwords as outlined in the HIPAA policy.

Applicants Initial/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 acknowledgment of the patient being discharged.

I always pledge to make every effort to keep patient's Protected Health Information protected.

Applicants Initial/Date: _____

Corporate Compliance Policy

Acknowledgment of Receipt and Understanding

As you know, our 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 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. **Applicants Initial/Date: _____**

Employee Policies & 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 conductions 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 patients 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 planes of care, periodic patient 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 in-service training.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures required 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 patient 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 patient 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 statisti8cal or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of patient/ 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 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 tis discretion. I understand that this company is an "At Will" organization and may hire or fire at will. **Applicants Initial/Date: _____**

Field Employee Standards & Procedures

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/family. This included personal hygiene, jewelry, hair and makeup.
2. Please do not smoke in the presences of a patient.
3. Always wear you photo ID Badge.
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 assent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOU 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, but call the Agency immediately.
6. If the patient 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 or take home any property that belongs to the patient.
9. There shall not be any involvement with the patient's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient 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 you pay or any other personal affairs with the patient/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/family. If you are requested to do so, please have the patient contact us.
14. It is important 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 is unable to sign your note, a family member or responsible party may sign.
15. During employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with patient employment and will not be disclosed to anyone without authorization from the Agency.

Applicants Initial/Date: _____

Personal Protective Equipment for Safety and Infection Control Acknowledgement

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
- Biohazard Bag
- Sharps Container
- 3M Respirator Mask (N95 or similar purchased from Ullin.com)

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.

Applicants Initial/Date: _____

Signature Attestation

The Signature Attestation statement identifies the author associated with initials or illegible signature.
The signature of physicians and staff who document on patient charts will then be able to be identified as per federal, state and accreditation requirements.

I do hereby attest that this information and below signature is mine, true, accurate, and complete.

Full Printed Name with Credentials _____

Signature as used in medical records _____

ELECTRONIC DOCUMENTATION AND SIGNATURE AUTHENTICITY AGREEMENT

I understand that Agency staff may use electronic signatures on all computer-generated documentation. An electronic signature will serve as authentication on patient record documents and other agency documents generated in the electronic system.

For the purpose of the computerized medical record and other documentation for agency purposes, I acknowledge my use of the Signature Passcode and my Login authentication password will serve as my legal signature. I further understand that the Administrator issues employee passwords and the Signature Passcode's are issued by the software application.

Signature Passcodes and passwords will be changed on an as needed basis if system security is breached. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of electronic signature, my documentation on the field-based or office computer. (OASIS Comprehensive Assessments will not require electronic signature until required information is obtained, which may be up to five days after the corresponding MO date i.e.: MOO30, MOO32 etc.) I understand that: I cannot divulge my login password, Signature Passcode, I must exit the computerized application at the end of each working day or whenever the computer is not in my immediate possession, I must type in (rather than save) the login password that allows me access to the agency computer network, and my Signature Passcode. I must review all my documentation online prior to submitting to the agency server.

Applicants Initial/Date: _____

Applicant's Acknowledgement

I certify that the facts set forth in this application for employment are true and complete to the best of my knowledge.
I understand that if I am employed, false statements may result in immediate termination. I authorize Infinity Home Healthcare to conduct an investigation of any of the facts set forth in this application. I authorize the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you.

I understand Infinity Home Healthcare, is a Drug-Free Workplace. Should I be offered a position, I may be asked to submit to a drug test prior to, and during employment. A positive testing result now or in the future may disqualify me from employment.

I understand and agree to terms and information shown above. **Applicants Initial/Date:** _____

Acknowledgement

I have received my job description. The Director of Nursing or his/her representative has reviewed and explained to Infinity Home Healthcare policies and procedures. I further understand that if I need further information about the stated policies and procedures I, on my own time can review The Agency's written policy and procedure manual.

I_____ have read and understand Infinity Home Healthcare policies and procedure. I fully understand and agree to all the terms of this agreement.

Applicant's Signature: _____**Date:** _____

Authorized Agency Representative: _____ **Title:** _____ **Date:** _____

SWORN DISCLOSURE STATEMENT OR AFFIRMATION

To the Applicant:

Sections 32.1-162.9:1 of the Code of Virginia require that any person desiring work at a licensed home care organization provide the Commissioner's representative with a sworn disclosure or affirmation disclosing (1) whether the applicant has a criminal conviction or is the subject of any pending criminal charges within or outside The Commonwealth of Virginia, and (2) whether the applicant has been the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth of Virginia.

Any person making a false statement on this form regarding any criminal offense shall be guilty upon conviction of a Class 1 misdemeanor.

Further dissemination of the information provided on this form is prohibited other than to the Commissioner's representative or a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.

_____

Last Name First Middle/Maiden Social Security Number

_____

Street/P.O. Box City State Zip Code

2. Have you ever been convicted of a crime within or outside Virginia (but excluding offenses committed before your eighteenth birthday that were finally adjudicated in a juvenile court or under a youth offender law? Yes Yes_____ No____. If yes, list all and explain: _____

_____

_____

3. Are you the subject of any pending criminal charges within or outside Virginia?
Yes _____ No____. If yes, list all and explain: _____

_____

_____

4. Have you ever been the subject of a founded complaint of child abuse or neglect within or outside Virginia?
Yes _____ No____. If yes, list all and explain: _____

_____

_____

I hereby affirm that the information provided on this form is true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part to any employment offered by this facility. I understand that all information on this form is subject to verification.

Applicant's Signature: _____ Date: _____

HEPATITIS VACCINE REQUIRMENT

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 the by declining the vaccine I to be at risk of acquiring Hepatitis B, as 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 are not charged to me.

- ☐ Provide written proof of immunity (attach)

- ☐ Provide written proof of previous vaccination (attach)

- ☐ Provide written proof of medical contraindication (attach)

Signature: _____ Date:_____

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
Diptheria	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: _____

		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?

- ☐ Silicosis (Lung Disease)
- ☐ Gastrectomy
- ☐ Intestinal Bypass
- ☐ Weight 10% or more below ideal body weight?
- ☐ Chronic Renal Disease
- ☐ Diabetes Mellitus
- ☐ Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy
- ☐ Hematologic Disorder 1.e. leukemia or lymphoma
- ☐ Exposure to HIV or AIDS
- ☐ Other malignancies

_____ _____

Employee Signature Date

_____ _____

Reviewed by Date

Influenza Vaccination Employee Statement

I_____ am aware of Infinity Home Healthcare influenza (flu) policy and have had a chance to have my questions answered about influenza vaccination. I understand the benefits and risks of the vaccine, and:

☐	I **agree** to have the influenza vaccine for the current influenza season. *(Documentation of influenza administration is attached)*
☐	I **decline** influenza vaccination for the current influenza season. I understand I may rescind this declination at any time.

_____ _____

Signature Date

COVID-19 Vaccination Employee Statement

I_____ acknowledge that I am at risk of exposure or have been unknowingly exposed to COVID-19 as a result of my employment. I am aware Infinity Home Healthcare's recommendation to receive the vaccine and I understand the benefits and risks of the vaccine.

☐	I **agree** to have the COVID-19 vaccine. *(Documentation of vaccine administration is attached)*
☐	I **decline** the COVID-19 vaccination. I understand I may rescind this declination at any time.

_____ _____

Signature Date

REFERENCE CHECK FORM

_____ has applied for employment with Infinity Home Healthcare and has indicated that they have worked for you and you are willing to provide a reference for them. Please rate the following Performance areas by circling the number best describing their job performance

Reference Name: _____ Title: _____
Name of Company: _____ Employment Date(s): _____
Address: _____
Phone Number: _____ Fax Number: _____

Employment dates: From: _____ To: _____ Position Held: _____

If separated, reason for separation from your company?

_____
_____

Would you rehire? ☐ Yes ☐ No. If no, please explain_____

Performance Area	*Very Good*	*Good*	*Average*	*Poor*	*Very Poor*	*No Comment*
Attendance/ Punctuality	5	4	3	2	1	0
Reliability	5	4	3	2	1	0
Work Quality	5	4	3	2	1	0
Initiative/ Motivated	5	4	3	2	1	0
Timely Submission of documentation	5	4	3	2	1	0
Interpersonal skills with patients	5	4	3	2	1	0
Interpersonal skills with co-workers	5	4	3	2	1	0
Interpersonal skills with supervisors	5	4	3	2	1	0
Adherence to agency's policies and procedures	5	4	3	2	1	0
Planning and organizational skills	5	4	3	2	1	0
Ability to work independently	5	4	3	2	1	0
Ability to work as a team member	5	4	3	2	1	0

Additional Comments: _____

_____

Agency Representative Verification completed by:

Name: _____ Date: _____

The information contained within this document or any of its attachments is not shared with any third parties except the employer's if required for audit. The information is used as an aid in the hiring process and kept in the employee's file during employment and as required by law. The Reference evaluator, by signing this document of answering the questions over the phone gives the employer consent to collect the information contained herein and use for the specific purpose.

REFERENCE CHECK FORM

_____ has applied for employment with Infinity Home Healthcare and has indicated that they have worked for you and you are willing to provide a reference for them. Please rate the following Performance areas by circling the number best describing their job performance

Reference Name: _____ Title: _____
Name of Company: _____ Employment Date(s): _____
Address: _____
Phone Number: _____ Fax Number: _____

Employment dates: From: _____ To: _____ Position Held: _____

If separated, reason for separation from your company?

_____
_____

Would you rehire? ☐ Yes ☐ No. If no, please explain_____

Performance Area	*Very Good*	*Good*	*Average*	*Poor*	*Very Poor*	*No Comment*
Attendance/ Punctuality	5	4	3	2	1	0
Reliability	5	4	3	2	1	0
Work Quality	5	4	3	2	1	0
Initiative/ Motivated	5	4	3	2	1	0
Timely Submission of documentation	5	4	3	2	1	0
Interpersonal skills with patients	5	4	3	2	1	0
Interpersonal skills with co-workers	5	4	3	2	1	0
Interpersonal skills with supervisors	5	4	3	2	1	0
Adherence to agency's policies and procedures	5	4	3	2	1	0
Planning and organizational skills	5	4	3	2	1	0
Ability to work independently	5	4	3	2	1	0
Ability to work as a team member	5	4	3	2	1	0

Additional Comments: _____

_____

Agency Representative Verification completed by:

Name: _____ Date: _____

The information contained within this document or any of its attachments is not shared with any third parties except the employer's if required for audit. The information is used as an aid in the hiring process and kept in the employee's file during employment and as required by law. The Reference evaluator, by signing this document of answering the questions over the phone gives the employer consent to collect the information contained herein and use for the specific purpose.

Virginia Department of Social Services
Adult Protective Services Program
801 E. Main Street
Richmond, VA 23219
Telephone: 804-726-7533

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

(This is an optional form for employers of mandated reporters to document that their employees have been notified of their mandated reporter status. An acknowledgement form developed by the employer is also acceptable. ***If this form is used, page one should be retained by the employer. Page two listing indicators of adult abuse, neglect and exploitation should be retained by the employee****).*

I, _____, understand that when I am employed as a
(Employee Name)

_____,
(Type of Employment)

I am a mandated reporter pursuant to §§ 63.2-1603 through 1610 of the Code of Virginia. This means that I am required to report or cause a report to be made to Virginia Adult Protective Services (APS) either by calling the APS Hotline (1-888-83-ADULT) or the appropriate local department of social services whenever I have reason to suspect that an adult age 60 or over or an incapacitated adult age 18 and over and who is known to me in my professional or official capacity may be abused, neglected, or exploited. I understand that I must follow the reporting protocol, if any, of my employer, but my employer may not prohibit me from reporting directly to APS.

I understand that if I suspect a death of an adult age 60 or over or an incapacitated adult age 18 and over occurred due to abuse or neglect, I must report the death to the medical examiner and the law enforcement agency in the locality in which the death occurred.

I understand that I am immune from civil or criminal liability on account of any reports, information, testimony and records I release if the report is made in good faith and without malicious intent. My identity will be held confidential unless I authorize the disclosure or disclosure is ordered by the court.

I understand that if I fail to make a required report of suspected adult abuse, neglect, or exploitation, immediately upon suspicion, I may be subject to a civil money penalty imposed by the Commissioner of the Virginia Department of Social Services. If I am a law-enforcement officer, I understand the money penalty does not apply to me but that I will be referred to the court system for non-reporting of suspected adult abuse, neglect, or exploitation. If I am licensed, certified, or regulated by a health regulatory board, I may also be subject to administrative action or criminal investigation by the appropriate licensing, regulatory, or legal authority.

I understand that there is no charge when calling the Hotline number (1-888-83-ADULT or 1-888-832-3858) and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me pursuant to §§ 63.2-1603 through 1610 of the Code of Virginia.

_____
Signature of Applicant/Employee

_____
Date

Indicators of Adult Abuse, Neglect or Exploitation

ABUSE		
• Multiple/severe bruises, welts • Bilateral bruises on upper arms • Clustered bruises on trunk • Bruises which resemble an object • Old and new bruises • Signs of bone fractures • Broken bones, open wounds, skull fracture • Striking, shoving, beating, kicking, scratching	• Internal injuries • Sprains, dislocation, lacerations, cuts, punctures • Black eyes • Bed sores • Untreated injuries • Broken glasses/frames • Untreated medical condition • Burns, scalding • Restrained, tied to bed, tied to chair, locked in, isolated • Overmedicated	• Verbal assaults, threats, intimidation • Prolonged interval between injury and treatment • Fear of caregiver • Individual is prohibited from being alone with visitors • Individual has recent or sudden changes in behavior • Unexplained fear • Unwarranted suspicion
SEXUAL ABUSE		
• Genital or urinary irritation, injury, infection or scarring • Presence of a sexually transmitted disease • Frequent, unexplained physical illness	• Intense fear reaction to an individual or to people in general • Mistrust of others • Nightmares, night terrors, sleep disturbance • Direct or coded disclosure of sexual abuse	• Disturbed peer interactions • Depression or blunted affect • Poor self-esteem • Self-destructive activity or suicidal ideation
NEGLECT		
• Untreated medical condition • Untreated mental health problem(s) • Bedsores • Medication not taken as prescribed • Malnourished • Dehydrated • Dirt, fleas, lice on person	• Fecal/urine smell • Animal infested living quarters • Insect infested living quarters • Non-functioning toilet • No heat, running water, electricity • Homelessness • Lacks needed supervision • Lack of food or inadequate food • Uneaten food over period of time	• Accumulated newspaper/debris • Unpaid bills • Inappropriate or inadequate clothing • Needs but does not have glasses, hearing aid, dentures, prosthetic device • Hazardous living conditions • Soiled bedding/furniture • House too hot or cold
FINANCIAL EXPLOITATION		
• Unexplained disappearance of funds, valuables, or personal belongings • Adult child is financially dependent upon the older person or the older person is dependent on caregiver • Misuse of money or property by another person • Transfer of property or savings	• Excessive payment for care and/or services • Individual unaware of the amount of his or her income • Depleted bank account • Sudden appearance of previously uninvolved relatives/friends • Change in payee, power of attorney or will • Caregiver is overly frugal • Unexplained cash flow	• Unusual household composition • Chronic failure to pay bills • Individual is kept isolated • Signatures on check that do not resemble the individual's signature • Individual doesn't know what happened to money • Checks no longer come to house • Individual reports signing papers and doesn't know what was signed

The Indicators of Adult Abuse, Neglect and Exploitation (page 2 of this form) should be retained by the mandated reporter. Suspicions of abuse, neglect or exploitation should be reported to the 24-hour, toll-free APS hotline at 1-888-832-3858 or to the local department of social services.

INFINITY
HOME HEALTHCARE

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

TITLE OF POSITION: REGISTERED NURSE

TITLE OF IMMEDIATE SUPERVISOR: Director of Nursing

RISK OF EXPOSURE TO BLOODBORNE PATHOGENS – HIGH

DUTIES
To provide nursing care in accordance with the client's plan of care to include comprehensive health and psychosocial evaluation, monitoring of the client's condition, health promotion and prevention coordination of services, teaching and training activities and direct nursing care.
RESPONSIBILITIES
Coordinate total client care by conducting comprehensive health and psychosocial evaluation, monitoring the client's condition, promoting sound preventive practices, coordinating services and teaching and training activities.
Evaluate the effectiveness of nursing service to the client and family on an ongoing basis.
Perform admission, transfer, re-certification, resumption of care and discharge OASIS for the home care client.
Prepare and present client's record to the Clinical Record Review Committee as indicated.
Consult with the attending physician concerning alterations of client care plans, checks with the appropriate supervisor and makes changes, as appropriate.
Coordinate client services.
Submit clinical notes no less often than weekly, and progress notes and other clinical record forms outlining the services rendered as indicated.
Submit a tally of client care visits made each day.
Participate in case conferences, discuss with the supervisor problems concerning the clients and how they may best be handled.
Discuss with the appropriate supervisor the need for the involvement of other members of the health team such as the Home attendant, the Physical Therapist, the Speech Therapist, the Occupational Therapist, The Medical Social Worker, etc.
Obtain orders for paraprofessional service and submits a referral to the appropriate personnel.
Participate in the client's discharge planning process.
Cooperate with other agencies providing nursing or related services to provide continuity of care and to implement a comprehensive care plan.
Participate in staff development meeting.
Continually strive to improve his/her nursing care skills by attending in-service education, through formal education, attendance at workshops, conferences, active participation in professional and related organizations and individual research and reading.
Participate in the development and periodic revision of the physician's plan of treatment and processes change orders as needed
Submit clinical notes within seventy-two (72) hours, and progress notes and other clinical record forms outlining the services rendered.
Participate in the client's discharge planning process.
Maintain an on-going knowledge of current drug therapy.
Adhere to Federal, State and accreditation requirements including Medicare and Medicaid regulations.
May be requested by Director of Nursing to fill in for the other nurses.
COORDINATES THE ADMISSION OF A CLIENT TO THE AGENCY

Conduct an initial and ongoing comprehensive assessment of the client's needs, including Outcome and Assessment Information Set (OASIS) assessments at appropriate time points.
Obtain a medical history from the client and/or a family member particularly as it relates to the present condition.
Conduct a physical examination of the client, including vital signs, physical assessment, mental status, appetite and type of diet, etc.
Evaluate the client, family member(s) and home situation to determine what health teaching will be required.
Evaluate the client's environment to determine what assistance will be available from family members in caring for the client.
Evaluate the client's condition and home situation to determine if the services of a Home Attendant will be required and the frequency of this service.
Explain nursing and other agency services to clients and families as a part of planning for care.
Develop and implement the nursing care plan.
May be requested by the Director of Nursing to fill in for other nurses who are on vacation or sick.
PROVIDES SKILLED NURSING CARE AS OUTLINED IN THE NURSING CARE PLAN
Nursing services, treatments and preventative procedures requiring substantial specialized skill and ordered by the physician.
The initiation of preventative and rehabilitative nursing procedures as appropriate for the client's care and safety.
Observing signs and symptoms and reporting to the physician reactions to treatments, including drugs, as well as changes in the client's physical or emotional condition.
Teaching, supervising and counseling the client and caregivers regarding the nursing care needs and other related problems of the client at home.
ASSUMES RESPONIBILITY FOR THE CARE GIVEN BY THE HOME ATTENDANT
Supervise and evaluate the care given by the Home Attendant as needed, and at a minimum of once every 14 days.
Submit to the appropriate department/individual, a written evaluation of the Home Attendants who are providing service to the clients in his/her geographical area.
Participate in periodic conferences with the Home Attendant supervisor concerning the HA's performance.
Chart those services rendered to the client by the staff nurse and changes that have been noted in the client's condition and/or family and home situation, makes revisions in the nursing care plan as needed, records supervisory visits conducted with the Home attendant, evaluates client care and progress and closes charts of discharged clients.
Evaluate the effectiveness of her nursing service to the individual and family.
Consult with the attending physician concerning alteration of the plan of treatment in consultation with the supervisor.
Submit clinical notes no less often than weekly, and progress notes and other clinical record forms outlining the services rendered as indicated.
Submit a tally of visits made each day.
Participate in case conferences.
Discuss with the supervisor problems concerning the clients and possible resolution.
Discuss with the supervisor the need for involvement of other members of the health team such as the home attendant, physical therapist, speech therapist, occupational therapist, social worker, etc.
Obtain orders for paraprofessional service and submits referral to appropriate personnel.
Provide guidance and supervision to the LPN and supervises the LPN once monthly.
Coordinate total client care.
Cooperate with other agencies providing nursing or related services to provide continuity of care and to implement a comprehensive care plan.
Participate in staff development meetings.
Participate in the educational experiences for student nurses.

Continually strive to improve his/her nursing care by attending in-service education, through formal education, attendance at workshops, conferences, goal setting, active participation in professional and related organizations and individual research and reading.

Participate in the planning, operation and evaluation of the nursing service.

Participate in the development and periodic revision of the physician's plan of treatment and processes change orders as needed.

Participate in the client's discharge planning.

Submit clinical notes no less often than weekly, and progress notes and other clinical record forms outlining the services rendered as indicated.

Maintain an on-going knowledge of current drug therapy.

Prepare the care plan for the Home attendant.

JOB CONDITIONS

Must have a driver's license and be willing and able to drive to client's residences.

The ability to access clients' homes which may not be routinely wheelchair accessible is required. Hearing, eyesight and physical dexterity must be sufficient to perform a physical assessment of the client's condition and to perform and demonstrate client care.

Physical activities will include, walking, sitting, stooping, and standing and minimal to maximum lifting of clients and the turning of clients.

The ability to communicate effectively both verbally and in writing in English, is required as frequent communication by telephone and in writing is required.

EQUIPMENT OPERATION

Thermometer, B/P cuff, glucometer, penlight, hand washing materials.

COMPANY INFORMATION

Has access to all client medical records, personnel records and client financial accounts which may be discussed with the Director of Nursing.

QUALIFICATIONS

1. Must be a graduate from an accredited School of Nursing.
2. Must be licensed in Virginia as a Registered Nurse.
3. A minimum of one year experience in community/home health agency or hospital setting, prefer home care.
4. Must have knowledge of Medicare regulations/guidelines.
5. Must have a working knowledge of home health care and the principles and techniques of professional nursing and required documentation that pertains to it.
6. Skillful in organization and in the principles of time management and have knowledge of management processes.
7. Must be able to contribute to the quality of care being rendered through constructive communication with nursing managers and staff.
8. Must have a criminal background check.
9. Must have a current CPR certification.

ACKNOWLEDGMENT

EMPLOYEE NAME:

EMPLOYEE SIGNATURE: **DATE:**

INFINITY
HOME HEALTHCARE

ORIENTATION CHECKLIST

Name: _____ Date: _____

CHECKLIST	DATE COMPLETED	ORIENTATION BY WHOM	PERSONNEL INITIALS
1. Tour of office/introduction of organization personnel			
2. Completion of all employment forms			
3. Submission of personnel file documents ☐ Application and Resume ☐ Professional license, certification, and verification as appropriate ☐ Driver's license, Social Security Card (I-9 Attachments) as appropriate ☐ Criminal background check conducted. ☐ PPD Skin test or chest x-ray ☐ CPR certification ☐ Liability Insurance *(if applicable)*			
4. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided: • General orientation to organization, including Mission, Philosophy, Vision • Review of organizational chart A. Human resources processes ☐ Hours of operation ☐ Equal Employment Opportunity Act ☐ Cultural Diversity and sensitivity ☐ Sexual Harassment Act ☐ Unemployment and Worker's Compensation ☐ Family/State Medical Leave Act ☐ Job Description ☐ 90-Day and Annual Evaluations ☐ Initial and Annual Competencies ☐ In-Services Training ☐ W-2/W-9 and I-9 B. Confidentiality of organization and patient information/HIPAA ☐ Appropriate policies and procedures ☐ Advance directives ☐ Patient Rights and Responsibilities ☐ Other patient care and service responsibilities ☐ Fraud and Abuse ☐ Ethical issues, Conflict of Interest and Confidentiality of Patient Information			

☐ Complaints/Grievance Policy ☐ Cultural Diversity ☐ Communication Barriers C. Care and services provided by the organization ☐ Type of care delivered in the patient's environment ☐ Guideline for appropriate referrals ☐ Available community resources Specific tests to be performed by organization personnel (i.e., venipuncture, HGM) ☐ Screening for abuse and neglect ☐ Death and dying ☐ Information regarding services provided by other members of the organization personnel D. Organization safety review ☐ Risks within agency and patients home ☐ Fall Risk Prevention ☐ Incident Reporting and Protocols ☐ Communication Protocols ☐ Emergency preparedness within the organization and home care setting Home safety issues ☐ Electrical, Bathroom, Environmental, Fire ☐ Actions in unsafe situations ☐ Understanding and coping with Alzheimer's Disease and Dementia E. Infection prevention and control within the organization ☐ OSHA Requirements ☐ Influenza vaccination program ☐ Blood Borne Pathogens ☐ Tuberculosis Program ☐ Hand Hygiene/ Aseptic Procedures ☐ Communicable Infections ☐ Standard Precautions ☐ Protective Identification, handling and disposal of hazardous or infectious materials ☐ Infection control practices F. Performance improvement process ☐ Quality Assurance and Corporate Compliance Program ☐ Performance Improvement Program ☐ Fraud/Abuse/ False Claims, False Statements, Whistle Blowing G. Equipment management			

□ Medical Device Reporting Act □ Storage, handling and access to supplies, medical gases and drugs H. Documentation and Record Keeping □ Tellus System Training □ Electronic Signature Policy			

INITIAL COMPETENCY CHECKLIST
RN/LPN/LVN

NAME _____ RN _____ LPN _____

Date and RN's signature indicates that the nurse has been checked off on the procedure.

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
1. Urinary catheters:				
a. Foley insertion–male/female				
b. Suprapubic insertion/removal				
2. Central Cath Lines				
3. Enteral Feedings:				
a. Bolus				
b. Continuous				
c. Removal/insertion PEG tubes				
4. Equipment:				
a. IV pumps				
b. Enteral pumps				
c. Oxygen concentrator				
d. Oxygen tank				
e. Nebulizer				
5. IV therapy:				
a. Peripheral/INT				
b. Adm fluids/meds				
c. Dressing change				
6. Irrigations:				
a. Bladder				
b. Colostomy				

Initial Competency Checklist RN/LPN/LVN (continued)

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
7. Suctioning:				
a. Nasal				
b. Oral				
c. Tracheal				
8. Tracheostomy Care				
9. TPN:				
a. Administration				
b. Labs				
c. Starting/stopping				
d. Additives				
10. Venipunctures				
11. Transporting lab specimens				
12. Wound care:				
a. Aseptic technique				
b. Sterile technique				
13. Standard Precautions:				
a. Gloves				
b. Gowns				
c. Masks/goggles				
d. Shoe covers				
e. CPR resusci masks				

DATE OF INITIAL COMPLETION: _____

_____ _____

Employee Signature/Title *Observer Signature/Title*

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.