Application Questionnaire sheet:

Name:_____ Today's Date:_____

Position applying for:_____ Month/Year of EXPERIENCE:_____
Social Security#:_____DOB:__/__/__ Male:_____ Female:_____

Current Address_____City_____ State_____ Zip_____
Home #:_____ Cell:_____Email:_____

Have you ever been convicted of a crime? Yes:_____ or NO:_____ (If yes, please explain)
_____
_____

Present or Former Employer information:_____
Employer Address:_____City:_____State:_____Zip:_____
Supervisor:_____Phone:_____May we contact your employer: Yes:_____NO:____
Position:_____ Dates of employment: To:_____From:_____Pay rate_____
Duties:_____
_____

Reason for leaving:_____
_____

If hired are you willing to travel: Yes_____ or No_____
If yes, How far: Bronx____ Queens_____ Brooklyn_____ Staten Island_____ Suffolk _____
Nassau_____

If no, Please explain:_____
_____

Availability:
Morning Shift 7a-3p_____ Evening Shift 3p-11p_____ Night Shift 11p-7a_____
Sunday_____ Monday_____ Tuesday _____ Wednesday_____Thursday_____ Friday_____
Saturday_____
All agency aides and nurses are required to work weekends and holidays, are you able to work those requested days? Yes_____ or No_____
Available to work double shifts? Yes_____ or No_____
If not, explain_____

Please check the holidays willing to work:

New Years Eve_____ New Years Day_____ Christmas Eve_____ Christmas Day_____

Thanksgiving Day_____ Labor Day_____ 4th of July_____ Memorial Day_____

I/we declare that all information given in this application is true and correct. We authorize Weimark on behalf of the employer to verify and obtained a complete consumer Credit report, driving records, criminal records and employment verification, and supply information obtained to their clients. This information is not privileged. This authorization shall be valid in original or fax copy form.

Applicant Signature:_____ **Date:**_____

1583 40th Street
Brooklyn, NY 11218
Tel.718-435-6600
Fax: 718-977-5640

Our Nurses. Our Patients. A Caring Bond.

EMERGENCY CONTACT FORM

Employee Name: _____

Department: _____ Position: _____

Home Tel #: _____ Cell: _____

Personal Email Address: _____

In Case of emergency, please contact: ***(please print)***

PRIMARY CONTACT:

Name: _____

Relationship to employee: _____

Address: _____

_____

Telephone: Home: _____ Work/Cell: _____

SECONDARY CONTACT:

Name: _____

Relationship to employee: _____

Address: _____

_____

Telephone: Home: _____ Work/Cell: _____

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, *or*
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**	_____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B**	_____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**	_____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**	_____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E**	_____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**	_____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G**	_____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	**H**	_____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	7	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

Empro INC. d/b/a Medistar
1418-65th Street.
Brooklyn, NY 11219
T: 718-435-6600
F: 718-977-5640

Notice and Acknowledgement of Wage Rate(s) for Temporary Help Firms
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employee Name

   Name: _____

2. Notice given:
   ☑ At Hiring
   ☐ On or before February 1
   ☐ Before a change in pay rate(s), Allowances claimed or payday

3. Payday (check one):
   ☐ Regular Payday: _____
   ☐ Unknown the payday is based on the payday of the assigned organization.

4. **Rate of pay (check one):**
   ☐ Average wage rate range for assignment(s) _____
   ☐ Employee's rate of pay:
   $___ Per_____
   $___ Per_____
   $___ Per_____

5. Allowances taken:
   ☑ None
   ☐ Tips _____ per hour
   ☐ Meals _____ per meal
   ☐ Lodging _____
   ☐ Other _____

6. Payday is:
   ☑ Weekly
   ☐ Bi-weekly
   ☐ Other

7. Overtime Pay Rate:
   $____per hour for most workers in NYS this rate must be at least 1 ½ times the regular rate of pay, for all hours worked over 40 per workweek (44 hours for certain residential employees). The Temporary Help Firm should count all hours worked in all assignments during a workweek. Some assignments are only required to receive overtime pay at 1 ½ times the minimum wage. When you receive your assignment, your employer will tell you the overtime rate and the reason why if you are not eligible for overtime for that assignment.

8. **Employee acknowledgement:**
   On this day, I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated payday. I told my employer what my primary language is.

   Check one:

   ☐ I have been given this pay notice in English because it is my primary language.

   ☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language

   _____
   Employee Signature

   _____
   Date

   _____
   Preparer's Name and Title

   The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

MediStar Policy /Agreement for Orientation and Payment of New Employees

It is our duty to make sure our employees give the best care to our client's residents/patients; each new employee will be required to have an orientation when they are sent to a new nursing home. It depends on the facility that you are sent to; they will let us know how many days are required for orientation. This will include all aspects of your new job. MediStar Personnel agrees to compensate employees who successfully complete the orientation period at their designated salary.

The payment for orientation will be as follows:

Orientations may be provided at client sites, as per their own requirements. These orientations are designed to familiarize you to their specific policies and procedures, their own physical plant, fire safety, infection control protocols, and staff hierarchy. These orientations differ in content, duration, and individual requirements. Some may last 1 day; others may last the better part of three days. In any case, employees will be paid for their time only after a combined five (5) days of onsite participation/service has been completed.

- If orientation lasts for one (1) day, employees will be required to work four (4) additional days (5 total onsite) before orientation is paid for;
- If orientation lasts three (3) days, employees will be required to work and additional two (2) days before orientation is paid for;
- If orientation is not completed, for any reason, than no part of the orientation completed will be paid for;
- If orientation is completed, but the facility decides not to hire you, for cause, or hires you, then determines that a particular candidate is not suitable to their needs, and releases you, for cause, you will not be paid for that period of time because you did not/could not complete the mandatory five (5) days of combined service time.

I, _____ (Name of Applicant) hereby read and understand the policy of orientation and procedure manual of MEDISTAR PERSONNEL and agree to all information stated on orientation and employee handbook.

Signature:_____ Date:_____

MEDISTAR

Authorization For Search and Exchange of Information

I, _____ (Name of applicant for employment), hereby authorize MEDISTAR, to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Service Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health and MEDISTAR. This information may be used only by MEDISTAR and only for the purpose of determining my suitability for employment in a position involved in direct patient care.

Signature: _____ Date:_____

Name:_____

MEDISTAR

I, _____ (Name of applicant for employment), hereby read and understand the policy and procedure manual of MEDISTAR and agree to all information stated in the employee handbook.

Signature: _____ Date:_____

Name:_____

MediStar PERSONNEL

1583 40th Street
Brooklyn, NY 11218
718-435-6600
718-977-5640

Our Nurses. Our Patients. A Caring Bond.

Employment Verification

I, _____ voluntarily and knowingly authorize Medistar Personnel to contact my provisos employer listed below to give information they may have concerning my present or prior employment and any other information requested to determine my eligibility for employment.

Signature: _____

TO: _____ DATE: ____/____/____
EMPLOYER: _____ TELPHONE: _____
ADDRESS: _____ POSITION APPLIED FOR: _____
_____ S.S. #: _____

The above named applicant has indicated that he/she was previously your employer. An honest evaluation will be appreciated and will be held in strict confidence. Both the applicant and I will benefit from an early reply, since his/her employment is

Applicant was employed in the position of: _____
From: ____/____/____ Through: ____/____/____

Quality of work		Excellent		Good		Average		Poor
Cooperation		Excellent		Good		Average		Poor
Initiative		Excellent		Good		Average		Poor
Judgment		Excellent		Good		Average		Poor
Reliability		Excellent		Good		Average		Poor
Neatness		Excellent		Good		Average		Poor
Attendance		Excellent		Good		Average		Poor
Integrity		Excellent		Good		Average		Poor

Reason for separation: _____
Would you re-hire? Yes No if not please explain: _____
_____
COMMENTS: _____
_____
_____

Signature: _____ Title: _____ Date: ___/___/___

Information requested by: _____ _____
Name Title

MediStar PERSONNEL

1583 40th Street
Brooklyn, NY 11218
718-435-6600
718-977-5640

Our Nurses. Our Patients. A Caring Bond.

Employment Verification

I, _____ voluntarily and knowingly authorize Medistar Personnel to contact my provisos employer listed below to give information they may have concerning my present or prior employment and any other information requested to determine my eligibility for employment.

Signature: _____

TO: _____ DATE: _____/_____/_____
EMPLOYER: _____ TELPHONE: _____
ADDRESS: _____ POSITION APPLIED FOR: _____
_____ S.S. #: _____

The above named applicant has indicated that he/she was previously your employer. An honest evaluation will be appreciated and will be held in strict confidence. Both the applicant and I will benefit from an early reply, since his/her employment is

Applicant was employed in the position of: _____
From: _____ / _____ / _____ Through: _____ / _____ / _____

Quality of work		Excellent		Good		Average	Poor
Cooperation		Excellent		Good		Average	Poor
Initiative		Excellent		Good		Average	Poor
Judgment		Excellent		Good		Average	Poor
Reliability		Excellent		Good		Average	Poor
Neatness		Excellent		Good		Average	Poor
Attendance		Excellent		Good		Average	Poor
Integrity		Excellent		Good		Average	Poor

Reason for separation: _____
Would you re-hire? Yes No if not please explain: _____
_____
COMMENTS: _____
_____
_____

Signature: _____ Title: _____ Date: ___/___/___

Information requested by: _____ _____
Name Title

MediStar Personnel

Direct Deposit Agreement Form

Authorization Agreement

I _____ hereby authorize MediStar Personnel to initiate automatic deposits to my account at the financial institution named below. I also authorize MediStar Personnel to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold MediStar Personnel responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until MediStar Personnel receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ ☐ Checking | ☐ Savings

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check or deposit slip and return this form to the Payroll Department.

MediStar
PERSONNEL

Friendship has its rewards!
Refer a friend Today, Earn a referral bonus!

We have found that our best healthcare professionals come from your referrals. That is why we are Excited to announce our "Refer-A-Friend" Program.

Refer a qualified nurse to our company and you will receive a $25 dollar bonus.
You will receive your bonus once your referral completes 120 clinical hours.

This program rewards you for referring great healthcare professionals to our company. You can make a referral by contacting our Recruiters at 718.435.6600 or by completing the form below, (All fields are required) and Fax it to 718.977.5640. One of our recruiters will contact you regarding your referral.

Your Name:_____ Phone(___)-___-____
Email: _____
Address:_____
City:_____ State:_____ Zip:_____

I'm Pleased to Refer:

Name:_____ Phone(___)-___-____
License Type:_____
Email:_____

Referral bonuses are paid only for referrals that are not already in Medistar Personnel's applicant database. If the person referred has already applied for a position with any Medistar Personnel staffing serviced division or office, they are not eligible for this program. Bonuses are paid only for qualified referrals that register with Medistar Personnel, meet our hiring criteria, accept an assignment or full time position, and fulfill the terms of that assignment or position. Only one bonus paid per person referred. Medistar Personnel does not guarantee employment to any individual and reserves the right to change these program rules at any time.

Recruiter Name:_____

NYS Department of Health | CRIMINAL HISTORY RECORD CHECK

Resubmission ○

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - ___ - ____ Date of Birth mm/dd/yyyy __ / __ / ____

LAST Name _____ FIRST Name _____ M.I. _

Maiden Name _____ Alias (AKA) _____

Street Nmbr _____ Street Name _____ Apt # _____

City _____ St __ Zip _____ Home Phone ___ - ___ - ____

Sex _ Birth Country/Place _____ Cell Phone ___ - ___ - ____

Race _ Height (ft-inch) _ - __ Weight (lbs) ___ Hair ___ Eyes ___

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Miltary ○ School ○ Other Identify: _____

Issuing State/Country/Armed Force/School: _____ ID Number _____ ID Expire Date mm/dd/yy __ / __ / __

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI# ____ ○ LHCSA LICENSE # _____

Full name of Agency where applicant will be working _____ Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name _____ FIRST Name _____

Agency's Street Nmbr _____ Street Name _____

City _____ State __ Zip _____

Authorized Party's e-mail: _____

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person: _____ Date: __ / __ / __ (MM / DD / YY)

SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION

Fingerprint Method:
○ Ink & Roll
○ Live Scan

Name & Address of Location where fingerprint services were performed _____

City _____ State __ Zip _____

Identification verified before fingerprinting: (refer to Instruction #4)
○ Yes
○ No

The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated.

Signature: _____

First Name: _____

Last Name: _____

Title: _____

Date Fingerprinted __ / __ / ____ (MM / DD / YYYY)

51289

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.

DOH CHRC 102 (1/07)

NYS Department of Health
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.

3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.

4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.

5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.

7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   _____

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

MEDISTAR

EMPLOYEE HANDBOOK

It gives me great pleasure to welcome you to MEDISTAR. I hope that your association with us will be happy and rewarding.

This Handbook will familiarize you with the general policies, benefits, obligations and services for all MEDISTAR employees. While you will receive additional information both through orientation, training and your work experience, this Handbook will serve as an ongoing reference guide for you.

Any and all questions regarding personnel, recruitment, payroll, employee benefits, and employee discipline should be directed to the Director of Nursing.

Our goal is to provide the highest quality of care to all of our patients. We are equally dedicated to helping our employees find satisfaction in the work they do and pride in a job well done.

MISSION STATEMENT

It is our mission to provide our patients with the finest health care services available, rendered in a manner and in an environment that preserves the dignity, autonomy and well - being of each individual. We are committed to employing a dedicated, competent staff to ensure achievement of this mission.

ABOUT THIS HANDBOOK

MEDISTAR Licensed Home Health Care Services Agency has prepared this handbook as a set of guidelines to inform you about its policies and procedures. Please read it carefully and keep it for future reference.

All of your questions may not be answered in this booklet. If you have any questions about our policies and procedures or any other matter concerning your employment, please consult with the Director of Nursing.

MEDISTAR reserves the right to modify, amend or eliminate plans, policies or procedures. Change and adaptability are a key part of MEDISTAR's pledge to service.

Therefore, this handbook should only be considered a set of guidelines. It is not a "contract of employment". We will try to keep you advised and updated about any changes that affect you.

GENERAL POLICIES

EQUAL EMPLOYMENT OPPORTUNITY

MEDISTAR is committed to providing equal opportunity in all employment-related matters, without regard to race, color, religion, sex, national origin, age, marital status, sexual orientation, citizenship status, veteran status, genetic predisposition or carrier status or any other legally protected characteristic. Decisions affecting your position including recruitment, hiring, promotion, transfer, compensation, benefits, training, tuition assistance, layoff and recall and terminations will be made in accordance with this policy.

EMPLOYMENT AT WILL

Neither this Handbook nor any other letter, offer or statement of employment written or oral may be construed as a contract of employment. Any individual may voluntarily leave their employment and may be terminated by MEDISTAR at any time. Any oral or written statements or promises to the contrary are hereby expressly disavowed.

DISCRIMINATION, SEXUAL HARASSMENT AND HARASSMENT OF ANY KIND

It is MEDISTAR's policy to prohibit the harassment of any employee by another employee, supervisor, service contractor, volunteer or patient on the basis of any personal characteristic such as race, color, religion, sex, national origin, age, marital status, sexual orientation, citizenship status, veteran status, genetic predisposition or carrier status or any other legally protected characteristic.

While it is not easy to define precisely what sexual harassment is, it does include unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature such as uninvited touching or sexually related comments. Harassment can also include improper joking, teasing or other conduct that creates an unprofessional and hostile environment. All employees of MEDISTAR will be held accountable for the effective administration of this policy. Anyone who feels that he or she has been subjected to sexual or other harassment or discrimination or who has become aware of possible harassment or discrimination should immediately report the matter to the Director of Nursing. Discrimination, sexual harassment or harassment of any kind is grounds for termination of employment.

DRUG-FREE WORKPLACE

MEDISTAR is committed to and has a vital interest in ensuring a safe and healthful drug-free workplace for its employees that will ensure a safe environment for patients, visitors and the community in which we serve.

It is MEDISTAR's policy that:

1. The unlawful manufacture, distribution, sale, possession or use of a controlled substance in the workplace is absolutely prohibited.

2. MEDISTAR expects every employee to cooperate with the policy of maintaining a drug-free workplace. Violation of this policy is extremely serious and may result in termination of employment.

DRUG-FREE WORKPLACE (cont.)

3. All employees must report any criminal drug statute conviction to their supervisor no later than five (5) days after such conviction

Simply stated, unlawful drug use has no place at work and its use cannot and will not be tolerated.

4. MEDISTAR reserves the right to request random drug screenings of all employees without prior notice and upon reasonable suspicion for the presence of drugs and/or alcohol. MEDISTAR also reserves the right to terminate without notice any employee who has tested positive for drugs or alcohol, or is found to possess drugs or alcohol on the job site. Drug and/or alcohol use will not be tolerated.

WORKPLACE VIOLENCE

It is the policy of MEDISTAR to ensure the safety and health of its employees. MEDISTAR will not tolerate violence in the workplace and will make every effort to prevent violent acts from occurring through the implementation of programs and systems for identifying and addressing violence in the workplace.

ABUSE PROHIBITION PROGRAM

It is the philosophy of this Agency that every patient has the right to be free from abuse, mistreatment, neglect and misappropriation of property. To this end, MEDISTAR has developed policies and procedures for: the screening and training employees, the protection of patients and or the prevention, identification, investigation and reporting of abuse, neglect, mistreatment and misappropriation of property. It is our policy to do all that is within our control to prevent such occurrences.

YOUR DIRECTOR OF NURSING

Your Director of Nursing is a vital part of the management team and is directly responsible for helping to ensure the quality of your work and providing you with whatever assistance you may need. He or she can help to resolve problems, to arrange training; to address employee discipline issues and to provide feedback. An important part of your director's responsibilities is to answer questions, listen to your work problems and take action where appropriate. To achieve this goal, please discuss any problem or concern you may have with your Director of Nursing or supervisor. If your Director of Nursing does not have an answer to your question, he or she will make sure that you get an answer.

EMPLOYMENT POLICIES

IMMIGRATION REFORM AND CONTROL ACT OF 1986 ("IRCA")

Under IRCA, MEDISTAR is required to verify that any person it hires is legally employable in the United States. Employees are responsible for maintaining their employment eligibility while working for MEDISTAR.

ORIENTATION

Prior to your first day of employment you will attend a New Employee Orientation. This meeting is designed to familiarize you with MEDISTAR's services and objectives, policies, and mandated training in areas such as fire, safety, infection control and hazardous materials. Attendance at orientation is mandatory.

While you are at Orientation, you will be issued a copy of your Job Description and will be required to sign off on its receipt.

Additional Orientations may be provided at client sites, as per their own requirements. These orientations are designed to familiarize you to their specific policies and procedures, their own physical plant, fire safety, infection control protocols, and staff hierarchy. These orientations differ in content, duration, and individual requirements. Some may last 1 day; others may last the better part of three days. In any case, employees will be paid for their time only after a combined five (5) days of onsite participation/service has been completed.

- If orientation lasts for one (1) day, employees will be required to work four (4) additional days (5 total onsite) before orientation is paid for;
- If orientation lasts three (3) days, employees will be required to work and additional two (2) days before orientation is paid for;
- If orientation is not completed, for any reason, than no part of the orientation completed will be paid for;
- If orientation is completed, but the facility decides not to hire you, for cause, or hires you, then determines that a particular candidate is not suitable to their needs, and releases you, for cause, you will not be paid for that period of time because you did not/could not complete the mandatory five (5) days of combined service time.

EMPLOYEE IDENTIFICATION BADGES

Upon employment, you will be provided with a Photo Identification Badge issued by MEDISTAR which is to be worn at all times while on the job. It identifies you, your position and as a person authorized to enter and work for MEDISTAR.

If you lose your Identification Badge you may be required to pay a fee for a new one. Upon termination of employment, you are required to return your Identification Badge to the Director of Nursing.

PERSONNEL RECORDS

Your confidential personnel file is the property of MEDISTAR and it contains the following information: application, resume and/or references, copies of degrees and licenses, copies of your identification cards and/or social security card and work authorization forms, including but not limited to physicals, lab reports and other required medical documents, tax forms, a signed copy of your job description and all other forms completed upon employment or provided to us post employment. During the course of your employment your file will also contain performance evaluations, signed copies of revised job descriptions, changes of name, withholding tax exemptions, address, telephone number, disciplinary actions and letters of commendation. It is your responsibility to keep your personal information up-to-date.

Employees may review their personnel file by making an appointment with the Director of Nursing.

UNIFORMS

Certain MEDISTAR staff members may be required to wear uniforms in the performance of their job duties. Your ID Badge is always part of your required uniform.

PROBATIONARY PERIOD

All new employees are hired on a probationary basis. The probationary period is ninety (90) days. This probationary period allows you to decide if you are satisfied with your position. It also allows your director an opportunity to evaluate your performance and to provide you with assistance learning your new position. Your immediate director's evaluation of your performance will be discussed with you during this period and decisions concerning continued employment will be made.

PERFORMANCE APPRAISALS

It is important for employees to meet with the director to discuss their work performance, their strengths and weaknesses, and to plan for future training and/or responsibilities. To that end, all employees will have their job performance evaluated through an administrative and a clinical evaluation program.

You will be evaluated, initially, during your probationary period and then annually. If you should change positions during your employment you will be evaluated during and at the end of your new probationary period and then annually.

Any relevant evaluations will become part of your personnel file. You will be asked to sign the evaluation acknowledging that it has been discussed with you. You may have a copy of your evaluation as long as you have signed it.

As part of the review process, your director may verify the current status of licenses, certifications and other documentation to assure that they are valid.

PROMOTIONS

MEDISTAR's policy is to promote qualified employees to open positions whenever possible. To be eligible for promotional consideration you must have completed the probationary period of your current position and meet the educational skill and experience required for the new position. A position that pays more and has more responsibility than your present position is considered to be a promotion.

HOURS OF WORK

MEDISTAR operates 24 hours a day, 365 days a year. Your normal workday is your regularly scheduled number of hours, which can include a meal period and break periods. In cases where an unexpected staffing shortage or emergency exists, you may be required to work hours in addition to your regularly scheduled hours.

TIME RECORDS

It is your responsibility to record your actual time worked. You are the only person who may record your time. Violations of this rule will result in serious disciplinary action.

PHYSICAL EXAMINATION

As a new employee you are required to have passed a pre-employment physical which included a PPD (Tuberculosis test), Chest X-Ray if your PPD was positive, Drug screening and to have provided evidence of immunity to Measles (Rubeola) and Rubella and information about your Hepatitis B Vaccination status prior to your start date. As an MEDISTAR employee you will be required to submit an annual Employee Health Assessment Form and have an annual PPD and Drug Screening. Your failure to comply will result in your being taken off the work schedule and may result in disciplinary action up to and including suspension and/or termination. As applicable to your degree of exposure, the Hepatitis B Vaccine is offered to all employees at risk of occupational exposure to blood –borne pathogens. *In addition, you will be offered the Influenza (Flu) vaccine on an annual basis at MEDISTAR's expense.*

HOLIDAYS

MEDISTAR recognizes the following **five (5)** paid holidays:

New Year's Day	**Labor Day**
Thanksgiving Day (1st day)	**Christmas Day**
Independence Day	

Probationary employees within their first 30 days of employment are not eligible to receive paid holidays.

TERMINATION RULE

Upon termination of employment, you will not be entitled to your vacation pay, if you are terminated for cause or if you have failed to give the equivalent of your vacation entitlement as written notice of resignation, or if after giving such notice you fail to work as scheduled during the required notice period.

WORK RELATED INJURIES AND CONDITIONS

Accidental injuries which occur during working hours or conditions caused by work activities may be covered under our Worker's Compensation policy. This insurance provides for payment of medical expenses as provided by law during the period of disability. If you are injured on the job you must immediately report that injury to MEDISTAR, who will initiate the appropriate paperwork. **ALL ACCIDENTS AND INJURIES, NO MATTER HOW SLIGHT MUST BE REPORTED.**

NON-WORK RELATED INJURIES AND CONDITIONS

If you are injured off the job or have an illness or a disabling condition, you may be eligible to apply for short-term disability benefits. Eligible employees utilizing disability insurance benefits may also qualify for a *Family Medical Leave of Absence* or a Disability Leave of Absence.

You must inform the Director of Nursing as soon as you know that as the result of a disability you will be absent from work for any period of time.

DEATH IN FAMILY

Upon successful completion of your ninety (90) day probationary period, you may be granted a leave of absence in the event of the death of your spouse, mother, father, or child. In the event of the death of brother, sister, grandparent, grandchild, mother-in- law and father-in-law you may be granted leave if it is authorized by your supervisor in advance. These days must be taken consecutively within a reasonable time of the date of death, or date of the funeral and may not be split or postponed.

You will be required to submit documentation regarding the deceased family member.

LEAVES OF ABSENCE

There are various types of leaves of absence that can be granted to you. There are various rules governing approval of leaves of absences that differ, depending on the specific type of leave requested.

Military Leave

If you enter the Armed Forces, your position or a like one with MEDISTAR will be held open for you (for four (4) years (or for five (5) years if ordered by the President) provided that you return to

work within ninety (90) days of discharge and are honorably discharged from active military status. Time in military service will be considered an unpaid leave of absence.

If you are a member of the National Guard or Reserve Unit and are required to attend an annual two (2) week training camp you may take this time as vacation if it is owed to you, or as an unpaid leave. You must submit duty orders immediately upon receipt from the military and complete and submit an MEDISTAR Request for Leave of Absence Form.

Personal Leave

If you have been continuously employed for a period of one (1) year you may request a Personal Leave of Absence, which may be granted at the discretion of MEDISTAR. You must submit your request, in writing, to the Director of Nursing as soon as you are aware of your need for such a leave.

Medical/Disability Leave Of Absence

If you are a regular full-time or regular part-time employee and have a disability or serious health condition, which renders you unable to perform your job functions, MEDISTAR may authorize a leave of absence for you. This leave may begin after expiration of the twelve (12) week leave provided in our Family and Medical Leave Policy if you are eligible for leave under that Policy. A Medical/Disability Leave of Absence may not exceed twelve (12) months. You will be required to provide periodic medical evidence to continue on your leave. Two (2) weeks prior to your return from this leave you must provide medical evidence from your physician permitting you to return to full duty.

Family and Medical Leave

MEDISTAR supports and complies with the federal Family and Medical Leave Act. If you have twelve (12) or more months of service and with a minimum of one thousand, two hundred and fifty (1,250) hours worked within the 12 months immediately preceding the request you may apply for up to twelve (12) weeks of unpaid Family and Medical Leave to care for a family member with a serious health condition, to care for a newborn or newly placed adopted or foster child, or to recover from your own serious illness.

Prior to taking a Family and Medical Leave you must first use your Sick Days, if the leave is due to sickness or injury, and/or any accrued Personal Days and Vacation. When you take a leave of absence that meets the qualifications of the Family and Medical Leave Act, you will automatically be placed on Family and Medical Leave.

You will be required to provide periodic medical evidence to continue this leave. Two (2) weeks prior to your return from this leave you must provide medical evidence from your physician permitting you to return to full duty.

INSURANCE BENEFITS

NEW YORK STATE DISABILITY

This disability plan covers absences due to illnesses other than work related illnesses and injuries, in excess of five (5) working days. The plan will pay up to 50% of an employee's average last eight (8) weeks earnings to a maximum weekly allowance of $170 for a maximum of 26 weeks in a 52 week period.

NEW YORK STATE WORKER'S COMPENSATION

Employees are covered for absences and medical bills incurred due to a work-related illness or injury. Coverage includes medical bills from date of injury or illness; wages will be reimbursed at the rate of sixty-six and two-thirds percent (66 $^{2/3}$%) of an employee's average earnings of the last 52 weeks to a maximum $400 a week.

PROFESSIONAL LIABILITY INSURANCE

MEDISTAR's insurance program provides professional liability coverage for its employees.
This insurance is limited to claims that occur as a result of an employee's authorized activities on behalf of MEDISTAR Licensed Home Health Care Agency.

YOUR SALARY

OVERTIME

Except in emergency situations where prior notification is impossible, all overtime work by must be authorized in advance by the Director of Nursing/Designee. Personnel who work over forty hours per week are compensated for overtime at the rate of one and one-half (1½) times the minimum wage rate of pay for part-time workers and one and one half (1½) times their wage for full time staff, in accordance with state and federal law.

PAY PERIODS

Pay periods begin on Saturday at 12:01am and ends on Friday at midnight. You will receive your paycheck on Fridays at the end of each pay period. Please note that each Friday you are being paid for the previous weeks pay period and **not** for the pay period of that Friday.

PAYCHECKS

Under general circumstances your paycheck will be mailed to you unless 3 days prior notice is given and it is authorized by your supervisor to have it picked up at MEDISTAR. You should keep your check stub for your records and should refer to it, if you have any questions regarding payment for that pay period. MEDISTAR reserves the right to insist that an employee come into the office to pick up his or her check

PAYROLL DEDUCTIONS

A variety of deductions are required by law to be made from your gross earnings. FICA (Social Security), federal, state and applicable local taxes will be deducted each pay period. No other deductions will be made without your knowledge or written permission, unless we are required to do so by a legal judgment. These may include any judgment or lien received by MEDISTAR for you.

LOST PAYCHECKS

If you should lose your paycheck you must notify MEDISTAR immediately. Payment on the check will be stopped and you will receive a replacement check as soon as it is reasonably possible.

TERMINATION PAY

You will receive your final paycheck on the payday following your last regular paycheck.

If you have been discharged for cause or have failed to give proper notice or failed to work during the notice period you will forfeit any vacation or sick days you may be entitled to.

YOUR OBLIGATIONS

As a member of the staff of MEDISTAR your job performance and your customer service skills have a direct impact on the care provided to patients and to the success of MEDISTAR.

You have a responsibility to perform your duties, communicate and interact with patients, families, visitors and other staff members with courtesy, respect and understanding.

CONFIDENTIALITY

Employees may, at times, have access to confidential information regarding MEDISTAR and/or its patients. Confidential information may include, among other things, medical records, knowledge of a patient's identity and/or condition, information from employee records or personal information regarding another employee.

It is your obligation to keep all such information confidential. Failure to do so will result in the termination of your employment.

FIRE AND SAFETY

MEDISTAR has an obligation to insure the safety of the patients, visitors and employees. However, it is everyone's obligation to assist in this effort.

You will receive an orientation and ongoing training concerning fire regulations, safety rules and safety equipment.

It is your obligation to follow these regulations and to perform your job safely at all times.
Be aware of conditions around you and immediately report anything that may be hazardous.

DRESS CODE

All staff members are expected to report for duty dressed appropriately, professionally and wearing your ID Badge at all times. If you are required to wear a uniform it should be clean, neat and in good repair.

The general MEDISTAR dress-code, requires that employees do not wear jeans, open toed shoes, halter tops, dangling jewelry, shorts, and tight fitting clothing such as spandex. During Orientation you will be given more detailed information regarding appropriate dress code for MEDISTAR.

SMOKING

Smoking is not permitted on agency property or in patient homes.

ABSENTEEISM AND LATENESS

It is your obligation to be on time to your appointments. If you are ill and unable to report for duty or if you will be late in reporting for duty you must call MEDISTAR at least two (2) hours before you are scheduled to begin work. If you are out of work due to illness for several days you must advise the Director of Nursing of the approximate length of your absence and date of return.

You must keep the Director of Nursing informed of your progress by calling in on each day of absence and alerting him/her if any change occurs in your planned date of return.

Excessive lateness, absenteeism and/or failure to report on duty without notifying MEDISTAR will result in progressive discipline up to and including discharge. Patterns of repeated offenses will be cause for suspension and /or discharge.

PERSONAL MAIL

Your personal mail must not be routed to you or by you through MEDISTAR. MEDISTAR processes business mail only.

Please do not arrange to receive packages at your work place. The Receiving Department is authorized to accept agency packages only.

MEDISTAR is not responsible for the loss of any personal mail and/or packages.

PERSONAL TELEPHONE CALLS

Agency telephones are for Agency business only and not for personal use. Employees may not use phones in patient homes.

Cell phone usage in MEDISTAR is prohibited.

PERSONAL PROPERTY

MEDISTAR is not responsible for your personal property. Please leave your personal items at home. If you discover the loss of property (personal or agency) you must immediately report it to the Director of Nursing.

NO SOLICITATION AND DISTRIBUTION

The solicitation or hand billing by any person who is not employed at this Agency is prohibited. MEDISTAR employees must follow this rule as well as all other Agency rules. MEDISTAR employees may not engage in solicitation of any kind during work time. Persons employed at MEDISTAR may not engage in the distribution of any material in any working area or patients care before, during or after the time they are assigned to be working. Persons employed at MEDISTAR are prohibited from engaging in solicitation and distribution of any kind during working and non-working time.

EMPLOYEES ON AGENCY PREMISES

MEDISTAR does not allow persons employed at MEDISTAR to enter or remain on the premises unless you are on duty or have business with MEDISTAR. The only exception to this rule is if you have business to transact, such as picking up your paycheck. During working hours employees are required to wear /show their ID Badges.

PACKAGE INSPECTION

When entering or leaving MEDISTAR, employees will be subject to package inspection by authorized personnel.

VISITORS

MEDISTAR does not permit unauthorized visitors to enter the premises. MEDISTAR employees may not receive visitors while on duty. Please do not ask friends or family to meet you in MEDISTAR or a patient's home. Unauthorized visitors to MEDISTAR will be removed from the premises. Infringements on this policy may result in disciplinary action up to or including termination.

GRATUITIES

As an employee you are prohibited from soliciting or accepting tips or gratuities offered by patients, visitors, suppliers, and others. Accepting tips or gratuities may result in your termination from employment.

WITNESSING DOCUMENTS

Employees are not authorized to witness legal documents for patients.

PUBLIC STATEMENTS

MEDISTAR employees are prohibited from taking pictures, making public statements concerning MEDISTAR, its policies and its patients. Administration responds to inquiries from the media. Please refer these requests accordingly.

CARE OF AGENCY EQUIPMENT

Equipment and supplies are provided for you by MEDISTAR to assist you in the performance of your duties. You have the obligation to use these items carefully and properly. If equipment becomes damaged, report the damage to the Director of Nursing immediately.

STANDARDS OF CONDUCT

MEDISTAR expects that all employees will conduct themselves in a professional manner that will contribute to the provision of the highest quality of care for patients and the safety and security of patients, visitors and fellow employees. Rules, regulations and policies have been developed to provide you with standards that will assist you in this effort. Employees must comply with all Agency rules and regulations.

CODE OF ETHICS/DISCIPLINE

By creating "Code of Ethics", for all employees, we want you to know what is expected of you while you are employed here and what type of behavior will not be accepted.

It is MEDISTAR's policy to take appropriate disciplinary action with any employee for acts of misconduct.

In addition to acts covered elsewhere in this Handbook, the following list although not exhaustive, sets forth examples of acts constituting violations of MEDISTAR's policy that will be subject to discipline and/or discharge.

Examples of misconduct may include the following:

1. Abuse (physical or verbal) of, actions or displayed attitudes detrimental to patient care.
2. Theft or willfully destroying any property of MEDISTAR, its patients, visitors or personnel.
3. Insubordination.
4. Reporting for, or attempting to work while under the influence of alcohol, drugs or narcotics.
5. Possession of alcoholic beverages, unlawful drugs or weapons while on the premises of MEDISTAR or in a patients home.
6. An incidence of physical or verbal altercation, "horseplay" or threatening anyone while on the premises of MEDISTAR or in a patient's home.
7. Signing for another employees' time worked.
8. Falsification of Records (Including fraudulent statements made on the employment application).
9. Careless disregard and/or refusal to comply with work directives, instructions and established policies and procedures. (i.e. Violations of safety and fire codes, safe clinical practices or sanitary rules and regulations.)
10. Failure to show up for work when scheduled, or failure to notify the Director of Nursing/Designee when you are unable to come to work.
11. Taking photographs while on the premises of MEDISTAR/or in a patients home without the permission of the Director of Nursing.
12. Failure to obtain permission from the Director of Nursing/Designee to leave your job, or the premises of MEDISTAR during working hours, or leaving your assignment without proper relief.
13. Harassment and threats of any kind.
14. Conduct which interferes with the efficient and successful operation of MEDISTAR.

CODE OF ETHICS/DISCIPLINE (CONT.)

15. Sleeping or watching television while on duty.
16. Accepting or soliciting tips or gratuities of any kind for the performance of services.
17. Engaging in any type of financial transaction with a patient.
18. Misrepresenting reasons when applying for a leave of absence or other time off from work, whether paid or unpaid.
19. Violation of Agency rules regarding solicitation and the distribution of literature.
20. Smoking or consuming food or beverages in unauthorized areas.
21. Performing personal work and/or having personal visitors while on duty.
22. Failure to comply with needs of MEDISTAR by providing the necessary paperwork enabling the employee to work. (i.e. Attending mandatory in-services, submitting annual physicals, maintaining current licensure, reporting all accidents, incidents.)
23. Poor job performance.
24. Breach of confidentiality involving patients and/or employees.
25. Frequent lateness.
26. Patterns of illness associated with weekends, vacations, holidays and/or scheduled days off.
27. Discrimination against anyone thus violating MEDISTAR's equal employment policy.
28. Gross negligence.
29. Any conduct which is contrary to MEDISTAR's mission and vision and/or contrary to the best interest of MEDISTAR, its patients and employees.

TERMINATION OF EMPLOYMENT

RESIGNATION

You are required to give written notice of your intention to leave your employment. This notice should be addressed to the Director of Nursing and your supervisor. Employees must give the equivalent of their vacation eligibility; those who do not shall forfeit any and all accrued and unused vacation, holiday and sick days.

All Agency property, uniforms, keys, etc. must be returned to the Director of Nursing on or before your last day of work.

EXIT INTERVIEWS

It is helpful for us to have feedback from you throughout your employment. It is also helpful for us to talk with you when you are leaving MEDISTAR. An exit interview has been designed for this purpose. Upon giving notice of your intent to terminate your employment you may be asked to meet with the Director of Nursing prior to your last day of work to discuss your experiences at MEDISTAR and to ask for suggestions which might help us in future recruitment.

If you are not asked to meet with the Director of Nursing you may get an exit interview form in the mail. If so, please take a few minutes to complete it and return it to MEDISTAR.

All responses to an exit interview, whether in person or in writing, will be held in the strictest confidence.

HIPAA COMPLIANCE

Employees agree to comply with the applicable provisions of the Administrative Simplification Section of the Health Insurance Portability and Accountability Act of 1996 as codified at 42 U.S.C. § 1320d through d-8 ("HIPAA"), and the requirements of any regulations promulgated thereunder including without limitation the federal privacy regulation as contained in 45 C.F.R. part 164 (the "Federal Privacy Regulations") and the federal security standards as contained in 45 C.F.R. Part 142 (the "Federal Security Regulations"). Employees agree not to use or further disclose any protected health information, as defined in 45 CFR 162.504, or individually identifiable health information, as defined in 42 U.S.C. § 1320d (collectively the "Protected Health Information"), concerning a patient other than is permitted by this Agreement and the requirements of HIPAA or regulations promulgated under HIPAA including without limitation the Federal Privacy Regulations and the Federal Security Regulations.