PERSONNEL FILE CONTENTS

LEFT SIDE

____ Copy of Professional License

____ Copy of CPR

____ Copy of Driver's License

____ Copy of SSN

____ Copy of Health Exam (if applicable)

____ Copy of Academic transcripts

____ Resume (if any)

RIGHT SIDE

______ Application

______ Reference(s) Verification

______ Signed Job Description (As applicable)

______ Orientation Check List (As applicable)

______ Criminal History Check, Applicant Misconduct Registry, Nurse Aide Registry Notification and Statement of Employability

______ License/ Permit/ Registration Verification

______ Disclosure of Drug Testing

______ Hepatitis B Notification Acceptance/Non-Acceptance

______ Application Form Waiver

______ Confidentiality and Non-Disclosure Agreement

______ HIPPA Certificate

______ Infection Control Policy

______ Reportable Conduct and Reporting Possible Victims of Alleged/Suspected Abuse, Neglect, Or Exploitation

______ Abuse, Neglect, Exploitation Procedures Wavier Services

______ EEO Policy

______ School Staff Do's and Don'ts

______ Applicant Compliance

______ Payroll schedule

______ I-9 form

______ W-4 form

PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE

DATE OF HIRE_________________________

APPLICATION FOR EMPLOYMENT

(APPLICANT MAY BE TESTED FOR ILLEGAL DRUGS)

PLEASE COMPLETE ALL PAGES DATE______________________

Name____
Last First Middle Maiden

Present Address____
Number Street City State Zip

How long__________________ Social Security No._____-_____-______
Telephone______________________ If under 18, please list age_________

Position applied for (1)__________________ salary desired (2)__________________ (Be specific)

How many hours can you work weekly? _______________ Can you work in Evening Shift? _________________________

Employment desired ❑FULL-TIME ONLY ❑PART-TIME/ADJUNCT ONLY ❑CONTRATCT ǁ When available for work?_______________

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. Or Trade School				
Professional School				

HAVE YOU EVER BEEN CONVICTED OF A CRIME? ❑YES ❑NO

If yes, explain numbers of conviction(s), nature of offence(s) leading to conviction(s), how recently such offence(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation. ____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name____ Telephone (___)______________________________

Address____ Relationship________________________________

PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE

APPLICATION FOR EMPLOYMENT

Work History: Please list your work experience for the last five years beginning with your most recent job held. If you were self-employed, give firm name. Attach additional sheets, if necessary.

Name of employer: Address: City, State, Zip Code: Phone number:	Name of Supervisor	Employment Dates	Pay or Salary
		From: To:	Start: Final:
	Your job title:		
Reason for leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company:			

Name of employer: Address: City, State, Zip Code: Phone number:	Name of Supervisor	Employment Dates	Pay or Salary
		From: To:	Start: Final:
	Your job title:		
Reason for leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company:			

WORK HISTORY (CONTINUED)
APPLICATION FOR EMPLOYMENT

<table>
<tr><td rowspan="3">Name of employer:

Address:

City, State, Zip Code:

Phone number:</td><td>Name of Supervisor</td><td>Employment Dates</td><td>Pay or Salary</td></tr>
<tr><td></td><td>From:

To:</td><td>Start:

Final:</td></tr>
<tr><td colspan="3">Your job title:</td></tr>
<tr><td colspan="4">Reason for leaving (be specific):</td></tr>
<tr><td colspan="4">List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company:</td></tr>
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APPLICATION FOR EMPLOYMENT

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City, State, Zip Code:

Phone number:</td><td>Name of last Employer</td><td>Employment Dates</td><td>Pay or Salary</td></tr>
<tr><td></td><td>From:

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<tr><td colspan="4">List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company:</td></tr>
</table>

PAGES HEALTH SERVICES, INC.
16100 Cairnway Dr # 355, Houston, TX 77084
Tel: (281)738-3641 Fax: (888)257-1326

REFERENCE VERIFICATION FOR EMPLOYMENT

DEAR APPLICANT: PLEASE COMPLETE THE INFORMATION BELLOW AS A PART OF YOUR REFERENCE VERIFICATION:

APPLICANT'S FULL NAME:______________________________________ SSN:XXX-XX-_____________

COMPANY / SCHOOL NAME:____

FAX:____________________________________TELEPHONE: __________________________________

APPLICANT'S SIGNATURE:____

TO BE COMPLETED BY REFERENCE /PREVIOUS EMPLOYER

AS A PART OF REFERENCE VERIFICATION FOR AN EMPLOYMENT FOR THE ABOVE APPLICANT, YOU ARE REQUESTED TO FAX THIS FORM DULY FILLED OUT:

DATE OF HIRE: _______________________ DATE OF LAST EMPLOYMENT:______________

POSITION HELD: __________________________________ ELIGIBLE FOR HIRE? YES/NO

REASON FOR LEAVING/SEPARATION: ____

APPLICANT'S ATTRIBUTES:

ITEM	EXCELLENT	ABOVE AVERAGE	AVERAGE	UNACCEPTABLE
QUALITY OF WORK				
COMMUNICATION SKILLS				
INTERPERSONAL SKILLS				
PROFESSIONAL COMPETENCY				
DEPENDABILITY				

COMMENTS: ____

INFORMATION GIVEN BY: ____TITLE:______________

SIGNATURE:______________________________________ DATE:_______________

FOR OFFICE USE ONLY

CHECKED BY:____ SIGN:___________________________

COMMENT(S):____ DATE:___________________________

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REFERENCE VERIFICATION FOR EMPLOYMENT

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COMPANY / SCHOOL NAME:____

FAX:______________________________________TELEPHONE: ____________________________________

APPLICANT'S SIGNATURE:____

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DATE OF HIRE:______________________ DATE OF LAST EMPLOYMENT:_____________

POSITION HELD: ________________________________ ELIGIBLE FOR HIRE?: YES/NO

REASON FOR LEAVING/SEPARATION:____

APPLICANT'S ATTRIBUTES:

ITEM	EXCELLENT	ABOVE AVERAGE	AVERAGE	UNACCEPTABLE
QUALITY OF WORK				
COMMUNICATION SKILLS				
INTERPERSONAL SKILLS				
PROFESSIONAL COMPETENCY				
DEPENDABILITY				

COMMENTS: ____

INFORMATION GIVEN BY: ______________________________________TITLE:_____________

SIGNATURE:_____________________________________ DATE:______________

FOR OFFICE USE ONLY

CHECKED BY:____ SIGN:__________________________

COMMENT(S):____ DATE:__________________________

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COMPANY / SCHOOL NAME:____

FAX:_______________________________TELEPHONE: ______________________________

APPLICANT'S SIGNATURE:____

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AS A PART OF REFERENCE VERIFICATION FOR AN EMPLOYMENT FOR THE ABOVE APPLICANT, YOU ARE REQUESTED TO FAX THIS FORM DULY FILLED OUT:

DATE OF HIRE:____________________ DATE OF LAST EMPLOYMENT:____________

POSITION HELD: ______________________________ ELIGIBLE FOR HIRE?: YES/NO

REASON FOR LEAVING/SEPARATION:____

APPLICANT'S ATTRIBUTES:

ITEM	EXCELLENT	ABOVE AVERAGE	AVERAGE	UNACCEPTABLE
QUALITY OF WORK				
COMMUNICATION SKILLS				
INTERPERSONAL SKILLS				
PROFESSIONAL COMPETENCY				
DEPENDABILITY				

COMMENTS: ____

INFORMATION GIVEN BY: ___________________________________TITLE:____________

SIGNATURE:__________________________________ DATE:_____________

FOR OFFICE USE ONLY

CHECKED BY:____ SIGN:_________________________

COMMENT(S):____ DATE:_________________________

CRIMINAL HISTORY CHECK, APPLICANT MISCONDUCT REGISTRY, NURSE AIDE REGISTRY NOTIFICATION AND STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by Pages Health Services that a criminal history check will be performed on my name. I have informed this agency of all names (i.e., maiden name, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary or interim pending the results of the criminal history check. I also understand that the agency will search the Employee Misconduct Registry and the Nurse Aide Registry (if applicable) to determine whether any acts of abuse, neglect or exploitation has occurred and whether my name is designated on either registry. If my name is designated on either registry I understand the agency must deny me employment.

I hereby profess that I have not been convicted of any of the following crimes which are a permanent automatic bar to employment by this agency (Ref: Texas Health and Safety Code §250.006**):**

Texas Penal Code

Chapter 19 — Criminal homicide: includes Murder, Capital Murder, Manslaughter, or Criminally negligent homicide

Chapter 20 — Kidnapping and unlawful restraint

§21.02 — Continuous sexual abuse of young child or children

§21.08 — Indecent Exposure

§21.11 — Indecency with a child

§21.12 — Improper relationship between educator and student

§21.15 — Improper photography or visual recording

§22.01 — Assault: Class A Misdemeanor or Felony conviction, which occurred within the previous five years.

§22.011 — Assault, Sexual

§22.02 — Assault, Aggravated

§22.021 — Assault, Aggravated Sexual

§22.04 — Injury to a child, elderly individual, or disabled individual

§22.041 — Abandoning or endangering a child

§22.05 — Deadly Conduct

§22.07 — Terroristic Threat

§22.08 — Aiding suicide

§25.031 — Agreement to abduct from custody

§25.08 — Sale or purchase of a child

§28.02 — Arson

§29.02 — Robbery

§29.03 — Robbery, Aggravated

§30.02 — Burglary: a conviction which occurred within the previous five years.

Chapter 31 — Theft: a conviction that is punishable as a felony which occurred within the previous five years.

§32.45 — Misapplication of fiduciary property or property of a financial institution: a Class A Misdemeanor or Felony conviction which occurred in the previous five years.

§32.46 — Securing execution of a document by deception: a Class A Misdemeanor or Felony conviction which occurred in the previous five years.

§33.021 — Online solicitation of a minor

§34.02 — Money laundering

§35A.02 — Medicaid fraud

§36.06 — Obstruction or Retaliation

§37.12 — False identification as a peace officer: a conviction which occurred in the previous five years.

§42.01(a)(7),(8), or(9) — Disorderly conduct associated with the discharge or display of a firearm in a public place: a conviction which occurred in the previous five years.

§42.09 — Cruelty to animals

§42.092 — Cruelty to non-livestock animals

A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed above.

(a) a conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.

(b) A person may not be employed in a position the duties of which involve direct contact with a consumer in a facility or may not be employed by an individual employer before the fifth anniversary of the date the person is convicted of:
(1) an offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony;
(2) an offense under Section 30.02, Penal Code (burglary);
(3) an offense under Chapter 31, Penal Code (theft), that is punishable as a felony;
(4) an offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of financial institution), that is punishable as a Class A misdemeanor or a felony;
(5) an offense under Section 32.46, Penal Code (securing execution of document by deception), that is punishable as a Class A misdemeanor or a felony;
(6) an offense under Section 37.12, Penal Code (false identification as peace officer; misrepresentation of property); or
(7) an offense under Section 42.01(a)(7), (8), or (9), Penal Code (disorderly conduct).

(c) In addition to the prohibitions on employment prescribed by Subsections (a) and (b), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

(1) of an offense under Section 30.02, Penal Code (burglary); or

(2) under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

(d) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Article 42A.111, Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

<u>Additional to Bars to Employment</u>

Bars pursuant to Texas Administrative Code, Title 40, Part 1, Chapter 3, §3.201 Texas Health and Safety Code:

- Chapter 481 **— Texas Controlled Substances Act: a conviction that is punishable as a felony (involving manufacture, delivery, intent to distribute, conspiracy to possess or produce with intent to distribute, distribution to a minor, illegal expenditure or investment, or transfer or receipt of chemical laboratory apparatus).**

<u>Texas Penal Code</u>

- §15.01 **— Criminal Attempt of any offense listed as a bar**
- §43.03 **— Promotion of Prostitution**
- §43.04 **— Aggravated Promotion of Prostitution**
- §43.05 **— Compelling Prostitution**
- §43.25 **— Sexual Performance by a Child**
- §43.26 **— Possession or Promotion of Child Pornography**

I understand that if I have been placed on deferred adjudication community supervision for an offense listed above, successfully completed the period of deferred adjudication community supervision, and received a dismissal and discharge according to Section 5(c), Article 42.12, Code of Criminal Procedure, I am not considered convicted of that offense.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment.

I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

______________________ ___________________________________ ____________________

Signature of Applicant **Print Name** **Date**

****

LICENSE/ PERMIT/ REGISTRATION VERIFICATION

Date: ___________________ Name: _________________________________

Type of License / Permit / Registration: ___________________________________

License / Permit / Registration (circle one) number: ________________________

Expiration Date: _________ Contacted _______________________ to verify

Verification status: ___________ Verification checked by: ___________________

APPLICANT'S MISCONDUCT AND NURSE AIDE REGISTRY CHECK

Date: ____________________ Name: _________________________________

Registry checked: Nurse Aide Registry: ______ Applicant Misconduct _______

Name on either / applicable registry: YES or NO Employable: YES or NO

(Please note: If the Applicant's name appears on either registry that the Applicant is not employable)

Registry (entries) checked by: ____________________________, Title: ____________

DISCLOSURE OF DRUG TESTING

POLICY

The School will provide a written statement describing the School's policy for drug testing of Applicants who have direct contact with patients to each person applying for services from the School and any person requesting the information.

The School recognizes its responsibility to protect its' Applicants and patients from the dangers posed by the use of illegal drugs, misuse of controlled substances, and the effects of alcohol use in the office or in the home setting. Applicants who illegally use drugs, misuse drugs, or use alcohol on the job create a serious risk to the safety, security, and health of themselves, other Applicants, and patients.

- In compliance with state and federal law, the School forbids any illegal or improper use of drugs and/or alcohol by its Applicants while on duty. (On duty includes rest periods, meal breaks, and on-call hours).
- The School forbids selling, dispensing, distributing, possessing, or manufacturing drugs, drug paraphernalia, alcohol, or controlled substances during work hours or during any work-related activities.
- Any Applicant who is found to have violated this policy will be disciplined or terminated.
- An exception to this policy covers any Applicant who, under the direction of a physician, is taking prescribed medication while at work, while using School equipment, while conducting School business, or while on breaks. In this circumstance, it is the responsibility of the Applicant to report the use of the prescribed medication that might affect job performance before job performance is actually impaired.

PROCEDURE

At Will Testing:

The School does not routinely test for drugs or alcohol; however, the School may at will request an Applicant to submit to a drug and or alcohol test if the Applicant is suspected of being under the influence of such. The School will not tolerate such use or possession of. The School reserves the right to require a drug screen and/or alcohol use. Alcohol or drug use may be evidenced by odor of alcohol or drugs on the Applicant's breath, or by inappropriate behavior or performance on the job. Testing may also be done after a work-related accident and as a condition for employment.

Prescription Medications:

If the Applicant is on prescription medication, it is the Applicant's duty to report the use of prescribed medication that might affect job performance before job performance is actually impaired. Reporting or excuses "after the fact" are not sufficient to limit or modify disciplinary or remedial actions taken. For the purpose of this policy, individuals who report to work or perform work while impaired or under the influence of a prescribed medication, the usage of which has not been reported previously, will be treated as having reported to work impaired or under the influence of a drug, and thus in violation of the policy.

Applicant Assistance:

Applicants in need of assistance in dealing with alcohol or drug-related problems are encouraged to seek professional help prior to the necessity for application of this policy and corresponding procedure. Any Applicant who violates the above prohibitions will be subject to termination of employment or other relationship with the School or, at the School's sole discretion, be required to satisfactorily participate in a drug and/or alcohol abuse assistance or rehabilitation program.

Method by Which Drug Testing Is Conducted:

The method(s) for drug testing will be either by urine, blood or breathalyzer data.

By signing this form, I, ___________________________________ acknowledge that I have read, understand
(PRINT YOUR NAME LEGIBLY)
and will comply with the School's drug testing policy.

____ ________________________
(APPLICANT'S SIGNATURE) (DATE)

HEPATITIS B NOTIFICATION ACCEPTANCE

Because of my occupational exposure to a blood and/or other potentially infectious materials, and my possible risk of acquiring Hepatitis B virus (HBV), it is my wish to receive the vaccination series offered by the School. I understand there will be no charge to me for this series of injections. I am aware, and signify by my signature below, that the School will monitor the administration of this vaccination series to me.

Applicant's Signature / Date School Representative Signature / Date

HEPATITIS B NOTIFICATION DECLINATION

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

Applicant's Signature / Date School Representative
Signature / Date

Appendix A to Section 1910, 1030- Hepatitis B Vaccine Declination (Mandatory)

PLEASE READ CAREFULLY

APPLICATION FORM WAIVER

In exchange for the consideration of my job application by **Pages Health Services,Inc.** (hereinafter called "the School"), I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of Applicant handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other School practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an Applicant of the School, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the owner or administrator of the School. Both the undersigned and the School may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the School may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the School permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the School from any liability as a result of such contract.

I further understand that my employment with the School shall be probationary for a period of ninety (90) days, and further that at any time during the probationary period or thereafter, my employment relation with the School is terminable at will for any reason by either party.

Signature of applicant____ Date: ___________________

This School is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this School depends solely on your qualifications.

Thank you for completing this application form and for your interest in our School.

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

To ensure the School is in compliance with the HIPAA regulations and to ensure the protection of Protected Health Information (PHI) and the prevention of unauthorized use the School will authorize those persons allowed to have access to PHI. The School must also ensure that what PHI is used by such authorized persons must be what is minimally necessary to perform / carry out the job duty / function.

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

________________ ____

Date Applicant's Signature

PAGES HEALTH SERVICES, INC.
THIS IS TO CERTIFY THAT

On ___________________________ _______, 20______,
(month) (day) (year)

______________________________________, ________
(name) (title)

Attended and Completed the
HIPAA In-Service Training Program Titled:

"Understanding HIPAA's Privacy Rule"

Topics Included:

- An overview of the HIPAA guidelines and regulations relative to the protection of of patient and School information;
- A review of the School's HIPAA policies and procedures;
- A review of the School's policies regarding the sharing of passwords and user ID codes, unauthorized use and reporting of such;
- The purpose of the School's user confidentiality agreement;
- The identity and location of the School's HIPAA Compliance Officer.

___________________________ ______________________________________

(Date) (Presenter's Signature)

INFECTION CONTROL

GOAL:

Prevention of dissemination of harmful pathogens from infected persons to uninfected persons by establishing mechanical barriers and carrying out protective techniques.

PROCEDURE:

All providers should routinely use appropriate barrier precautions to prevent the exposure of skin and mucous membranes when contact with blood and/or body fluids of any consumer is anticipated. Gloves should be worn for touching blood and/or body fluids, and for skin of all consumers, for handling items of surfaces soiled with blood or body fluids, and for performing Venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear of shields should be worn during procedures that are likely to generate splashes of blood or bodily fluids.

Rationale: all blood and body fluids should be treated as if they are potentially infectious.

Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.

All providers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures: when cleaning used instruments, during disposal of used needles, and when handling sharp instruments after procedures. To prevent needle stick injuries, needles should not be recapped, purposely bent or broken by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture resistant containers should be located.

____________________________________ ________________________

Signature Date

REPORTABLE CONDUCT AND REPORTING POSSIBLE VICTIMS OF ALLEGED/SUSPECTED ABUSE, NEGLECT, OR EXPLOITATION

State Laws require that we inform you of our policy on the reporting of Abuse, Neglect and exploitation

Policy

The Agency will define the process for identifying and reporting possible victims of alleged suspected abuse, neglect, and/or exploitation which will enable the Agency to protect the health and wellbeing of its clients and families.

If the Agency has cause to be believed that a client has been abused, neglected, and/or exploited by Agency employee, the Agency must report the information to:

- ➢ Call 800-458-9858 to report suspected abuse or neglect of people who are older or who has disabilities.

- ➢ Texas Department of Family and Protective Services (DFPS) Hotline at 1-800-252-5400. Reportable conduct definitions:

Physical abuse

- act or failure to act performed knowingly, recklessly, or intentionally, including incitement to act;
- act of inappropriate or excessive force or corporal punishment; or
- use of chemical or bodily restraints not in compliance with federal and state laws and regulations.

Sexual abuse

- unwanted hugging, kissing, stroking, fondling, indecent exposure, etc. with sexual intent.

Sexual exploitation

- a pattern of sexual abuse.

Verbal/emotional abuse

- curse, vilify, or degrade; or
- threaten with physical or emotional harm.

Neglect

A negligent act or omission by any individual responsible for providing, which caused or may have caused physical or emotional injury or death or which placed a person at risk of physical or emotional injury or death.

Exploitation

The illegal or improper act or process of using a person or the resources of a person for monetary or personal benefit, profit, or gain.

______________________________ Employee Signature

____________________ Date

ABUSE, NEGLECT, EXPLOITATION PROCEDURES WAVIER SERVICES

Policy

Pages Health Services Inc. will ensure that all allegations of abuse, neglect, and exploitation are reported within one hour of discovery to the Texas Department of Regulatory and Protective Services (Adult Protective Services or Child Protective Services.) and the Department of Human Services under the Home and Community Support Service Agency licensures rules. Mistreatment, neglect, abuse, or exploitation of any consumer is prohibited. Any person witnessing or having cause to believe that the physical or mental health of welfare of a consumer has been or may be adversely affected by abuse, neglect, or exploitation caused by another person shall be reported immediately (within one hour) to the appropriate regulatory agency (DHS or APS) and to their supervisor. The reported abuse or suspected abuse will be fully investigated and action taken to prevent reoccurrence.

Procedure

- The Administrator or designee will ensure that all Pages Health Services employees and contractors are trained in reporting of allegations (or suspicions) of abuse, neglect, or exploitation to DFPS within one hour of discovery.
- Acknowledgement of this information will be maintained in the employee/contract provider's file. Acknowledgement will include the provisions of the TDPRS toll free telephone number. DHS programs CLASS: 1-800-458-9858; APS PI: 1-800-647-7418.
- Reportable conduct by an employee is defined by Health and Safety Code 253.001 as:

  1. Abuse or neglect that causes or may cause death or harm to an individual receiving agency services.
  2. Sexual abuse of an individual receiving agency services
  3. Financial exploitation of an individual receiving agency services further defined under Texas Administrative Code Chapter 711 as the illegal or improper act or process of using a person served or thee resource of a person served for monetary or personal benefit, profit, or gain.
  4. Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services.

- HCS/TxHmL program, the administrator or designee will post the following information in a location at any respite and residential location in which the residential assistance provider of Pages Health Services holds a property interest:

  A) Name, address and telephone number of Pages Health Services Inc. local office, effective date of the Wavier Program Provider Agreement with DFPS, and name of the legal entity name on the Waiver Program Provider Agreement.

  B) The Administrator or designee will also ensure that the consumer and the Legally Authorized Representative (LAR) are informed in writing of how to report all complaints against the HCSSA agency and the reporting process for allegations of abuse, neglect, or exploitation. The written information will include names of agencies and phone numbers.

- Documentation of this will be maintained in the form of an acknowledgement form, completed upon admission, and when changes occur. A copy of this acknowledgement will remain in the consumer's record.

C) All alleged consumer abuse, neglect, exploitation or life-threatening situation shall also have reported within one hour of discovery by the Administrator or designee to the appropriate regulatory agency identified below: Note this may be a second report to the agency as all employees are obligated to report directly to the regulatory agency if they witness, suspect, or have an allegation made to them of abuse, neglect or exploitation.

1) HCS/TxHmL Texas Department of Protective and Regulatory Services (Adult Protective Services or Child Protective Services) (APS PI: 1-800-647-7418). Contact can also be made to HHSC/DADS to initiate complaints. (1-800-458-9858).

D) Pages shall take all necessary actions to secure the safety of any suspected or alleged victim of abuse, neglect or exploitation including but not limited to: for the alleged victim as necessary;

- Restricting access by the alleged perpetrator of the abuse, neglect, or exploitation to the alleged victim and other individuals pending investigation of the allegation; and
- Notifying, as soon as possible but no later than 24 hours after the program provider reports or is notified of an allegation, the alleged victim and the alleged victim's legally authorized representative of the allegation report and the actions that have been or will be taken.

E) Complaints or concerns of misconduct by a Pages Health Services employee or contractor (including failure to report a suspicion or allegation) will result in immediate suspension pending completion of investigation by Pages, DFPS, and DHS as appropriate. Determination of continued employment or contractual arrangement will be made based on results of the investigation and handled in accordance with the Discipline and Discharge Policies of Pages Health Services Inc. or the contract specifications.

F) Pages will cooperate completely with any DFPS or DHS investigation, and provide access to all sites owned, operated, or controlled by Pages Health Services Inc. and to all individuals receiving services and their individual records as requested for review in the investigation process. This would include access to (but not limited to any employee, any contact agent of Pages Health Services any subcontractor for the provision of services, additional agency providers, day habilitation providers, contract providers, etc.)

G) Pages will cooperate in the preservation and protection of any evidence related to the allegation in accordance with DFPS instructions.

Response to the regulatory agency's investigation will be completed in accordance with specific agency's accreditation guidelines (ie: CLASS Handbook, HCS/TxHmL- TDMHMR Letter dated 2/3/00, or HCSSA adopted rules dated 6/15/00).

Additionally, in the HCS program, the following steps will be taken: investigations of abuse, neglect or exploitation will be sent to the department in accordance with department procedures within 14 calendar days of the program provider's receipt of the investigation findings.

Notification to the alleged victim or Legally Authorized Representative DFPS investigation findings and will include: The investigation findings, the corrective action taken by the program provider if TDPRS confirms that the abuse, neglect or exploitation occurred. The process to appeal the investigation findings as described in 40 TAC Chapter 711, subchapter M relating to requesting an appeal if you are a reporter, alleged Victim, legal guardian or with advocacy, incorporated and the process for requesting a copy of the investigation report from the program provider. A copy of the DFPS investigative report after

concealing any information that would reveal the identity of the reporter or of any individual who is not the alleged victim will be provided to the alleged victim or the Legally Authorized Representative upon request.

H) If abuse, neglect or exploitation is confirmed by the DFPS investigation, Pages shall take appropriate action to prevent the reoccurrence of abuse, neglect or exploitation including but not limited to:

1. Disciplinary action against Pages personnel confirmed by the DFPS investigation to have committed abuse, neglect, or exploitation.

2. Termination against Pages personnel confirmed by the DFPS investigation, to have committed abuse, neglect, or exploitation.

3. Cancellation of contract services with any provider confirmed by the DFPS investigation to have committed abuse, neglect, or exploitation.

ABUSE, NEGLECT, EXPLOITATION REPORTING

Texas Department of Family and Protective Services (DFPS)

Abuse Hotline for APS Facility Investigations: 1-800-647-7418

Additional complaints can be reported to:
HHSC/DADS: 1-800-458-9858
CLASS ------ in life threatening situations, the CLASS program Specialist.

Abuse Hotline Number: 1-800-252-5400 HCSSA
Licensure: 1-800-458-9858

______________________________ ______________________
Employee Signature Date

______________________________ ______________________
Pages Health Representative Date

EEO POLICY: PAGES HEALTH CAREER INSTITUTEIS AN EQUAL OPPORTUNITY EMPLOYER, AND SELECTS THE BEST MATCHED INDIVIDUAL FOR THE JOB BASED UPON RELATED QUALIFICATIONS, REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN AGE, HANDICAP OR OTHER PROTECTED GROUPS UNDER STATES, FEDERAL OR LOCAL EQUAL OPPORTUNITY LAWS.

I UNDERSTAND AND AGREE THAT:

Any materials misrepresented or deliberated omission of fact in my application may be justification for refusal of, or if employed, termination from employment.

It is my understanding that Pages Health Services, Inc. will make a thorough investigation of my entire network history and may verify all data given in my application for employment, related papers, or oral review. I authorize such investigations and the giving and receiving any information requested by Pages Health Services and I release from liability and or other derogatory information discovered as a result of this investigation may prevent my being hired, or if hired subject to immediate dismissal.

I agree that my employment may be terminated by Pages at any time without liability for wages or salary except such as may have earned at the date of such termination. If requested by the management at any time, I agree to submit to search of my personal or of my locker that may be assigned to me, and I hereby waive all claims for damages on account of such examination by some qualified personnel at the discretion of my employer. I understand that the results of my medical exams are the property of Pages Health Services, Inc. and will be kept confidential to full extent of the law.
Although management makes every effort to accommodate individual's preferences, business needs may make the following conditions mandatory: overtime, shift work, a rotating work schedule, or a work schedule other than Monday through Friday, I understand and accept these conditions of my continuing employment.

I understand that this application for employment is for no definite period of time and that the association can change wages, benefits and conditions anytime.

I also understand that due to the nature of the business, I will not receive any overtime pay for the hours I work more than 40 in a week. I will receive only regular pay for any hours I work more than 40 a week. By accepting the employment at Pages Health, Inc. I agree to this regulation.

I undersigned certify that I have and fully comprehend this form in its entirety and that all the information provided are true and complete to the best of my knowledge.

I understand that should any statement that I have made prove false, misleading or erroneous, it may result in the rejection of my application. I authorize the association to obtain from my present (unless otherwise indicated) and past employers all data needed to support this application, I further understand that this application becomes property of PAGES HEALTH SERVICES, INC. and will not be returned.

________________________	______________________________	_______________
Applicant's Signature	Full Name	Date

SCHOOL STAFF'S DO'S AND DON'TS

1. Do not accept money, gift, food or entertainment from your clients and/or their families, significant others etc.
2. Do not allow your clients to become dependent upon you. The goal of home health is to encourage independence and have the clients lead a normal of a life style as possible (without you).
3. Do not provide money, food or other necessities to your clients. If clients need these things, then contact your Supervisor who can make arrangements for the client.
4. Do not provide any other services for your clients such as transportation, private duty, errands, and or bank transactions while the client is on service with the School.
5. Do not give out any of your numbers including your pager, cell, home etc. to your clients. Again, this only encourages the clients to become dependent on you.
6. Do not instruct your clients to call the School or their physician's office for assistance.
7. Do not discuss your personal matters and problems with your clients.
8. Do not maintain a professional relationship and boundaries with your clients.
9. Do not use any client knowledge or information acquired through your relationship with the client to your advantage, profit or gain. Not only is this a conflict of interest but also is exploitation.
10. Do follow the service plan and your assignment.
11. Do contact the office if the client has any concerns (complaints) regarding the care that is to be provided or fails to be provided or due to a lack of respect for the client's property.
12. Do call the office immediately if you suspect anyone including School staff of abusing, neglecting and/or exploiting (obtaining financial gain without the clients consent).

Applicant's Signature_______________________________________

Print Name____

Date_________________________

JOB DESCRIPTION

Basing on the position, job description for respective positions will be attached as Annexure (s) shown under:

1. Annexure – A: Job Description for Director of Vocational Nursing
2. Annexure – B: Job Description for Faculty
3. Annexure – C: Job Description for Clinical Faculty
4. Annexure – D: Job Description for Administrative Assistant to Director of Vocational Nursing
5. Annexure – E: Job Description for Receptionist for Vocational Nursing Program
6. Annexure – F: Job Descriptions for Student Support Services
7. Annexure – G: Job Description for Housekeeping for Vocational Nursing Program
8. Annexure – H: Job Description for Information Technology Specialist for Nursing Program

CHECK LIST

Check list for nursing and non- nursing faculty, as applicable, will be attached as Appendix to this application as under:

1. Appendix- 1 - Nursing Faculty Orientation Checklist

2. Appendix- 2 - Staff (Non-nursing) Orientation Checklist

APPLICANT'S COMPLIANCE

I,______________________________________ have read, understood, and will comply with
(Print Name)
All applicable School policies.

______________________________________ ____________________
Applicant's Signature Date

PAYROLL SCHEDULE FOR THE YEAR-20___

THE FOLLOWING PAY SCHEDULE WILL BE APPLICABLE FOR THE YEAR 20___. IF PAY DAY FALLS ON A HOLIDAY, NEXT WORKING DAY WILL BE THE PAY DAY. PAY CHECKS WILL BE ISSUED ONLY AFTER YOUR TIME SHEET IS RECEIVED IN THE OFFICE.

PAY PERIOD		PAY DAY	
DECEMBER	01-15	DECEMBER	31
DECEMBER	16-31	JANUARY	15
JANUARY	01-15	JANUARY	31
JANUARY	16-31	FEBRUARY	15
FEBRUARY	01-15	FEBRUARY	28
FEBRUARY	16-28	MARCH	15
MARCH	01-15	MARCH	31
MARCH	16-31	APRIL	15
APRIL	01-15	APRIL	30
APRIL	16-30	MAY	15
MAY	01-15	MAY	30
MAY	16-31	JUNE	15
JUNE	01-15	JUNE	30
JUNE	16-30	JULY	15
JULY	01-15	JULY	31
JULY	16-31	AUGUST	15
AUGUST	01-15	AUGUST	31
AUGUST	16-31	SEPTEMBER	15
SEPTEMBER	01-15	SEPTEMBER	30
SEPTEMBER	16-30	OCTOBER	15
OCTOBER	1-15	OCTOBER	15
OCTOBER	16-31	NOVEMBER	15
NOVEMBER	01-15	NOVEMBER	30
NOVEMBER	16-30	DECEMBER	15

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4.*

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. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

▶ **Whether you're 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

2018

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 filing separately, check "Married, but withhold at higher Single rate."
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 800-772-1213 for a replacement card.** ▶ ☐

5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . **5**

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $

7 I claim exemption from withholding for 2018, 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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	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 03/31/2016

▶**START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ________________

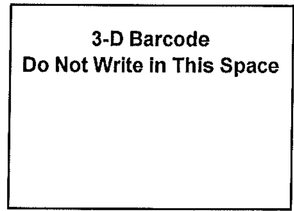
☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________ . Some aliens may write "N/A" in this field. *(See instructions)*

For aliens authorized to work, provide your Alien Registration Number/USCIS Number ***OR*** *Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: ________________

OR

2. Form I-94 Admission Number: ________________



If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ________________

Country of Issuance: ________________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

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

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

Employer Completes Next Page

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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:				**3-D Barcode Do Not Write in This Space**
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, ____ ,have been notified that a computerized criminal
APPLICANT or EMPLOYEE NAME (Please print)
history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

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

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee of $9.95 to the fingerprinting services company, L1Enrollment Services.

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

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

____
Signature of Applicant or Employee

____
Date

Pages Health Services Inc.
Agency Name (Please print)

Oluwatoyin Ajiboye
Agency Representative Name (Please print)

____
Signature of Agency Representative

____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ______ NO _____ ________ initial

Purpose of CCH: Employment

Hire ______ Not Hired ______ ________ initial

Date Printed:_______________ ________ initial

Destroyed Date:____________ ________ initial

Retain in your files