HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 746-9930

Application for Employment

FOR OFFICE TO COMPLETE:
Hire Date _____ Company_____

FOR APPLICANT TO COMPLETE**:**

Today's Date_____

Name: _____ Social Security #_____

Present address: Date of Birth: _____

Street: _____ Apt #_____

City: _____ State: _____ Zip Code: _____

Phone # _____ Cell# _____

Cell Phone Carrier _____ Email: _____

In case of Emergency notify:
Name: _____ Phone # _____

Address: _____ Relationship_____

How did you hear about our agency? ☐ Indeed ☐ Walk in ☐ Recruiter ☐ Other: _____

If you are under 18, can you furnish a work permit? ☐Yes ☐ No

Position_____ Date you can start_____ Salary_____

Are you currently employed?_____ If so, may we contact your present employer? ☐Yes ☐No

Are you on layoff and subject to recall? ☐Yes ☐No Will you travel if required? ☐Yes ☐No

Will you relocate if job requires it? ☐Yes ☐No Will you work overtime if required? ☐Yes ☐No

Are you able to meet the attendance requirements of this position? ☐Yes ☐No

Have you ever been Bonded? ☐Yes ☐No

Have you ever been convicted of a felony in the past 7 yrs ☐Yes ☐No

Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with this company:

_____

_____

Please list any foreign languages that you know: _____

_____

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INITIAL **Conditions of Employment – please read carefully**

_____ Reporting to work with impaired abilities; or the possession, consumption or distribution of drugs or alcohol on company premises and/or worksites, shall be grounds for disciplinary action, including discharge. A condition of employment includes willingness on the part of the applicant or employee to agree to physical examination, polygraph and/or substance testing, if required by the company. We are committed to operating a drug free workplace. Violations of our drug and alcohol policy will result in dismissal.

_____ It is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service, if I have been employed. Furthermore, I understand that just as I am free to resign anytime, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

_____ I give the employer the right to investigate all police, driving, and personal records and references, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

____ The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state or federal law.

____ Any controversy of any kind arising between the parties under this agreement or otherwise (or any agent, officer, director or affiliate of any party), including but not limited to common law, statutory, tort or contract claims, will be submitted to mediation, and failing settlement in mediation, to binding arbitration. Unless otherwise agreed, a mediation and arbitration designated by staff professionals will govern any mediation and arbitration. The parties will select the mediator or arbitrator from the designated company.
Panel of mediators and will notify the designated company, in writing, to initiate the selection process. The arbitration will be subject to and governed by the provisions of the Federal Arbitration Act. 9 U.S.C. Section 1-et seq. The parties hereto stipulate that this agreement involves matters affecting interstate commerce.

____ This application is current for 60 days. At the conclusion of this time, if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

_____ _____

Signature of Applicant **Date**

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EMPLOYEE NAME: _____

PRINT NAME

Drug Screening and Inspection Consent Form

DRUG FREE WORKPLACE

The Agency has a policy against drug and alcohol abuse and reserves the right to screen its employees as an enforcement measure in providing a safe, healthy, and productive working environment.

1.By my signature below, I am freely and voluntarily agreeing and consenting to submit a personal specimen of urine for chemical analysis and testing to determine the presence of any illegal, abused, or prohibited drugs/alcohol or substances in my body fluids, on a random basis as well as annual testing and for-cause testing. I understand that my refusal to submit a specimen of my urine for testing upon request will be grounds for my dismissal.

2.I hereby authorize the agency's duly appointed collection facility, and their personnel, to obtain, process, and test the specimen and to release and discuss the results of the analysis and test to the Director of Human Resources or designee for employment purposes. Said information will be handled as confidentially as is reasonably possible, shared only on a "need to know" basis.

3.I understand a documented chain of custody will be created to ensure the identity and integrity of my specimen throughout the collection and testing process.

4.As an employee, I understand if I have a positive test or refuse to submit to this drug/alcohol screening analysis and test, this will constitute a violation of the agency's policy and I will be subject to disciplinary action up to and including termination of employment. I understand that at the time of drug testing, I will be required to show copies of prescriptions for drugs prescribed and taken within the last thirty (30) days.

5.I hereby release, forever discharge, and hold harmless the agency , any physician, technician, medical facility and laboratory facility and all of their respective officers, directors, employees, representatives, and agents from any and all claims of whatever nature arising out of or in connection with any act or omission relating to any (1) examination, (2) test, (3) collection, (4) procedure, (5) chain of custody, (6) disclosure, (7) analysis, (8) diagnosis, (9) inaccuracy,(10) report, or (11) action performed. This release applies to any negligence, sole negligence, comparative negligence, concurrent negligence, gross negligence, recklessness, wantonness, willfulness, error, act, or omission of any of the individuals or entities covered hereby.

6.I understand and acknowledge that I will be required to allow the agency to search my person, personal effects, vehicle/ and other property located on agency premises or worksites, including agency vehicles and private vehicles located at the agency's premises or worksites. I also understand and acknowledge that my refusal to allow such searches to occur will be grounds for my immediate dismissal.

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

_____ _____

Employee Signature ***Date***

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

CONFIDENTIALITY OF INFORMATION AGREEMENT

EMPLOYEE NAME: _____
PRINT NAME

Confidentiality of Information

- All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered maintained or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

- In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for following this Confidentiality Policy Agreement & The Guidelines, Both Written and Verbal.

_____ _____

Employee Signature ***Date***

Permanent Residential Addresses

As per DOH regulations and in accordance with OCS statutes, please list **all** permanent residential addresses since birth, Including the month and year of residency.

1) _____
_____

2) _____
_____

3) _____
_____

4) _____
_____

5) _____
_____

HHA/PCA Application

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PERSONAL REFERENCE

Please provide the following information of one individual not related to you, to whom you have known at least one year

Name: _____

Phone: _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

APPLICANT NAME: _____

The above named applicant has applied for employment with our agency and requests/authorizes you to release all information below under the provisions of the Privacy Act of 1974. All information will be held in strict confidence.

_____ _____

Signature of Applicant **Date**

STOP – OFFICE USE ONLY

EVALUATION: Please check one for each statement

	YES	MOST OF THE TIME	SOME OF THE TIME	NO
Is this person dependable?				
Is this person trustworthy?				
Does this person follow instructions?				
Is this person cooperative?				
Does this person have a positive attitude toward others?				
Is this person able to cope with difficult situations?				

How long have you known this person? _____

Additional comments: _____

_____

Signature_____ **Date** _____

Verbally verified by _____ **Date**_____

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PROFESSIONAL REFERENCE

Name: _____

Agency/ Company Name: _____

Phone: _____ **Fax:** _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

The undersigned has applied for employment with our company and authorizes you to provide information concerning past performance under the provisions of the Privacy Act of 1974. All information is kept confidential.

APPLICANT NAME: _____ ***S.S.#*** _____

DATE: _____ **APPLICANT SIGNATURE:** _____

Please, do not complete anything below this line

==========

Please complete and sign

EMPLOYMENT DATES: From _____ To _____ POSITION: _____
Month/Yr. Month/YR.

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ YES ☐ NO

COMMENTS: _____

_____

_____

SIGNATURE: _____ **DATE:** _____

POSITION OR TITLE: _____ wkref

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

PROFESSIONAL REFERENCE

Name: _____

Agency/ Company Name: _____

Phone: _____ **Fax:** _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

The undersigned has applied for employment with our company and authorizes you to provide information concerning past performance under the provisions of the Privacy Act of 1974. All information is kept confidential.

APPLICANT NAME: _____ ***S.S.#*** _____

DATE: _____ **APPLICANT SIGNATURE:** _____

Please, do not complete anything below this line

==========

Please complete and sign

EMPLOYMENT DATES: From _____ To _____ POSITION: _____
Month/Yr. Month/YR.

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ YES ☐ NO

COMMENTS: _____

_____

_____

SIGNATURE: _____ **DATE:** _____

POSITION OR TITLE: _____ wkref

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:

HHA/PCA Application

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Employee's Information for Fingerprint Request

Date: _____

Print Name: _____

Address: _____

City/State/Zip: _____

DOB: _____

Last 4 of Social: _____

Maiden Name: _____

Telephone #: _____

Place of Birth (Country): _____

Gender: _____

Race: _____

Height: _____

Weight:_____

Color of Eyes:_____

Color of Hair:_____

Citizenship: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐ Married, but withhold at higher single rate ☑
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Complete the worksheet on page 4 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 20)*	**1**	
2 Total number of allowances for New York City *(from line 35)*	**2**	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount	**3**	
4 New York City amount	**4**	
5 Yonkers amount	**5**	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an ***X*** in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instructions)*:

A Employee claimed more than 14 exemption allowances for NYS ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*: ☐

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*: ☐

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)*	Employer identification number

Instructions

Changes effective for 2020

Form IT-2104 has been revised for tax year 2020. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2020 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you do not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $107,650 or more during the tax year.

MARQUIS
HOME CARE

230 N. Main Street, Spring Valley, NY 10977 Phone: (845) 363-8140 Fax: (845) 363-8141

Name: _____

DOB: _____

Date: _____

Referred By:

_____

$150.00 gift card given after employee works for 1 month

Medflyt broadcasts all of our open cases to our dear employees and keeps you updated about available opportunities. In case you didn't download it yet, please see instructions for downloading below:

1. Go into app store or follow the link from the text Medflyt sent.
2. Put in your cell phone number – the phone number that you are currently using.
3. You will get a text with a five-digit code.
4. Enter the five-digit code.
5. You will see your personal info and will be asked to confirm.
6. You can now enter a picture or choose to skip.
7. Now you will need to enter a four-digit password. This is your personal password that you can create.
8. You will be asked to reenter the password.
9. Put in our company code of 56153. (This is only necessary you downloaded the app on your own. If you followed the link that Medflyt sent, this isn't necessary.)
10. Lastly, set your availability to open so that you have access to all the cases. Request only the cases that work for you.
11. Keep in mind that these cases are broadcasted to numerous aides at the same time and therefore they are grabbed very fast! In order for you not to miss any opportunities we suggest that you check the app every time you get a notification.

If you are having a problem downloading and for support about medflyt please call Amy at 845-363-8140 ext 6002.

Good Luck and we look forward to work with you!

HHA/PCA ORIENTATION

230 N. Main Street, Spring Valley, NY 10977

Employee Authorization for the Release of Medical Information

I, _____, do hereby authorize any physician, dentist, chiropractor, therapist, clinic, hospital or other health care provider or administrative staff, to release to *Marquis Home Care,* all medical records related to my examination, evaluation, and/or treatment by such health care provider including but not limited to, the following:

1. All clinical records;
2. Results of all laboratory tests, including x-rays;
3. Records of all prescribed medications and treatments;
4. All correspondence between my doctors or their administrative staffs or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I am, or have been, a patient or from whom I received medical care;
5. All correspondence either by facsimile, electronic mail or hard copy between my doctors or their administrative staffs, or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I am, or have been, a patient or from whom I have received medical care, and any insurance companies or their representatives concerning any claims made on my behalf for medical treatment or for benefits of any nature including, but not limited to, disability benefits, social security benefits, and Veteran's Administrative benefits;
6. All notes, correspondence, or other records of any nature made by my physicians, nurses, or any other persons concerning me, my condition, or my treatment.

A photocopy of the signed original of this "Authorization For Release of Medical Information" shall have the same force and effect as the original and shall be sufficient for the same purposes.

_____
Signature

_____
Witness

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

HEPATITIS INFORMATION ACKNOWLEDGEMENT
ACCEPT OR DECLINATION STATEMENT

I have read and understand the information in the Hep B Packet. My signature below indicates my acknowledgement of this information and my decision to either accept the Hep B Vaccination or decline the Hepatitis B Vaccination program.

Only choose **ONE** option:

DECLINE

☐ 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.

☐ I have received the Hepatitis B Vaccination series, and **decline** vaccination at this time.

ACCEPT

☐ I **accept** this opportunity to participate in the Hep B program, which includes a series of 3 injections at 0, 30, and 180 day intervals. I will comply with the administration procedure and am aware of adverse effects, contraindications, and complications that may occur due to the Hepatitis B Vaccination.

Employee Signature:_____ Date_____

Name (Print):_____

Agency Representative Signature_____ Date_____

Declination of Influenza Vaccination for Health Care Personnel

Employee's Name: _____ Employee's ID#: _____ DOB:_____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider.

I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this agency's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear.
- My shedding the virus can spread influenza to patients in this agency.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this agency, coworkers, my family and my community.

- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: _____ Date: _____

HR Representative: _____ Date: _____

2019-2020 Seasonal Pneumonia Declination Form

Last Name First Name Middle Initial	Date of Birth
Address	Age: _____ **Gender**: ☐ Male ☐ Female
City State Zip code	Telephone #

DECLINATION AND SIGNATURE

I DECLINE to be vaccinated against the pneumonia virus. I have had the opportunity to be vaccinated, but refused. I accept responsibility for my declination.

Signature_____
Date_____

HHA/PCA

Phone: (845) 363-8140 Fax: (845) 205-4296

Employee Name: _____

ANNUAL TUBERCULOSIS QUESTIONNAIRE

For personnel who have a known positive PPD or whole blood assay are required to complete this questionnaire with either a yes or no.

HAVE YOU NOTICED ANY OF THE FOLLOWING?

1. Unexplained fevers	☐ **Yes** ☐ **No**
2. Night Sweats	☐ **Yes** ☐ **No**
3. Unintentional weight loss	☐ **Yes** ☐ **No**
4. Cough	☐ **Yes** ☐ **No**
5. Hoarseness	☐ **Yes** ☐ **No**
6. Bloody Sputum	☐ **Yes** ☐ **No**
7. Have you completed INH therapy?	☐ **Yes** ☐ **No**
8. Have you ever had a BCG vaccine?	☐ **Yes** ☐ **No**
9. Have you had an x-ray while employed here?	☐ **Yes** ☐ **No**

_____ _____

Employee Signature ***Date***

Comments: _____

_____

_____

_____

Agency Representative: _____ ***Date***_____

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

Medical Documents Required

In order for your medical file to be complete, the following information must be submitted:

1. Physical:
    - Clearance clause must include employee is cleared to work as well as the Habituation part.
    - Vitals must be completed
    - Must have doctors stamp/license number
    - Must be dated within the last six months
2. PPD results:
    - A skin test must be performed: the date PPD was placed, date read, results in millimeters and results read should be documented. PPD needs to be read within 2-3 days of being placed.
    - A Quantiferon can also be performed in place of a PPD (Lab report showing your results, if you are negative/positive)
    - ❖ If PPD is positive:
        1- You must submit a form with the date you became positive
        2- They need to submit a chest x-ray that is clear
3. Proof of immunity to Rubella and Rubeola (Measles). You can submit it as follows:
    a. Lab report showing the immunity, it should include the reference range
    b. 2 MMR shots done more than a month apart, you just need the dates of shots, immunity and signature

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 746-9930

EMPLOYEE'S PHYSICAL EXAM FORM TO BE COMPLETED BY PHYSICIAN

Dear Doctor: Please complete this form on the following person. This information is mandatory for employment in the health field.

NAME _____ DATE OF BIRTH _____ GENDER: _____

HISTORY

	YES	NO		YES	NO		YES	NO
Heart Disease	[ ]	[ ]	Hepatitis	[ ]	[ ]	Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Alcohol/Drug	[ ]	[ ]	Thyroid	[ ]	[ ]
Back Problems, Injuries	[ ]	[ ]	Anemia	[ ]	[ ]	Seizure Disorder	[ ]	[ ]
Arthritis	[ ]	[ ]	Asthma	[ ]	[ ]	Hernia	[ ]	[ ]
Emotional or Mental Problems	[ ]	[ ]	Cancer	[ ]	[ ]	Poor Hearing	[ ]	[ ]
Poor Vision	[ ]	[ ]	Tuberculosis	[ ]	[ ]	Allergies	[ ]	[ ]

If yes, please describe: _____

_____

Previous medical illness or surgical procedures: _____

_____

PHYSICAL EXAM

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Respirations: _____

SKIN _____ HEART _____

HEAD _____ LUNGS _____

EYES _____ ABDOMEN _____

ENT _____ BACK _____

NECK _____ EXTREMITIES _____

NEUROLOGIC _____

Please describe abnormalities (include any lifting restrictions): _____

_____

IMMUNIZATION HISTORY

[ ] PPD (Mantoux): Date Implanted _____ Manufacturer: _____ Lot #_____

Expiration date:_____ Date Read _____ Results _____(mm) Interpretation _____Read by:_____

[ ] **For Positive PPD or History of positive PPD, where PPD contraindicated**

[ ] Chest X-Ray: Date/Result: _____ (Attach original report)

TB Prophylaxis initiation date: _____, Completion date:_____

[ ] Rubella Titer -Attach lab report Date: _____ Result: _____ [ ] Immune

[ ] Rubeola Titer -Attach lab report Date: _____ Result: _____ [ ] Immune

OR:

[ ] Rubella Immunization (Only if titer shows no immunity): _____

[ ] Rubeola Immunization (Only if titer shows no immunity): 1st Dose _____ 2nd Dose _____

[ ] Influenza Vaccine Date: _____ Lot #_____

WORK CLEARANCE

The above named person is found to be in good mental/physical health. He/she is free from signs and symptoms of habituation or addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter the person's behavior. He/she is free from any condition or communicable disease which could endanger his/her safety as well as the client.

Physician Signature _____ Exam Date _____

Stamp: _____ License No. _____

Submit