Wise Medical Staffing, Inc.

Verification of Conditional Job Offer and Essential Job Functions

Print Name: _____ SS#:_____

As you know, we are a staffing service that provides assignments for qualified individuals. Assignments may last a day. Assignments may last a month. Assignments may be part time or full time. We sometimes have jobs available very quickly, or it may take a month for us to locate an assignment for which you are qualified. Sometimes we never have positions available for some applicants. However, you seem to have the qualifications, skills and experience for which we are looking. Therefore, we would like to put you an assignment contingent on additional orientation, reference checks, and/or your ability to do the essential functions of the job.

By completing and signing this form, I am verifying that I have been presented with a conditional job offer, based on the qualifications stated on my application form and in the job interview. I understand that I have been offered a job with your organization conditional upon completing this form and the essential job functions worksheet, and upon successful review of my former employment references and background check. I understand that any misstatement, omission, falsification, or misrepresentation of fact on this form, the essential job functions worksheet, or any other employment related form is grounds for withdrawal of the conditional job offer, or if assigned to job, termination of employment. I further understand that this information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the Americans Disability Act.

1. Do you currently have any medical restrictions that would prevent you from performing the duties of this position with or without reasonable accommodation?
____ Yes ____ No If yes, please explain _____
_____

2. Do you have any medical conditions requiring special care of which we should be aware? (i.e. diabetes, seizures, etc.)
____ Yes ____ No If yes, please explain _____
_____

3. Are you currently taking any prescription medications? ____ Yes ____ No
If yes, would taking this medication affect your ability to perform the duties of this position safely and effectively?
____ Yes ____ No If yes, please explain _____
_____

4. Have you ever had any serious wrist and/or hand problems, including carpal tunnel syndrome?
____ Yes ____ No If yes, please explain _____
_____

5. Have you ever had any serious back, neck, shoulder and/or knee problems that would affect your ability to perform the duties of this position with or without reasonable accommodation?
____ Yes ____ No If yes, please explain _____
_____

6. Can you interact in a cooperative manner with your coworkers, supervisors and the outside public?
____ Yes ____ No

7. Can you consistently be punctual and report to your job assignments on a regular basis?
____ Yes ____ No

8. Are you able to work in an honest and forthright manner in any type of work environment?
____ Yes ____ No

Wise Medical Staffing, Inc.

PRE-COMPETENCY ASSESSMENT

POSITION: STAFF NURSE

To perform this job successfully, an individual must meet or be able to perform each essential qualification and duty satisfactorily. These bona fide physical requirements are essential functions of the job and are in addition to the skills, certification, years of experience or other qualifications required to perform the job for which you have applied. Reasonable accommodations may be made to enable an individual with a disability to perform the essential functions.

YES	NO	
____	____	able to read/write and perform moderately complex mathematical computations (drug dosages)
____	____	vision ability sufficient to read, see near/far, depth perception, peripheral vision and color vision
____	____	able to communicate interpersonally (hear/speak) and via telephone
____	____	able to stand for 75% of each shift
____	____	able to walk for 50% of each shift
____	____	able to assist in lifting patients and equipment approximately 300 lbs.
____	____	able to push carts and beds (on wheels) weighing up to 350 lbs.
____	____	able to reach/pull 4 hours per shift
____	____	able to kneel to administer CPR in emergency situations
____	____	able to manipulate objects, tools and equipment
____	____	exposure to moderate and extreme heat – occasionally
____	____	exposure to moderate and extreme cold – occasionally
____	____	exposure to body fluids
____	____	exposure to chemicals (chemotherapy drugs)
____	____	exposure to various contagious disease
____	____	exposure to odors (medications, patient care activities) frequent
____	____	understand hazardous communications and safety information

_____ _____

Applicant Signature/Employee Date

_____ _____

Personnel Representative Date

Misrepresentations as to pre-existing physical or mental conditions may void your worker's compensation benefits.

Signature of Employee _____ Date _____

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Wise Medical Staffing, Inc.

Certified Nursing Assistant Job Description

Job Summary:

Responsible for providing direct patient care to an assigned group of patients or one on one patient care during a shift. Responsible for prioritizing the delivery of direct patient care using time and resources efficiently.

Qualifications:

1. High school or GED certificate with proof of completion of a basic nursing assistant/personal care attendant training program consistent with state requirements or completion of a state approved exam, which includes clinical requirements.
2. Must have at least one-year experience.
3. A current certificate as a Certified Nursing Assistant.
4. A current CPR card with the expiration date.

Duties and Responsibilities:

- Assists patients with personal hygiene such as bathing, shaving, shampooing and oral/denture care.
- Assists with activities of daily living which include dressing, ambulating, toileting and safe transfer techniques as directed by the nursing supervisor.
- Documents the care and observations in the appropriate client record during the shift.
- Identifies safety concerns and maintains a safe environment for the patient/client.
- Reports significant changes in the patient condition to the nursing supervisor.
- Reports to the supervising nurse when the assigned duties are not able to be completed on the shift so additional support can be arranged and the assignment completed prior to the next shift.
- Serves as a role model by demonstrating honesty, dependability and maintaining confidentiality in all patient matters.

I have read the description of my professional responsibilities as an employee of Wise Medical Staffing, Inc. and agree to adhere to the standards described above.

Signature Date

Wise Medical Staffing, Inc.

Employment History Check

COMPANY NAME:____

START DATE:____________________END DATE:_____________________

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE #: ____

COMMENTS:____

Would you hire this nurse again? ______YES_______NO FULL TIME/PART TIME

Evaluator: _______________________ Title: ______________ Date: _________

COMPANY NAME:____

START DATE:____________________END DATE:_____________________

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE #: ____

COMMENTS:____

Would you hire this nurse again? ______YES_______NO FULL TIME/PART TIME

Evaluator: _______________________ Title: ______________ Date: _________

COMPANY NAME:____

START DATE:____________________END DATE:_____________________

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE #: ____

COMMENTS:____

Would you hire this nurse again? ______YES_______NO FULL TIME/PART TIME

Evaluator: _______________________ Title: ______________ Date: _________

Verify by: ____

Wise Medical Staffing, Inc.

PROFESSIONAL REFERENCE CHECK

(Please have your reference fill out form completely before returning it to Wise Medical Staffing, Inc.)

I authorize_____
(Name of Nurse Manager, Nurse Director, or Medical Director)

From _____
(Facility Name/Address/Phone)
to release information about me for the purpose of supplying a reference check.

Applicant Signature_____ Date _____

DO NOT WRITE BELOW THIS LINE (Office Use Only)

PERFORMANCE EVALUATION

Dear, _____ (Name of Reference)

(Name of nurse) _____ has applied for a nursing position with Wise Medical Staffing, Inc. and has given us your name as a professional reference.

We would appreciate it if you would evaluate the applicant's past performance and make any additional comments you feel might assist us in making our decision in hiring this nurse. Your comments will be kept in strict confidence.

Date of Employment: From _____ To _____

	Greatly Exceeds Standards	Exceeds Standards	Meets Standards	Does Not Meet Standards
Competency/Skills				
Reliability/Dependability				
Cooperation/Attitude				
Work/Patient Relations				
Adaptability/Flexibility				
Attendance				

Reason this nurse left your employ: Terminated _____ Lay-off _____
Resigned _____ Temporary _____

Comments (please continue on back if necessary) _____
_____
_____

Would you hire this nurse again? ____ Yes ____ No Part-time ___ Full-time ___

Signature of Evaluator _____Title _____ Phone # _____

May we call you if we need further information? ___ Yes (_____)_____ No ___

Wise Medical Staffing, Inc.

PROFESSIONAL REFERENCE CHECK

(Please have your reference fill out form completely before returning it to Wise Medical Staffing, Inc.)

I authorize_____
(Name of Nurse Manager, Nurse Director, or Medical Director)

From _____
(Facility Name/Address/Phone)
to release information about me for the purpose of supplying a reference check.

Applicant Signature_____ Date _____

DO NOT WRITE BELOW THIS LINE (Office Use Only)

PERFORMANCE EVALUATION

Dear, _____ (Name of Reference)

(Name of nurse) _____ has applied for a nursing position with Wise Medical Staffing, Inc. and has given us your name as a professional reference.

We would appreciate it if you would evaluate the applicant's past performance and make any additional comments you feel might assist us in making our decision in hiring this nurse. Your comments will be kept in strict confidence.

Date of Employment: From _____ To _____

	Greatly Exceeds Standards	Exceeds Standards	Meets Standards	Does Not Meet Standards
Competency/Skills				
Reliability/Dependability				
Cooperation/Attitude				
Work/Patient Relations				
Adaptability/Flexibility				
Attendance				

Reason this nurse left your employ: Terminated _____ Lay-off _____
Resigned _____ Temporary _____

Comments (please continue on back if necessary) _____
_____
_____

Would you hire this nurse again? ____ Yes ____ No Part-time ___ Full-time ___

Signature of Evaluator _____Title _____ Phone # _____

May we call you if we need further information? ___ Yes (_____)_____ No ___

Wise Medical Staffing, Inc.

RELEASE OF CRIMINAL RECORDS

In connection with my application for employment, I understand that an investigative consumer report may be requested that will include information as to my character, work habits, performance and experience, along with reasons for termination of past employment. I understand that as directed by company policy and consistent with the job described, you may be requesting information from public and private sources about my: workers' compensation injuries, driving record, court record, education, credentials, credit and references.

Medical and workers' compensation information will only be requested in compliance with the Federal Americans with Disability Act (ADA) and/or any other applicable state laws. I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency. If so, I will be notified and given the name and address of the agency or the source which provided the information.

I, the undersigned, do hereby authorize, without reservation, any law enforcement agencies, institution, information services bureau, school, employer, reference or insurance company contacted by Wise Medical Staffing, Inc. or its agent, to furnish the information described above. I, the undersigned, do also authorize Wise Medical Staffing, Inc. and the company assigned to, to examine any and all criminal records on file in the counties of any state. In doing so, I understand that I am waiving my right of confidentiality concerning my criminal history.

Signature: _____ Date: _____

Print Name: _____ SSN: _____

Driver's License Number / State: _____

Address: _____

_____

Wise Medical Staffing, Inc.

DRUG SCREEN AUTHROIZATION FORM

I hereby authorize and give full permission to have Wise Medical Staffing, Inc. and/or their medical company physician send a specimen of my urine and/or blood to a laboratory for screening test for the presence of illegal drugs, alcohol or prescription medicine taken without prescription.

I will hold all parties harmless, meaning I will not sue or hold responsible for any alleged harm to me or interfering with my obtaining a job or continuing employment due to not submitting to the tests or as a result of report of the test. Such waived and released claims include, but not limited to, invasion of privacy, intentional infliction of mental distress, handicap discrimination and possible clerical or laboratory error.

Required drug screens will be paid by the employer. However, if the drug screen comes back positive, if I refuse the assignment, if I voluntary quit or I am let go for the cause within the first ninety (90) days, I will be expected to pay for the cost of the drug screen. The cost of the drug screen is forty ($40.00) dollars. The cost of the drug screen will be deducted from my final check.

This policy has been explained to me in a language I understand and told if I have any questions they will be answered about the test. I understand this is a legal binding document which is binding because Wise Medical Staffing, Inc. is sending me for the examinations and paying for it.

I UNDERSTAND WISE MEDICAL STAFFING, INC. WILL REQUIRE A DRUG SCREEN TEST WHENEVER AN ON THE JOB ACCIDENT OR INJURY IS REPORTED IN ACCORDANCE WITH WISE MEDICAL STAFFING'S POLICY AND THIS AUTHROIZATION AND CONSENT. MY REFUSAL TO SUBMIT TO DRUG TESTING WILL BE GROUNDS FOR TERMINATION.

Signature _____ Date _____

Print Name: _____

Wise Medical Staffing, Inc.

PHYSICIAN'S STATEMENT

(Please print clearly)

Employee/Applicant: _____
(Please print full name)

I have examined the individual named above on _____ and have found no
(Date of exam)
condition that should prevent or interfere with the performance of her/his duties. I have found no apparent signs or symptoms which might pose a health hazard to clients under her/his care and no evidence of communicable disease.

_____
Signature of Physician/Practitioner Date

_____
Printed Name of Physician/Practitioner

_____
Physician/Practitioner Address

_____
Physician/Practitioner Phone

Wise Medical Staffing, Inc.
Hepatitis B Virus Consent/Declination

I understand the hazards and OSHA guidelines regarding exposure to blood or other infectious diseases due to my occupation and that I may be at risk of acquiring the Hepatitis B virus infection.

Check one and sign at the bottom.

☐ I have already received the vaccine and will provide a copy to WMS.

☐ I understand the OSHA guidelines and **DECLINE** the Hepatitis B Vaccination.

_____
Signature:

_____
Date:

Wise Medical Staffing, Inc.
Flu Vaccine Consent/Declination

Complete either Part I, **accepting** the flu vaccination and providing the date you received it, or Part II, **declining** the flu vaccination and provide your reason for declining it.

Part I

I **accept** the CBC's guidelines and record of vaccination is as follows:
Signature:_____
Date:_____

-OR-

Part II

I understand the CBC's guidelines and I choose to **decline** the flu vaccine.
Signature:_____
Date:_____

Please briefly state on the lines below why you have chosen to decline the vaccination:

_____
_____
_____
_____
_____
_____

Wise Medical Staffing, Inc.

TB Screening Questionnaire

_____ _____

Name: **Date:**

TB skin test (2Step PPD) Date: _____

Have you ever had a positive TB skin test in the past? Yes_____ No_____

Last Chest X-ray date: _____

Please indicate if you have had any of the following symptoms for the last three to four weeks or longer:

1. Chronic Cough (greater than 3 weeks) Yes_____ No _____
2. Production of Sputum Yes _____ No _____
3. Blood-Streaked Sputum Yes _____ No _____
4. Unexplained Weight Loss Yes _____ No _____
5. Fever Yes _____ No _____
6. Fatigue/Tiredness Yes _____ No _____
7. Night Sweats Yes _____ No _____
8. Shortness of Breath Yes _____ No _____

The above personnel has no evidence of TB or Contagium:

_____ _____

Applicant Signature: Date:

_____ _____

WHS Signature Date:

DIRECT DEPOSIT AUTHORIZATION

I (we) hereby authorize **Wise Medical Staffing, Inc. - 30001726** hereinafter called COMPANY, to initiate credit entries and initiate, if necessary, debit entries for any credit entries made in error to my (our) account listed below and the financial institution named below, hereinafter called INSTITUTION, to credit or debit the same to such account.

Employee_____

Social Security Number_____

Financial Institute_____

_____

City State Zip Code

Account Number_____

Routing Number_____

Checking _____ Savings_____

( ) I hereby request the direct deposit of my payroll check into the above-named bank account each pay period.

( ) I hereby cancel the authorization for direct deposit or payroll deduction deposit previously submitted.

_____

Signature(s) on account: Date

Please attach a copy of cancelled check

Ohio Department of Job and Family Services

OHIO NEW HIRE REPORTING

Ohio Revised Code section 3121.89 to 3121.8910 requires all Ohio employers, both public and private, to report all contractors and newly hired employees to the state of Ohio within 20 days of the contract or hire date. Information about new hire reporting and online reporting is available on our website: **www.oh-newhire.com**

Send completed forms to:
Ohio New Hire Reporting Center
PO Box 15309
Columbus, OH 43215-0309
Fax: (614) 221-7088 or toll-free fax (888) 872-1611

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C		1	2	3

EMPLOYER INFORMATION

Federal Employer ID Number (FEIN) *(Please use the same FEIN as the listed employee's quarterly wages will be reported under):*

Employer Name: Wise Medical Staffing Inc

Employer Address *(Please indicate the address where the Income Withholding Orders should be sent).*

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

Employer Phone (optional): 8772077060 Extension: Employer Fax (optional):

Email:

EMPLOYEE OR CONTRACTOR INFORMATION

Social Security Number (SSN) ☐ (Check here if using FEIN for the Contractor)

State of Hire:

First Name: Middle Initial:

Last Name:

Address:

City: State: Zip Code (5 digit):

Date of Hire: Date of Birth: Is this a Contractor? Yes ☐ No ☐

Date payments will begin for Contractor: Length of time the Contractor will be performing services: months

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

Questions? Call us at (614) 221-5330 or toll-free (888) 872-1490

Wise Staffing Group
City Withholding Questionnaire

Do you live within city limits? Yes _____ No_____

If so, what is the name of the city? _____

If you do not live within city limits, would you like for city taxes to be withheld?

Yes _____ No _____

It is the responsibility of the employee to file city taxes in the appropriate city. If you need taxes to be withheld, please notify payroll to make these changes.

_____

Signature:

_____

Date:

Wise Medical Staffing, Inc.

EMPLOYMENT AGREEMENT

I hereby authorize Wise Medical Staffing, Inc. to contract and represent me in staffing hospitals, nursing homes, physician's offices, and any other facility requiring the services of my nursing skills, based upon the needs of the facility and Wise Medical Staffing.

I understand the work schedule is based on client needs or hospitals census. Wise Medical Staffing cannot guarantee a set amount of hours.

Professional Conduct: Nurse is committed, in both daily performance and presentation, to act in totally professional manner throughout the course of the assignment. Nurse will learn and adhere to the rules, policies, and procedures of the facility including all information presented during orientation. Nurse will follow all reasonable direction received from facility management or supervision and understand that Wise medical cannot accept responsibility for the actions of the facility personnel during the course of the assignment. Allegations of commission of acts of negligence, malpractice, tardiness, unauthorized absence, substance abuse, insubordination, violation of facility rules or other unprofessional conduct or breach of neglect of duty will be grounds for immediate termination of the assignment by facility and Wise Medical Staffing.

I hereby agree that by signing this agreement, I am making a commitment to work for Wise Medical Staffing. I agree not to accept any assignment that I would not be able to complete. Any extensions of assignment or any additional time worked at facility on a temporary or per diem basis beyond 90 days of end date (last day worked at facility) will be worked only through Wise Medical Staffing.

I also understand that in the even I would be a NO SHOW or let go for cause (reasons stated above), I will be paid minimum wage on my final check.

I have read and understand the policies and procedures of Wise Medical Staffing.

I understand that I am an AT WILL EMPLOYEE, which means my employment with Wise Medical Staffing, Inc. can be terminated by either party at any time.

Signature _____ Date _____

Witness _____ Date _____

Wise Medical Staffing, Inc.

Confidentiality Statement

As an employee, contractor, or any person or entity working for Wise Medical Staffing at any facility or location you have a definite obligation to protect the privacy of: Patients, Residents, Co-Workers, the operations of Wise Medical Staffing, and facility or location of assignment. You will not discuss any events of patient/client care, business operations with anyone other than in the line of duty. Everything which takes place within the facility or off site locations is understood to be confidential information whether it be verbal, by action, or in writing.

Breach of the personnel policy will result in disciplinary action and could possibly result in legal action and/or dismissal of your employment with Wise Medical Staffing.

Wise Medical Staffing employees represent a diverse group of people in various job duties. Thus is all inclusive of employees of every department and/or service.

> ***"I understand the importance of maintaining confidentiality. I also agree to comply with this policy and all other policies as a condition of employment with Wise Medical Staffing. I understand the disciplinary action that can be taken should I violate the confidentiality to which I have been entrusted."***

_____ _____

Date Employee Signature

_____

Witness

Social Media Policy and Guidelines

Purpose

The following are guidelines for Wise Medical Staffing employees who participate in social media. Social media includes personal blogs and other websites, including Facebook, LinkedIn, Twitter, YouTube and any other internet tools used for sharing and discussing information. These guidelines apply whether employees are posting to their own sites or commenting on other sites. The procedures below apply to all employees and are designed to reduce the likelihood that their personal social networking activities will have an adverse effect on themselves, clients/patients, employees, or the company.

Policy

It is important that employees follow all applicable Wise Medical Staffing policies. Among the policies most pertinent to this discussion are those concerning client/patient confidentiality, email & internet acceptable use, and the code of ethics.

1. Ensure that your social media activity does not interfere with your work commitments.
2. Individuals may not participate in social media activities during work time unless required by their position. Under no circumstances may an Individual access social media on mobile devices while driving for work related reasons or performing other safety sensitive work functions.
3. Individuals must speak for themselves and not on behalf of Wise Medical Staffing unless authorized to do so as part of their job responsibility.
4. Under no circumstances may Individuals post fake blogs, create false positive or fake negative reviews of Wise Medical Staffing, its affiliates, or its competitors.
5. Individuals may not use Wise Medical Staffing logos, trademarks or proprietary graphics that would create the appearance they are speaking on behalf of Wise Medical Staffing.
6. Individuals may not share any confidential or identifiable information of any kind about Wise Medical Staffing or its clients/patients, including photographs, videos, or audio recordings on any social media platform or smartphone application. Additionally, online activities regarding client/patients within the Wise Medical Staffing network of care that may compromise a client/patient's dignity or otherwise make them question the confidentiality of the services provided by Wise Medical Staffing are prohibited.
7. Individuals are responsible for any publicly viewable intentionally false statements that may damage the company or the company's reputation.
8. Prior to establishing an online relationship with a vendor or client/patient through social networking sites, Individuals should consider potential conflict of interest issues, given the unique association between patients and health care providers.
9. Individuals shall not use social networking activities, including personal e-mail and mobile (text) messaging, to transmit, receive, or store information regarding Wise Medical Staffing's network of care, its employees or patients that is illegal, discriminatory, harassing, libelous, slanderous, and/or protected under HIPAA or state law.

THIS POLICY MAY BE UPDATED AT ANY TIME WITHOUT NOTICE. By continuing to post any content after such new terms are posted, you accept and agree to any and all such modifications to this Policy.

_____ _____

Signature Date

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

► **Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.***

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

---

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► **Date**

Wise Medical Staffing, Inc.

Orientation Acknowledgement Form:

_____

Name of Applicant:

- Policy and Procedure manual overview _____
- Professionalism _____
- Hand Book _____
- Risk Management _____
- Monitoring Vital Signs _____
- Working with Elderly and Disabled _____
- Oral Care, Hair and Nail Care _____
- Signs of Deteriorating Health _____
- Nutrition, Hydration and Elimination _____
- Bathing and Skin Care _____
- Signs of Neglect, Abuse & Exploitation _____
- Incident Reporting, Significant Changes _____
- Stress Management, Conflict Resolutions _____
- Documentation Basics _____
- Safe food handling _____
- Universal Precautions _____
- ASP, Patient Centered Plan of Care _____
- Performing Home Care Tasks , Blue Folder _____
- CEU's (12 Annually) _____
- Expectations of the Employee _____
- Lines of Communication/ On call _____
- Videos: Infection Control, Incident _____
- Videos: Hippa and Basics of Aging _____

I have read and understand the above training and orientation program of Wise Medical Staffing, Inc. I understand that a copy of this document will be kept in my file and shared with any clients that I accept assignments with.

_____ _____

Applicant Signature:

Wise Medical Staffing, Inc.

Orientation Acknowledgement Form:

(Annual Mandated Procedures)

_____

Name of Applicant:

Mission Statement	_____
Business Code of Ethics/PP	_____
Policy & Procedure Checklist	_____
Harassment Policy	_____
Reporting of Abuse	_____
Database checks	_____
Patient Rights	_____
HIPPA/Confidentiality Statement	_____
Universal Precautions	_____
Hand washing Policy	_____
Skill Checklist (Return demonstration)	_____
Fire Safety	_____
Electrical Safety	_____
Disaster Safety	_____
BWC Policy	_____
Lifting & Moving Safety	_____
Handling Medical Waste	_____
Age Specific Competency	_____
CEU's (12 Annually)	_____
Safety Orientation Quiz	_____
CNA Test	_____
Medication Tests	_____
Business Code of Ethics	_____

I have read and understand the above training and orientation program of Wise Medical Staffing, Inc. I understand that a copy of this document will be kept in my file and shared with any clients that I accept assignments with.

_____ _____

Applicant Signature: Date:

I have read the below information and understand Wise Medical Staffing, Inc. policy and procedures for reporting on the job injury and medical treatment. I have received a written copy.

_____

Employee Signature Date

Wise Medical Staffing, Inc.

Workman's Compensation

POLICY AND PROCEDURES

Employee Responsibility:

1. On the job injury should be reported to job site supervisor immediately.
   Failure to report an accident promptly may void your workman's compensation benefits.

2. Speak with your Wise Medical Staffing, Inc. office manager concerning medical attention.

3. Should you make a decision to finish your shift, then receive medical attention:

   Day shift employees- call your office manager at Wise Medical Staffing, Inc. office immediately after your shift to receive instruction for your physician appointment.

   Evening and Night shift employees- call your office manager at Wise Medical Staffing, Inc. office by 9:00 A.M. the following day, to receive instruction for your physician appointment.

4. You must obtain from Wise Medical Staffing, Inc. office, Authorization To Treat / Work Status Form to take with you to treating medical clinic. Treatment at the emergency room is for acute serious injury only, employee can be liable for unauthorized medical treatment.

WISE MEDICAL STAFFING, INC. OFFICE Phone Number _____.

I HEREBY ACKNOWLEDGE RECEIPT OF WISE MEDICAL STAFFING, INC. GENERAL SAFETY RULES AND WILL FOLLOW THEM.

_____

Print Name Date

_____

Signature

Wise Medical Staffing, Inc.

READ THEM
LEARN THEM
FOLLOW THEM

General Safety Rules and Regulations are not optional! They are a condition of employment.

1. Comply with all safety policies and procedures.

2. An employee is not expected to take risks.
   * Use common sense.
   * Be properly trained.
   * Report any hazards.
   * Do not engage in horseplay or unauthorized activity.

3. Follow specific safety procedures.
   * Stairs - Always take one at a time.
   * Passageways- Always use marked passageways, inside and outside.
   * First Aid - Report any illness or accident, even small cuts or bruises.
   * Lifting - Do it correctly: use legs and lift slowly, ask for help.
   * Dress appropriately - Clothing, jewelry, hair, etc.
   * Use proper safety equipment - Safety glasses, gloves, etc.
   * Wash hands to avoid skin irritaion.
   * Keep work area clean.
   * Hazardous equipment/materials - use proper safety measures.

4. Accidents and Worker's Compensation.
   * Immediately notify your supervisor and Wise Medical Staffing, Inc. of any accident or injury.
   * Wise Medical Staffing, Inc. will investigate every accident.
   * A drug screen is required for any injury requiring medical treatment.
   * Light duty jobs are always available.

Failure to comply with General Safety Rules and Accident Procedures could result in termination.

Wise Medical Staffing, Inc.

Reporting of Abuse/ Exploitation of Residents Policy

Any person who, within the scope of his or her facility, has knowledge of or reasonable cause to believe that any resident of the facility has been victim of abuse, neglect or exploitation shall report the abuse, neglect or exploitation to the proper authority.

It is the policy of ***Wise Medical Staffing, Inc.*** for all employees to report any abuse, neglect or exploitation of residents in any facility. His should be reported to the Supervisor at the facility and to the administrative staff at *Wise Medical Staffing, Inc.* immediately as witnessed. Employee must give the name of the resident, associate(s) involved, the time and date, the place and description of what occurred. Failure to do so will result in disciplinary action up to and including termination.

Signs of Abuse:

1. **Physical signs- bruises, especially around the wrists, skin tears or cuts, bedsores and soiled sheets.**
2. **Change in personality- depression, withdrawal, fear or nervousness around a particular person.**
3. **Abuse such as yelling or pushing.**
4. **Possessions have disappeared from their home or spending patterns have changed.**
5. **Missed appointments.**
6. **Deterioration in thinking patterns.**
7. **Frequent trips to emergency room.**

All alleged reports will be reported to the proper authorities. It will be the responsibility of the Operations Manager to report any cases of suspected abuse to:

Passport Case Manager: 1-800-582-7277
Adult Protective Services: 1-614-466-1213
Job and Family Services: 1-614-466-1213
The Joint Commission: 1-630-792-5800

I have read the above statement and agree to abide by such policy.

_____ _____
Employee signature Date

_____ _____
WMS representative Date

UNIVERSAL PRECAUTIONS

Employees must protect themselves from direct exposure to blood or body fluids that are visibly contaminated with blood to prevent exposure to HIV. However, many potentially communicable diseases, such as hepatitis, are transmitted by body fluids such as saliva, urine or feces, regardless of contamination with blood. For this reason it is strongly recommended that precautions be taken to prevent direct contact with all bodily fluids, of all persons whether or not body fluids are visibly contaminated with blood.

Examination gloves should be worn at least in situations where direct contact with blood or body fluids that are visibly contaminated with blood is likely. Examples of such situations include but are not limited to: invasive or surgical situations, performing oral hygiene, providing would or decubitus care, cleaning up blood products, vomits or blood or body fluids contaminated with blood.

Examination gloves are not necessary for contact with intact skin or handling unsoiled objects previously in contact or handled by others.

Examination gloves shall be removed and discarded after contact with each patient, fluid items or surface. Hands should be washed immediately after gloves are removed. A new set of gloves should be used with each patient. Gloves should never be washed or wiped with any substance as these damages their integrity and increase permeability.

Gloves must be readily available at all times. Hands shall be washed between each resident whether gloves are worn or not.

Use general purpose gloves (i.e., rubber household gloves) for house keeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Rubber gloves may be decontaminated and reused, but should be discarded if they are peeling, cracked, or discolored, have a tear or puncture or other evidence of deterioration.

Eye protectors (goggles, glasses, or shield) and face masks shall be worn for all tasks or procedures that are likely to generate splash of blood or body fluids.

Impervious gowns or aprons shall be worn during all tasks or procedures that are likely to generate sprays, splashes of blood or body fluids.

Needles and other sharp objects shall be placed in a puncture resistant container immediately after use. Needles shall not be recapped, bent or broken prior to disposal.

Healthcare workers with weeping or execrative lesions or dermatitis which cannot be securely covered shall refrain both from patient care and from handling clean or soiled patient equipment.

Persons whose tasks include participation in cpr should use a one way mask when performing mouth to mouth.

Linen, clothing or other materials that are visibly contaminated with blood or body fluids shall be placed in bags or containers that are imperative to moisture before transport for cleaning. Gloves should be worn while bagging these materials.

WHAT TO DO IF EXPOSURE OCCURS

The employee should wash the affected area immediately and thoroughly. If an eye or mucous membrane (mouth) is contaminated rinse with water for 15 minutes.

The incident should be reported to the supervisor, charge nurse, or designated person. While saliva, urine, tears, and feces have not been implicated in the transmitting of HIV infection, other communicable disease may be transmitted by these fluids, and reporting of the incident to the supervisor, charge nurse or designated person is recommended.

_____ _____

Signature Date

Wise Medical Staffing, Inc.

Code of Conduct

WMS shall adopt and implement ethical standard to require Personal Care Aides to furnish services in an ethical, professional, respectful and legal manner and not to engage in any unethical, unprofessional, disrespectful or illegal behavior in including:

1. Consuming the consumer's food or drink, or using the consumer's personal property without his or her consent.
2. Bringing a child, friend, relative, pet or anyone else to the consumer's place of residence.
3. Taking the consumers to the provider's place of business.
4. Consuming alcohol while furnishing a service to the consumer.
5. Consuming medicine, drugs or other chemical substances not in accordance with the legal, valid, prescribed use and/or in any way that impairs the provider from furnishing a service to the consumer.
6. Discussing religion or politics with the consumer and others in the care setting.
7. Discussing personal issues with the consumer or any other person in the care setting
8. Accepting, obtaining or attempting to obtain money or anything of value, including gifts or tips from the consumer and his or her household members or family members.
9. Engaging the consumer in sexual conduct or in the conduct that a reasonable person would interpret as sexual in nature, even if the conduct is consensual.
10. Leaving the consumer's home for a purpose not related to furnishing a service without notifying the WMS supervisor, the consumer's emergency contact person, any identified caregiver or the consumer's case manager. "Emergency contact person" means a person the consumer or caregiver wants the provider to contact in the event of an emergency to inform the person about the nature of the emergency.
11. Engaging in any activity that may distract the provider from furnishing a service including:
    - Watching television or playing computer or video games
    - Engaging in non-care related socialization with a person other than the consumer (e.g. a visit from a person who is not furnishing care to the consumer, making or receiving a personal telephone call, or sending or receiving a personal text message or e-mail)
    - Furnishing care to individuals other than the consumer
    - Smoking without the consumer's consent
    - Sleeping
12. Engaging in behavior that causes or may cause physical, verbal, mental or emotional distress abuse to the consumer.
13. Engaging in behavior that reasonable person would interpret as inappropriate involvement in the consumer's personal relationships.
14. Being designated to make decisions for the consumer in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney, guardianship, or authorized representative.
15. Selling to or purchasing from the consumer products or personal items, unless the provider is the consumer's family member who does so only when not furnishing a service.
16. Engaging in behavior that constitutes a conflict of interest or takes advantage of or manipulates ODA-certified services resulting in an unintended advantage for personal gain that has detrimental results for the consumer, the consumer's family or caregivers or another provider.

I have read and understand the Code of Conduct and agree to abide by this code at all times while providing services as a Personal Care Provider for Wise Medical Staffing.

WMS Employee Signature: _____ Date: _____

9/14/12 dw

Wise Medical Staffing, Inc.

Patient Rights

Purpose: To assure all Wise Medical Staffing employees/clients are aware of the rights of patients.

Policy: Be cognitive that each patient you come in contact with has at a minimum the following rights.

1. Privacy in treatment and care.
2. To be free from mental and physical abuse.
3. To refuse treatment. They must be informed of the consequences of that decision; the refusal and its reason must be reported to the physician and documented in the patient's record.
4. To have their file kept confidential and private. Written consent by the patient must be obtained prior to the release of information except for person authorizes by law.
5. To expect WMS to use and disclose information pertaining to patient care in accordance with WMS's Notice of Privacy Practices. HIPPA guidelines must be followed.
6. To expect reasonable continuity of care and to be notified in advance service schedule and PCA performing service.
7. To be treated with consideration, respect and full recognition of his or her dignity and individuality.
8. To receive services without regard to age, race, color, sexual orientation, religion, marital status, sex or national origin.
9. To be informed of services provided by Wise Medical Staffing.
10. To be informed of the provisions for after hours coverage and emergencies.
11. To be informed for the charges for service and receive an explanation of their bill regardless of the source of pay.
12. To send and receive unopened mail.
13. To have an advance directive, such as Living Will or health care proxy. If the patient has a written advance directive, a copy should be provided to WMS.
14. To execute, modify or rescind a Living Will, do not resuscitate order or advanced directives.
15. To voice grievances and recommend changes in policies and services of the facility with freedom from restrain, interference, coercion, discrimination or reprisal.

Signature: _____Date: _____

Wise Medical Staffing, Inc.

HIPAA FORM
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and hoe you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use, and disclosure of your health records:

1. We are required by law to maintain privacy of their protected health information in your records and to provide you with the notice of your legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this notice currently in effect.
3. We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to the other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosures that are required by law or under emergency circumstances may be made without your acknowledgement or authorization. Under any circumstances, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed acknowledgement that you received this notice t use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, precertification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.
Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative

functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your acknowledgement or authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies, information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person is in immediate threat or danger to health or safety as a result of a violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. WE may use or disclose protected healthcare information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses or disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose our protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter id necessity ti treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug, and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may contained in your

health records. We, likewise, will not disclose your heath record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

1. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree with restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2. You have the right to request a receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
3. You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
4. All requests for inspection, copying and/or amending information in your health records and all requests related to your rights under this notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, and healthcare operations, disclosures required for disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
6. If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and take it home with you if you wish.

You may file a written complaint to us or the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's website: **http://www.hhs.gov/ocr/hipaa**.

Wise Medical Staffing, Inc.

I have been given a copy of the HIPAA Privacy Practice Form and by signing I acknowledge that I have read and understand it.

_____

Client OR Employee Signature Date

_____

Witness Signature Date