REQUIRED DOCUMENTATION CHECKLIST

(ALL COPIES MUST BE CLEAR AND LEGIBLE)

The Documentation Below Must Be In Your File Prior To Any Assignment.

Application Materials (forms provided in this document)

1. Employment Application must be completed in full. Please print or type neatly. You may include your resume, but it will not replace a complete job application.
2. Skills Checklist – Choose from List & Fill it online at below site: http://www.rehabilitycare.com/skills_checklists.aspx
3. Two References / Performance Evaluations – please ask former employer/ supervisor to accomplish
4. Employment Eligibility Form - I-9 Form
5. Direct Deposit Form with a copy of voided check
6. Signed Job Description
7. Professional Conduct Expectation
8. HIPPA Sign Off
9. Latex Allergy
10. Sexual Harassment
11. Orientation Checklist
12. In-service for JCAHO and OSHA
13. Employee to Release Info
14. Consumer Authorization and Background Release
15. Confidentiality Agreement
16. Employee Handbook Page

Medical Documentation (you may use the forms attached or provide clear, original copies with a Doctor's signature and an official stamp)

17. A current physical or Physician's Statement within previous 12 months.
18. 2 step TB screen current within 12 months or chest X-ray current within two years with positive PPD Prof.
19. Hepatitis B documentation (vaccination series of three, titer, booster, or signed declination).
20. Ten (10) panel NON DOT Drug test Lab Report- must requirement
21. Immunization Records (Influenza, MMR, Varicella, Tdap, if any available) Or Titers

Licenses, Professional Certifications, and Company Policies

22. Clear copies of all current Professional licenses and certifications e.g. PT or OT or RN etc.
23. Clear copy of a current CPR-BLS & (BCLS, ACLS, PALS– as per requirement) (front and back)
24. Clear Copy of SSN card
25. Clear Copy of Driver's License/ International Driver's License – front & Back
26. Clear Copy of EAD or Green Card – Front & Back
27. Clear Copy of Current Passport ID Page

All the above items must be in your *COMPLETED* file before you able to start any assignment.

Other Documents and Forms for Your Information and Use will be emailed directly:

1. Employee Handbook
2. Online Paystub Guide
3. Rehability Care Time Sheet
4. Vacation Request Form
5. Unpaid Leave of Absence Form
6. Employee Referral Form
7. Insurance Application
8. 401-K Application

Thank you for applying with Rehability Care

7345 Woodland Dr
Indianapolis, IN 46278
Ph: 317-388-0800
Fax: 317-388-0805

RN	_____	LPN	_____
SPL	_____	PT	_____
PTA	_____	OT	_____
COTA	_____	OTHER	_____

Personal Information

Name			Date
Social Security #		Date of Birth	
Present Address			
City	State		Zip
Home Phone ( )	Other Phone ( )		
Has your license or certification ever been under investigation?		Yes	No
CPR Expiration	Date of Last Physical Exam		Date of Last TB
Have you been convicted of a felony or a misdemeanor within the last 5 years?			Yes No
If yes, please describe			
Are you eligible to work in the United States?	Yes	No	
Drivers License #	State		
Name of person to be notified in case of an emergency			Phone ( )

Additional Information

Do you have any physical limitations that preclude you from performing any work for which you are being considered?
Yes No
If yes, what can be done to accommodate your limitation

Licensure and Certifications

PPD Test	Date Given	Date Read	Induration	Negative	Positive
Step 1					
Step 2					
Chest X-Ray	Date	Results (Results must be attached)			

Employment Desired

Position	Date available for work	Salary Desired
Are you currently employed?	If so, may we contact your present employer?	
By whom were you referred to us?		

Education

Name	Location	Graduated (Y/N)	Degree

Personal References

Name		**Name**	
Address		**Address**	
Phone	**( )**	**Phone**	**( )**

Employment Experience

Employer		**Address**		
Position	**From**	**To**		
Supervisor	**Phone**			
Reason for leaving?	**May we contact your supervisor?**		**YES**	**NO**

Employer		**Address**		
Position	**From**	**To**		
Supervisor	**Phone**			
Reason for leaving?	**May we contact your supervisor?**		**YES**	**NO**

Employer		**Address**		
Position	**From**	**To**		
Supervisor	**Phone**			
Reason for leaving?	**May we contact your supervisor?**		**YES**	**NO**

Experience

Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years
Alcohol Detox		Labor & delivery		Oncology		Psychiatric	
Burns		Medical Floor		Operating Room		Rehabilitation Care	
Cardiac Care		Medications		Orthopedics		Surgical Floor	
Doctor's Office		Neurological		OB/GYN		Urology	
Home Healthcare		Nursery		Pediatrics		Private Duty	
Intensive Care		Nursing Home					

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you. I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary be terminated at any time without prior notice. I under stand that I am not to transport patients in my automobile, nor am I to drive patients in the patient's automobile without written consent from the Rehability Care Office.

I agree, I will not seek or accept employment, either directly or indirectly in any capacity from any client of Rehability care to whom I have been assigned for at least 90 days after the last day of that assignment. I further understand that I cannot be paid until I present a time slip signed by both the client and me to the Rehability Care office.

Name of Applicant **Date**

Signature of Applicant **Date**

Reference Form

Employee Name: _____ Date of Evaluation: _____

Company/Facility: _____

Address: _____

Contact Person: _____ Title: _____

Phone #: _____ Signature: _____

Start Date: _____ End Date: _____ Specialty: _____

# of Beds: _____ Unit Description: _____

Eligible for Re-hire: _____ Avg. Patient Caseload: _____

EVALUATION:
Ratings: 4 = Outstanding 3 = Exceeds Expectation 2 = Meets job Requirement 1 = Not Met

Performance	Outstanding	Exceeded Expectation	Meets Job Requirements	Not Met
Job Knowledge				
Work Quality				
Initiative				
Dependability				
Creativity				
Accepts Directions				
Interpersonal Relationship				
Accurate Documentation				
Communicate Effectively				
Attendance				
Punctuality				

Reviewed By: _____ Date: _____

Title: _____

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

Direct Deposit Agreement Form

Authorization Agreement

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

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

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

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking ☐ Savings ☐

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Print Name: _____ SSN #: ___ -- ___

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

- o New Applicant
- o Change Current Direct Deposit
- o Cancel my Direct Deposit

7345 Woodland Drive, Indianapolis, IN 46278
Ph: (317)388-0800
Fax: (317)388-0805
www.RehabilityCare.com

JOB DESCRIPTION: PHYSICAL THERAPIST

REQUIREMENTS: The Physical Therapist must meet recognized standards of professional education and qualifications. The Physical Therapist must:

1. Must be a graduate of an educational institution with a degree in Physical Therapy.
2. Must be licensed in the State (as applicable) to practice Physical Therapy.
    a. Temporary license may be accepted
3. Display evidence of interest in continued education within the profession and is encouraged to be a member of the American Physical Therapy Association.

ESSENTIAL FUNCTIONS:

1. The staff Physical Therapist reports to the Area Administrator of Physical Therapy.
2. He/She may be responsible for supervising/training other personnel such as; Physical Therapy Assistants and/or Physical Therapy Aides.
3. Following receipt of a doctor's referral, the therapist is responsible for evaluating the patient within 24 hours of written referral.
4. After evaluating the patient, the therapist is responsible for planning, administering and supervising the Physical Therapy Assistant in an appropriate treatment plan.
5. The Physical Therapist will communicate with the referring physician and members of the rehabilitation team regarding the patient's total treatment program.
6. The Physical Therapist will maintain an accurate daily record of treatments given to patients.
7. The Physical Therapist will maintain an accurate daily record of treatments administered to patients.
8. The Physical Therapist will provide in-service education to facilities, supportive staff, students and community.
9. The Physical Therapist will perform other duties as assigned by the Area Administrator.
10. The Physical Therapist will follow established policies and procedures of Therapist Express.

TYPICAL PHYSICAL DEMANDS:

Physical Therapist assigned must be able to perform the following physical job functions with or without reasonable accommodation:

1. Lift up to 50 pounds from floor to knuckle occasionally.
2. Lift up to 30 pounds from the knuckle to shoulder occasionally.
3. Lift up to 10 pounds overhead occasionally.
4. Pivot transfer up to 200 pounds continuously.
5. Carry up to 25 pounds, 200 feet frequently.
6. Push/pull 40 pounds, 300 feet frequently.
7. Squat and stoop up to 20 minutes occasionally.
8. Kneel and crawl up to 5 minutes continuously.
9. Fine hand manipulation, bilaterally frequently.
10. Heavy grasp, bilaterally, continuously.
11. Visually acuity corrected to 20/20.
12. Tactile discrimination continuously.
13. Drive up to 2 hours.
14. Comprehensible verbal communication skills continuously.

Employee Printed Name:_____ Date: _____

Employee Signature: _____

Description: Occupational Therapist

Occupational Therapist Job Purpose: Facilitates development and rehabilitation of patients with mental, emotional, and physical disabilities by planning and administering medically prescribed occupational therapy.

Occupational Therapist Job Duties:

- Meets the patient's goals and needs and provides quality care by assessing and interpreting evaluations and test results; determining occupational therapy treatment plans in consultation with physicians or by prescription.
- Helps patient develop or regain physical or mental functioning or adjust to disabilities by implementing programs involving manual arts and crafts, practice in functional, prevocational, vocational, and homemaking skills, activities of daily living, and sensor motor, educational, recreational, and social activities; directing aides, technicians, and assistants.
- Promotes maximum independence by selecting and constructing therapies according to individual's physical capacity, intelligence level, and interest.
- Prepares patient for return to employment by consulting with employers; determining potential employee difficulties; retraining employees; helping employers understand necessary physical and job result accommodations.
- Evaluates results of occupational therapy by observing, noting, and evaluating patient's progress; recommending and implementing adjustments and modifications.
- Completes discharge planning by consulting with physicians, nurses, social workers, and other health care workers; contributing to patient care conferences.
- Assures continuation of therapeutic plan following discharge by designing and instructing patients, families, and caregivers in home exercise programs; recommending and/or providing assistive equipment; recommending outpatient or home health follow-up programs.
- Documents patient care services by charting in patient and department records.
- Maintains patient confidence and protects hospital operations by keeping information confidential.
- Maintains safe and clean working environment by complying with procedures, rules, and regulations.
- Protects patients and employees by adhering to infection-control policies and protocols.
- Ensures operation of equipment by completing preventive maintenance requirements; following manufacturer's instructions; troubleshooting malfunctions; calling for repairs.
- Maintains professional and technical knowledge by attending educational workshops; reviewing professional publications; establishing personal networks; participating in professional societies.
- Develops occupational therapy staff by providing information; developing and conducting in-service training programs.

- Complies with federal, state, and local legal and certification requirements by studying existing and new legislation; anticipating future legislation; enforcing adherence to requirements; advising management on needed actions.
- Contributes to team effort by accomplishing related results as needed.

Skills/Qualifications: Health Promotion and Maintenance, Creating a Safe, Effective Environment, Motivating Others, Legal Compliance, Bedside Manner, Medical Teamwork, Mental Health, Pain Management, Listening, Analyzing Information , Quality Focus

Employee Printed Name: _____ Date:_____

Employee Signature:_____

____ Traveling Nurse

____ PRN Nurse

REGISTERED NURSE JOB DESCRIPTION

OVERVIEW:
The registered nurse is a health care professional that possesses a distinct body of knowledge. This knowledge is obtained through educational and professional experience.

QUALIFICATIONS:
1. Currently licensed in the state as a registered nurse.
2. Currently CPR certified.
3. Minimum of 1 year current clinical experience.
4. Documentation of current immunization or proof of immunity (titers).
5. The ability to perform tasks involving physical activity, which may include heavy lifting, bending and prolonged standing.
6. Must pass appropriate skills tests.
7. Adheres to all policies and procedures of REHABILITY CARE and assigned facility.
8. The ability to communicate effectively.

RESPONSIBILITIES:
1. Performs nursing care using sound judgment.
2. Implements physician's orders in a safe and accurate manner.
3. Transcribes and implements new physician orders.
4. Assists with admitting, discharging and transferring patients.
5. Maintains detailed and accurate records of nursing actions.
6. Participates in health/therapeutic counseling, teaching, and emotional support for patients and their significant others.
7. Adapts to the needs of the unit by demonstrating flexibility/adaptability.
8. Makes rounds on assigned patients and prioritizes patient's needs.
9. Maintains a safe and clean environment for patients and co-workers.
10. Formulates, modifies and implements goal oriented patient care plans according to facility policies.
11. Provides and receives reports in status of patients at the change of shifts.
12. Administers medication and therapies within the scope of safe nursing practice.
13. Assumes responsibility to report clinical limitations or the need for assistance to the supervisor.
14. Performs all other duties as assigned by the nursing supervisor.

_____ _____

Signature Date

Professional Conduct Expectations

Your professional conduct and clinical performance on REHABILITY CARE assignments is directly related to our ability to solicit new and interesting job opportunities for you. Toward that end, we expect that you will adhere to the following Professional Conduct Expectations while on assignment for REHABILITY CARE. Failure to meet these expectations could lead to your termination from the company.

1. I will not discuss any elements of my compensation with anyone employed at the host facility.
2. I will not discuss any previous assignments worked for REHABILITY CARE with anyone employed at the host facility.
3. I will not recruit any therapies at the host facility.
4. I will communicate with the management, staff and patients of the host facility in a respectful manner at all times.
5. I will honor all terms of my agreement letter, including but not limited to beginning and ending assignment dates, housing arrangements, and travel arrangements.
6. I will honor the policies and procedures of REHABILITY CARE and the host facility.

I understand that by signing this agreement I have read, understood and intend to comply with these Professional Conduct Expectations.

_____ _____

Employee's Signature Date

_____

Please Print Name

HIPAA Sign Off Sheet

I have read, understand and have received a copy of the Rehability Care Notice of Privacy Practices for Long Term and Acute Care Facilities. I will abide by the patient health information use and disclosure guidelines it contains. I will actively protect patient privacy.

_____ _____

Employee Signature Date

Employee Printed Name:_____

_____ _____

Authorized Rehability Care Signature Date

LATEX ALLERGIES

The extensive gloving required by current universal precaution standards and the predominant use of latex and latex-bearing powder in gloves has caused a dramatic increase in the incidence of irritant contact dermatitis and allergic reactions in healthcare professionals.

According to the National Institute for Occupational Safety and Health (NIOSH), the incidence of latex allergies is on the rise with 12 percent of healthcare workers affected. Once a healthcare worker has begun to develop sensitivity, the signs and symptoms of latex sensitivity continue to increase until the professional takes steps to prevent repeated
exposure.

Latex use hit a previously unknown high in 1987 when the Centers for Disease Control (CDC) recommended universal precautions for healthcare workers and facilities.
These precautions led to a dramatically increased need for gloves. To cope with the growing
demands for gloves and the decreasing supply of pure latex, glove manufacturers had to make changes that lessened the purity of the latex found in gloves. The use of latex with a higher percentage of impurities has put more healthcare professionals at risk for the development of latex allergies.

The latex used in rubber gloves comes from the rubber tree *HEVEA BRASILIENSI*s. This latex is also used in medical devices from catheters to syringes, and everyday products such as balloons, rubber bands and telephone cords. It is important to be aware of all objects containing latex because once sensitivity is developed; it can become more severe with further exposure. Although direct skin exposure is the largest cause of sensitivity, airborne latex proteins can lead to inhalation-based sensitivities as well. Individuals with asthma or inhalant allergies, e.g., ragweed, are at a higher risk to develop a latex allergy.

Symptoms: Symptoms of a latex allergy are similar to other allergic responses:

Itching Watery or burning eyes Sneezing Coughing

These are only a few of the potential warning signs. As always, see your doctor if you have any concerns that you have or are developing a latex allergy.

Protection: There are simple ways you can protect yourself from latex exposure and allergy:

- Use non-latex gloves for any activities that will not involve direct contact with infectious material.
- If you must use latex gloves, use powder-free gloves with reduced protein content.
- Do not use oil-based hand creams or lotions with latex gloves. These lotions can deteriorate the gloves.
- Wash and dry hands thoroughly after removing the latex gloves.
- Keep the areas contaminated with latex dust clean.

Avoidance of latex is the only means to assure prevention of a latex allergy, and protection from its symptoms in a person who has already developed a latex allergy.

Definitions relative to latex allergies:

Latex sensitivity – a medical diagnosis of reaction to latex, ranging in reverse order from irritant contact dermatitis, allergic contact dermatitis (Type IV), to severe systemic allergic reaction (Type I).

Allergic Contact Dermatitis (ACD) (Type IV) – produces skin lesions or a crusty thickened appearance of the skin. The reaction usually appears some time after exposure, so sensitized individuals may not always associate it with latex gloves. The rash may persist for 7-10 days, and is usually limited to the area where the skin came into contact with the latex. ACD may also include contact pruritus, erythema, vesicular lesions, eczema and contact urticaria. Type IV reactions may occur alone, or may be accompanied by a Type I

response. Individuals with Type IV reactions are at increased risk for developing Type I response hypersensitivity.

IgE-mediated hypersensitivity (Type I) – this response to latex is more unusual. Immediate reactions within 30 minutes to 1 hour from exposure may affect the skin, upper respiratory tract, lower respiratory tract or gastrointestinal tract. Skin manifestations include flushing, swelling and contact urticaria. Other manifestations are runny eyes and nose, symptoms of asthma, especially expiratory wheezing, diarrhea and/or vomiting.

Irritant Contact Dermatitis (ICD) – ICD is different than ACD in that with ICD an external agent directly damages the skin, such as sweating and chafing due to prolonged glove use. ICD usually manifests itself as dry, crusty lesions where skin is exposed to latex.

Accommodations – provision to healthcare workers, including Travelers, of specific supplies, and /or recommended environmental changes which will decrease the risk of exposure to allergen.

Identification and accommodation:

The Company has a policy of identification and accommodation for Travelers who have developed latex sensitivity. If you believe you have such sensitivity, please request a copy of the Latex Allergy Assessment form from your Quality Management Specialist (QMS). Please have your physician complete the form and return it to your QMS before beginning your assignment.

Subsequent action and accommodation is dictated by the severity of the allergy, as documented by the physician on the Latex Allergy Physician Release form. The accommodations may include (but are not limited to) the following ranked in descending order of the severity of the allergy:

Contact allergy to latex:

If you have a documented contact allergy to latex, we will provide you with latex-free or powder-free gloves for use in any healthcare facilities that do not already provide such items for their own staff.

Inhalant allergy to latex:

If you have a declared allergy to latex, once you have interviewed for an assignment and accepted an offer, the Clinical Liaison (CL) will inform the human resources department at the facility of your allergy to determine the availability of latex risk management procedures at the institution.

Depending upon your individual triggers for an allergic reaction, the CL will ascertain if the facility:

1. Is entirely latex-free,
2. Can assign Traveler to an already latex-free unit, and/or
3. Can provide a powder-free and/or latex-free unit to protect the Traveler from inhalants.

Only when such accommodations can be arranged, will the assignment be confirmed with the facility and/or the Traveler given the approval by their Recruiter or Quality Management Specialist to depart for the assignment.

_____ _____

Signature Date

_____

Please Print Name

PREVENTING AND ADDRESSING SEXUAL HARASSMENT AND UNLAWFUL DISCRIMINATION

The Company is committed to working with Client healthcare facilities to provide a work environment that is free of harassment and discrimination. In keeping with this commitment, we do not tolerate any form of sexual harassment or any other form of unlawful discrimination.

Harassment based on race, sex, national origin, disability, sexual orientation; religion or other protected characteristic is a violation of state and federal laws. State and federal laws define sexual harassment to include unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature. Any person who commits such a violation may be subject to personal liability as well as disciplinary actions, up to and including termination.

Sexual harassment of employees by supervisors, co-workers or clients/customers is strictly prohibited. Such conduct is unlawful when:

- Submission to the conduct is made a term or condition of employment;
- Submission to or rejection of the conduct is used as the basis for an employment decision affecting an employee; or
- The conduct has the purpose or effect of unreasonably interfering with an employee's work performance, or creating an intimidating, hostile, or offensive work environment.

Examples of sexual harassment include unwelcome sexual flirtations, advances or propositions; verbal abuse of a sexual nature; subtle pressure or requests for sexual favors; unnecessary touching of an individual; a display in the workplace of sexually suggestive objects or pictures; sexually explicit or offensive jokes; or a physical assault.

If at anytime on your assignment you believe that you are being subjected to discrimination or harassed in any way, please express your assessment of remarks made or actions taken as "harassment," or "discrimination" and the facts of the incident(s) to your direct supervisor, the house supervisor, or, if you prefer, the assignment facility's Human Resources department.

In many situations, individuals are insensitive to the offensiveness of their words or behaviors, but will cease the offensive behavior when its impact is brought to their attention. Try this approach, bearing in mind that what is acceptable in one environment may not be acceptable in another.

While working as a Traveler you may find environments that are less tolerant of "kidding around" and "teasing" than you have been used to, or you may find yourself uncomfortable in an environment that is far more tolerant of "kidding around" or "teasing" than you have worked in before. In this situation, make your discomfort known through the appropriate chain of command at the healthcare facility.

If the situation is not resolved to your satisfaction, please report the facts of the incident(s) to the Clinical Liaison who will immediately investigate any complaint and work with the assignment facility to define and initiate appropriate preventive and/or corrective action(s).

No Traveler or corporate staff employee will be retaliated against for making a complaint or bringing inappropriate conduct to the Company's attention, for preventing unlawful practices, or for participating in an investigation, proceeding, or hearing conducted by any governmental agency.

TRAVELERS:

1. *Be aware that as a Traveler you will be viewed as a "newcomer," and may not ever become part of the facility's social "family." Be especially conscious of this status in your words and actions, taking care never to say or do anything that could be viewed as "in poor taste" or construed as harassing behavior. Always keep in mind that what is acceptable in one environment may not be acceptable in another, and that often one person's "kidding around" or "teasing" is another person's "harassment."*

2. *Show respect to everyone by refusing to participate in or tolerate inappropriate behavior.*

I have read, understood and intend to comply with these Professional Conduct Expectations.

_____ _____

Employee Signature Date

_____ _____

Please Print Name Date

ORIENTATION CHECKLIST

This document will serve as affirmation that I have received the entire Rehability Care orientation packet and received a copy of the Employee Handbook. The following Company policies and practices have been presented.

General Orientation

- Company Philosophy/Organizational Structure
- Review of Services
- Business Ethics
- Open Communications
- Other Requirements (e.g., state regulations/contracts)
- Introduce Office Staff/Tour of Office
- Supplies
- Assignment Procedures

Clinical Orientation

- Instruction on Delivery of Service
- Handling Client/Employee Cancellations
- Determining Clients' Needs/Communicating New or Unmet Needs
- Client Complaint Procedure
- Disaster Plan (Branch/Clients)
- Emergency Procedures/Safety in the Home

Employment Orientation

- New Employee Packet/Forms Review and Verification
- Review of Applicable Videos
- Exposure of Control Policies
- Blood borne Pathogens/Hepatitis B Vaccination Program
- Tuberculosis Control
- Health Clearance
- Licensure/Certification
- Statutes/Regulations
- CPR
- Job Description
- Employee Conduct/Performance Measures
- Pay Practices
- EOE/AA Employer
- Reasonable Accommodation, if applicable
- Introductory Period/Employee Supervision
- In-service/Training Requirements
- Dealing with Ethical Issues
- Insurance, where applicable
- Universal Precautions/Infection Control
- Osha / HIPPA

_____ _____

Employee Name/Signature/Date Agency Representative/Date

In-Service Attendance Record

I hereby certify that I have attended the following in-services:

Mandatory OSHA In-services	Date	Facility / Location
Blood Borne Pathogen / Infection Control		Rehability Care
Hazard Communication / Employee Right to Know		Rehability Care
Fire Safety		Rehability Care
Tuberculosis		Rehability Care
HIPPA (Confidentiality)		Rehability Care
TJC In-Services and other	**Date**	**Facility / Location**
Advance Directives		Rehability Care
Age Specific Patient Care / Growth & Development		Rehability Care
Earthquake Disaster Preparedness		Rehability Care
Emergency Plan		Rehability Care
Equipment and Electrical Safety		Rehability Care
Pain Management		Rehability Care
Patient Rights		Rehability Care
Small Pox		Rehability Care
Workplace Safety		Rehability Care
Hepa Respirator Fit Testing		Rehability Care

Print Name: _____

Signature: _____

Date: _____

7345 Woodland Drive, Suite C, Indianapolis, IN 46268 - Phone # 317-388-0800, Fax # 317-388-0805

EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING, AND PAYCHECK DEDUCTIONS:

By affixing my signature hereunder, I authorize REHABILITY CARE to release any and all confidential employment, background check and medical information contained in my employment file to any medical facility or entity with whom REHABILITY CARE has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, shall keep my employment records confidential and shall advise any medical facility or other entity to REHABILITY CARE whom records have been provided to also keep such records confidential. I hereby hold REHABILITY CARE harmless for any result(s) that arise with regards to the release of this confidential
Information by REHABILITY CARE.

Medical records information is confidential and REHABILITY CARE will instruct client facilities and/or other entities to treat the provided information confidential as well. I consent to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening tests. Furthermore, I consent to the release of the test results for purposes of determining the fitness for employment or continued employment.

I authorize REHABILITY CARE to deduct from my paycheck for any of the following: unpaid single-supplement housing expenses being the cost incurred for rooming by oneself instead of sharing a room with a roommate, non-authorized housing expenses including but not limited to housing items taken from room(s) or other provided housing, telephone and fax charges to room left unpaid at time of departure, any other room service charges such as movie rentals or dry cleaning costs, any damage/destruction done to room or other housing, and any other expenses due and owing to REHABILITY CARE.

My signature hereunder further indicates that I have read the EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING AND DEDUCTION FROM PAYCHECK POLICY in its entirety and understand its contents.

I understand that my employment is "at will" and may be terminated by me or REHABILITY CARE at any time, with or without prior notice, for any lawful reason or no reason. I further understand no contract is intended by me or REHABILITY CARE and as such my employment is not governed by any contractual relationship with REHABILITY CARE. I certify that the facts contained in this application are true and accurate. I understand that any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms, and/or corporations named above to answer any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

_____ _____

Signature Employee Name Date

REHABILITY CARE does *not discriminate in respect to hiring, firing, compensation, and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed, or disability.*

Sample documents should NOT be construed as legal advice, guidance or counsel. Employers should consult their own attorney about their compliance responsibilities under the FCRA and applicable state law. PeopleFacts expressly disclaims any warranties or responsibility or damages associated with or arising out of information provided. Employers seeking credit reports must provide additional notices pursuant to state law.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you,and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by PeopleFacts 135 Chesterfield Lane Maumee, OH 43537 800-772-0130 www.peoplefacts.com**.** The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature: _____ Date: _____

Employee Name: _____

Employee Printed Name: _____

Sample documents should NOT be construed as legal advice, guidance or counsel. Employers should consult their own attorney about their compliance responsibilities under the FCRA and applicable state law. PeopleFacts expressly disclaims any warranties or responsibility or damages associated with or arising out of information provided. Employers seeking credit reports must provide additional notices pursuant to state law.

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Employer at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by People Facts 135 Chesterfield Lane Maumee, OH 43537 800-772-0130 www.peoplefacts.com and/or Employer. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.
- A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
- By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.
Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Signature: _____ Date: _____

Employee Name: _____

Confidentiality Agreement

In connection with my activities as a _____. I agree to treat confidentially all information concerning patients, clients, and all other Rehability Care employees.

I will not divulge any such patient, client, or other Rehability Care employee information that comes tome as a result of working in or with the agency, nor will I secure information that is not of direct need tome in my with or in the agency.

I understand that if I wrongfully disclose such information or wrongfully access such information, I will be subject to a lawsuit for monetary damage and/or suspension, dismissal from my job, or disciplinary action appropriate to the offense and my position.

_____
Employee Print Name

_____
Employee Signature

_____
Signature of Witness

_____
Date

Confidentiality & Non-Compete Agreement

In connection with my activities as a _____. I agree to treat confidentially all information concerning patients, clients, and all other Rehability Care employees.

I will not divulge any such patient, client, or other Rehability Care employee information that comes to me as a result of working in or with the agency, nor will I secure information that is not of direct need to me in my with or in the agency.

I understand that if I wrongfully disclose such information or wrongfully access such information, I will be subject to a lawsuit for monetary damage and/or suspension, dismissal from my job, or disciplinary action appropriate to the offense and my position.

NON-COMPETE:

During the time Employee is employed by REHABILITY CARE , and for a one (1) year period after Employee's employment with REHABILITY CARE has been terminated (by either party and for whatever reason), Employee will not directly or indirectly:

1. Induce or attempt to persuade any current employee, agent, manager, consultant, director, or other participant in REHABILITY CARE . business to terminate such employment or other relationship in order to enter into any relationship with Employee, any business organization in which Employee is a participant in any capacity whatsoever, or any other business organization in competition with REHABILITY CARE 's business; or
2. Induce or attempt to persuade any current Client Facility of REHABILITY CARE or any employee affiliated with REHABILITY CARE to cease or limit being a Client Facility of REHABILITY CARE or employee associated with REHABILITY CARE or to become a Client Facility of or employee associated with any other medical facility or business organization in which Employee is a participant in any capacity whatsoever, or of any other business organization in competition with REHABILITY CARE business. The parties acknowledge that Employee working directly for a Client Facility would be a "limit" of affiliation and considered a breach of this Agreement.

_____
Employee Print Name

_____
Employee Signature

_____ _____
Signature of Witness Date

Rehability Care
Employee Handbook and Policy Manual

ACKNOWLEDGEMENT of RECEIPT of HANDBOOK

This is to certify that I have read this employee handbook and am familiar with its contents. I understand that it is not a binding contract but a set of guidelines for the implementation of personnel policies. I understand that Rehability Care may modify any of the provisions of this handbook at any time, with or without notice, and may deviate from any provision of this handbook in its sole discretion. I also understand that, notwithstanding any of the provisions of this handbook, I am employed on an at-will basis. My employment may be terminated at any time, by the Company, with or without cause. I understand that no representative of the Company, other than the president, has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing. I acknowledge that I do not in any way rely upon the provisions of this employee handbook in accepting or continuing my employment with the Company.

_____
Employee Signature

_____
Employee Name (Printed)

_____
Date

_____
Date received in office

_____
Print Name