

**Qualifications:**

Never have been shown by credible evidence to have abused, neglected, sexually assaulted, exploited, or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral or written statement to this effect obtain at the time of application.

Must participate in the orientation and training program of the Agency.

Must not have any material false statements concerning qualifications requirements either to the department or the provider.

Must be able to pass a criminal background check and a TB test. CPR/First Aide Certified.

**Education:**

At least an Associate's Degree in Business Administration, Human Services, Nursing or a related field.

**Duties & Responsibilities:**

- Job duties include full authority and responsibility for the operation of the PHCP
- Provides full authority and responsibility for the operation of the agency.
- Assist in the orientation of new employees
- Develop and implement policies and procedures
- Review clinical records and personnel records
- Monitor activities of governing body
- Supervise staff
- Implement quality improvement activities, i.e., client satisfaction surveys, complaints, accidents, corrective action plans
- Handles client and staff effectively
- Participates in hiring & firing of employees
- Provide watchful oversight of client care in conjunction with the Nursing Manager

## **ADMINISTRATOR DOCUMENTATION**

### **PURPOSE:**

Make sure that the administrator understands his/her responsibilities as regard to day-to-day operation of the private home care company. To ensure that the governing body appoints an administrator who shall have full authority and responsibility for the operation of the private home care company.

### **POLICY:**

**NATHAN HOME CARE AND NURSING AGENCY LLC** governing body shall appoint an administrator who shall will have full authority for the day today operation of the PHCP company.

Any administrator from this agency shall meet the following minimum qualifications:

1. Never shown by credible evidence (e.g. court or jury, a department of investigation, or other reliable evidence) to have abused, neglected, sexually assaulted, exploited, or deprived any person or to have subjected any person to serious injury as a statement to this effect obtained at the time of application.
2. Participate in the orientation and training required by private home care rules and regulations.
3. Not make any material false statements concerning qualifications requirements either to the department of community health or the provider.

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

- Oversees, develops & implements financial, budget, payroll, salaries, billing and timesheet policies and procedures.
- Other administrative duties as assigned by management.

**Acknowledgement:**

\*I have reviewed my job description and agree to perform all duties mentioned to the best of my ability; I understand that my job duties may change as the needs of the agency change. I further agree to notify my immediate management if I am unable to complete any of my job duties in a timely manner.

**Employee Name:**

**Print Name**

**Date**

**Employee Signature**

**Date**

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone: 856-236-5125

Email: Docdior2020@gmail.com

Dear Applicant,

Thank you for your interest in employment opportunities at **NATHAN HOME CARE AND NURSING AGENCY LLC**. At **NATHAN HOME CARE AND NURSING AGENCY LLC**, we are committed to the highest standards of conduct in serving our clients & employees.

**Application check list:**

Listed below are items required for employment with **NATHAN HOME CARE AND NURSING AGENCY LLC**.

- Current driver's license
- Social security card
- Current CPR and first aid
- Vehicle insurance card
- **Background check (at applicant expense average of \$51.50 will be setup by company but the cost is at your expense) . Will be deducted from your first paycheck**
- Current TB test results or TB symptom screen (at applicant expense)

Attached to this is the application packet. Please, take a few minutes to go over the application check list and complete the application. All information must be turned in by each applicant for employment consideration.

Sincerely,

The Team at  
**NATHAN HOME CARE AND NURSING AGENCY LLC**

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

☐ ADM

## APPLICATION FOR EMPLOYMENT

### Personal Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: ( ) \_\_\_\_\_ If you are under 18, can you furnish a work permit? ☐ Yes ☐ No

Email: \_\_\_\_\_

Driver's license number: \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth : \_\_\_\_\_

City of Birth & Country : \_\_\_\_\_

Have you Stayed in your  
Address for more than 2 years : Yes or No

If No Prior Address : \_\_\_\_\_

Available to do Fingerprint as Needed Yes or No

Employment desired ☐ Full time ☐ Part time ☐ Temp ☐ Seasonal

Position: \_\_\_\_\_ Date you can start? \_\_\_\_\_ Salary: \_\_\_\_\_

Are you employed now? ☐ Yes ☐ No If so may we inquire of your present employer? ☐ Yes ☐ No

Ever applied for this company before? ☐ Yes ☐ No Where: \_\_\_\_\_ When: \_\_\_\_\_

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

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

If yes, explain:

\_\_\_\_\_  
\_\_\_\_\_

Such conviction may be relevant if job related, but does not bar you from employment.

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

| EDUCATION            |                        | NAME AND<br>LOCATION<br>OF SCHOOL | # OF YEARS<br>COMPLETED | DID YOU<br>GRADUATE? | SUBJECT<br>STUDIED |
|----------------------|------------------------|-----------------------------------|-------------------------|----------------------|--------------------|
| Academic             | Currently<br>attending |                                   |                         |                      |                    |
|                      |                        |                                   |                         |                      |                    |
|                      | Last<br>completed      |                                   |                         |                      |                    |
|                      |                        |                                   |                         |                      |                    |
| Trade of<br>business | Currently<br>attending |                                   |                         |                      |                    |
|                      |                        |                                   |                         |                      |                    |
|                      | Last<br>completed      |                                   |                         |                      |                    |
|                      |                        |                                   |                         |                      |                    |

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

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

---

---

---

| DATE<br>MONTH / YEAR | NAME AND ADDRESS<br>OF EMPLOYER | SALARY | JOB | REASON FOR<br>LEAVING |
|----------------------|---------------------------------|--------|-----|-----------------------|
| From:                |                                 |        |     |                       |
| To:                  |                                 |        |     |                       |
| From:                |                                 |        |     |                       |
| To:                  |                                 |        |     |                       |
| From:                |                                 |        |     |                       |
| To                   |                                 |        |     |                       |

**References:** Give the names of three persons not related to you to whom you have known at least 1 year

| NAME | ADDRESS | PHONE NUMBER | YEARS<br>ACQUAINTED |
|------|---------|--------------|---------------------|
|      |         |              |                     |
|      |         |              |                     |
|      |         |              |                     |

List any foreign language(s) and check the box that best describes your skill level.

| LANGUAGE | READ AND WRITE | READ AND SPEAK | SPEAK ONLY |
|----------|----------------|----------------|------------|
|          |                |                |            |
|          |                |                |            |

In case of emergency notify:

|      |              |              |
|------|--------------|--------------|
| Name | Relationship | Phone Number |
|------|--------------|--------------|

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

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

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

\_\_\_\_\_ I give the private home care provider the right to investigate all police, driving, and personal records and references, if job related. I hereby release from liability the provider and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

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

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

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

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

|                                |
|--------------------------------|
| <b>AGENCY MANAGEMENT NOTES</b> |
| Hire date:                     |
|                                |
|                                |

## CONFIDENTIALITY OF INFORMATION AGREEMENT

Employee Name: \_\_\_\_\_  
Print Name

### Confidentiality of Information

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

### What we do to maintain confidentiality of information

- To protect any individual from invasion of privacy & to protect the interest of the Agency, any information gathered for client care will be gathered, maintained & stored in such a manner as to assure confidentiality.
- Access to information will be limited to need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to Agency policy, and staff will be sign confidentiality statement and it will be placed in the employee's file.
- Proven violation of breach of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for the information contained in the confidentiality of information agreement.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## ANNUAL TUBERCULOSIS QUESTIONNAIRE

For personnel who have a known positive PPD and previously negative chest x-ray, you are requested to complete this questionnaire with either a yes or no.

Have you noticed any of the following?

- |                                               |                              |                             |
|-----------------------------------------------|------------------------------|-----------------------------|
| 1. Unexplained Fevers                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Night Sweats                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Unintentional weight loss                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Cough                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Hoarseness                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Bloody Sputum                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you completed INH therapy?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you ever had a BCG vaccine?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Have you had an x-ray while employed here? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Employee Name: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## REPORTING TUBERCULOSIS AND HEPATITIS EXPOSURE

It is every employee's obligation to report known exposure to tuberculosis and hepatitis.

### **Tuberculosis**

I understand that I will provide the agency with my TB screening result each year that I am employed to work for the company. Negative TB results or tuberculosis (TB) symptom screen if I test positive are to be obtained for employment prior to getting assignments to work with clients.

### **Hepatitis B**

I understand that due to my occupational exposure to blood borne pathogens and/or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection, a serious disease. I have been informed and advised to be vaccinated with the hepatitis B vaccine;

I acknowledge that I have read the above. By signing this document, I certify that I understand and I was given the opportunity to ask questions and management is open to such questions.

Employee Name: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

|                           |
|---------------------------|
| <b>CELLULAR PHONE USE</b> |
|---------------------------|

The company does not permit employee whilst on company time to talk on the cellular phones while driving a vehicle. This is very dangerous and should be avoided any time. It is mandatory that I must pull over and stop my vehicle each time I conduct Agency business per cellular phone.

The company is not responsible for any moving violations, accidents or other incident that may occur while I am using my cellular phone and driving.

**I have read and understand the above information of the Agency regulation regarding cellular phone use and I will comply.**

Employee Name: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## EMPLOYEE DRESS CODE

Provider strives to present a professional and safe health care image to patients' families, the community, and other health care professionals.

NATHAN HOME CARE AND NURSING AGENCY LLC staff members adhere to the following standards in their dress code.

- **All staff** will wear an approved provider name badge when providing patient care.
- **Clothing** shall be clean, neat, & well maintained.
- **Allowed Clothing:** Loose comfortable clothing, scrubs, walking shorts that are at least mid thigh in length, hemmed blue jeans, plain t-shirt, and casual street wear. Appropriate undergarments should be worn.
- **Not Allowed:** mini skirts, short shorts, tank tops, halter-tops, midriffs, cut offs, frayed blue jeans, or t-shirts with any sayings on them.
- **Shoes** should be conservative and comfortable. We encourage closed toed shoes for personal safety and infection control while providing patient care. No flip-flops or thong sandals.
- **Nurses** should keep a clean lab coat available to wear over their clothes when accompanying patients to any medical appointment.
- Company employees will try to meet the requests of parents or primary caregivers within reason.
- **Employees** are expected to keep their hair dry, neat, and clean. Long hair must be styled so it does not come in contact with the patient. Mustaches and beards must be clean and trimmed.
- **Perfume** should be conservative.
- **Jewelry represents** a safety hazard, so it must be worn with discretion, i.e. wedding rings, rings without large mountings, small earrings or studs. Visible piercing, except for earrings, should be removed when providing patient care. Both professionalism and safety should be considered when wearing jewelry.
- **Fingernails** are to be kept clean, trimmed and moderately short for patient safety.

\* If an employee is sent home to change clothes due to inappropriate attire, the employee will be sent home on his/her own time and may result in disciplinary action.

\* **Interpretation of compliance** to this dress code policy is subject to the discretion of the Supervisor, or acting Supervisor.

Employee Name: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## DRUG TESTING POLICY

Agency employees may not possess, distribute and or use alcoholic beverages or controlled substances. Including inhalants while on premises of property controlled by the Agency or while in the course of conducting company business or engaged in any company sponsored activity.

Clients or visitors may not possess, distribute and or use alcoholic beverages or controlled substances, while on the premises of the property controlled by the Agency.

Any employee who has knowledge of a person or persons violating this policy must report it to his/her Supervisor immediately.

Based on reasonable cause, the Agency may conduct searches or inspections of an employee's personal belongings and may be asked to take a drug test. Refusal to consent may result in termination.

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

Employee Name: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

|                                      |
|--------------------------------------|
| <b>EMERGENCY CONTACT INFORMATION</b> |
|--------------------------------------|

In case of emergency please notify the following:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

|                                 |
|---------------------------------|
| <b>EMPLOYEE REFERENCE CHECK</b> |
|---------------------------------|

Company has my authorization to check my references.

Employee Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

---

Company Contacted: \_\_\_\_\_

Dear employer, this employee is seeking employment with our company. It is our policy to ask for references prior to employment. Please complete this form for our records and sign below. We would greatly appreciate your assistance.

Please verify employment dates:

From: \_\_\_\_\_ To: \_\_\_\_\_

Do you consider the employee eligible for rehire? ☐ Yes ☐ No

Comments:

---

---

---

---

Information was received by: ☐ Phone ☐ Mail ☐ Fax

Company Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

\* (IF FAXED) Company Contact Signature: \_\_\_\_\_

**STATEMENT OF GOOD FAITH  
(CREDIBLE EVIDENCE STATEMENT)**

I, \_\_\_\_\_, have applied for employment, do hereby certify that I have never been shown by credible evidence by a court, a department investigation, or other reliable evidence to have abused, neglected, sexually assaulted, exploited, deprived any person or to have subjected any to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral or written statement to this effect obtained at the time of application and have not made any material false statements concerning qualification requirement, either to the department or Provider.

In the event I am employed, I understand that false or misleading information given in my application or interview(s) may result in discharge.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

NATHAN HOME CARE AND NURSING AGENCY LLC

4375 RED ROCK POINT SUWANEE, GA 30024

Phone:856-236-5125

Email:Docdior2020@gmail.com

**STATEMENT OF UNDERSTANDING**

I, \_\_\_\_\_ understand and acknowledge that any false or misleading information that I give to Provider on my application and regarding my background check will be grounds for immediate termination.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

|                                                |
|------------------------------------------------|
| <b>ADMINISTRATOR SELF-ASSESSMENT OF SKILLS</b> |
|------------------------------------------------|

Please check if you have performed and can adequately demonstrate the following:

**Vital Signs**

- ☐ Oral Temperature
- ☐ Rectal Temperature
- ☐ Pulse
- ☐ Respirations
- ☐ Blood Pressure

**Personal Hygiene**

- ☐ Bed Bath
- ☐ Sponge Bath
- ☐ Tub Bath

**Skin Care**

- ☐ Lotion
- ☐ Powder
- ☐ Back Rub
- ☐ Basic Decubitus Ulcer Care
- ☐ Positioning to Relieve Pressure Areas
- ☐ Wash with Soap/Water
- ☐ Air Dry Skin/ Ulcer

**Mouth Care**

- ☐ Brush Teeth
- ☐ Brush Dentures
- ☐ Mouth Care for the Unconscious Patient

**Hair Care**

- ☐ Shampoo/ Comb
- ☐ Use of Shampoo Tray

**Nutrition**

- ☐ Simple Meal Preparation
- ☐ Offering Fluids to patients
- ☐ Measuring intake/output
- ☐ Feeding patient with chewing and swallowing problems

**Shaving**

- ☐ With electric razor
- ☐ With safety razor

**Nail Care**

- ☐ Clean and file fingernails
- ☐ Soak and file toenails

**Bed position**

- ☐ Side lying

- ☐ Probe (Neck lying)

- ☐ Use of Trochanter Rolls

- ☐ Use of Foot Board

- ☐ Use of Draw Sheet

**Dressing**

- ☐ Assist with Oxygen nasal prongs

- ☐ Assist with clothing bedfast patient

- ☐ Assist with clothing wheelchair patient

**Bed Making**

- ☐ Unoccupied

- ☐ Occupied

- ☐ Shower

**Other**

- ☐ Basic Communication

- ☐ Active listening

**Housecleaning**

- ☐ Laundry

- ☐ Home Cleaning

- ☐ Grocery Shopping

**Catheter**

- ☐ Foley Care/ Empty bag

- ☐ Cleaning perineum at catheter insertion point

- ☐ Care/Changing of leg bag

- ☐ Application of condom catheter

**Bowel**

- ☐ Colostomy Care/Empty bag

- ☐ Soapsuds enema

- ☐ Tap water enema

- ☐ Fleets enema

- ☐ Use of portable commode

**Transfers**

- ☐ To/From bath bench

- ☐ To/From wheelchair

- ☐ Bed to wheelchair

- ☐ Wheelchair to bed

- ☐ Wheelchair to toilet

- ☐ Wheelchair to tub

- ☐ Wheelchair to shower

- ☐ Transfer board

- ☐ Hoyer lift

## ADMINISTRATOR

### Job Summary :

The administrator is responsible for the overall operations, development and financial performance of the agency. The administrator supervises and manages all aspects of program delivery in accordance with federal, state and company guidelines. Assures the philosophy, mission and goals of the company are adhered to.

### Responsibilities

- Promotes the mission and vision of the company based upon the principals/values established.
- Ensure growth and profitability of the company through the responsible use of company resources and educating the community to our services.
- Assure compliance with all necessary standards and regulatory requirements on a timely basis to maintain Agency's licenses, certifications, accreditations and all operating activities.
- Planning, organizing, directing and evaluating operations to ensure the provision of adequate and appropriate care and services.
- Directs and participates in Agency's business development activities including community education, contract negotiations and development, and referral source relationship building. Ensure the accuracy of public information materials and activities.
- Coordinate clinical services and programs of the Agency.
- Develop & implement ongoing recruitment and retention program. Recruit, employ and retain qualified personnel to maintain appropriate staffing levels.
- Develops and recommends Agency's annual budget and strategic plan while soliciting input from other team members.
- Directs daily business operations of Agency's and implements company's financial policies, accounting and clinical systems and cost controls.
- Provides supervision, monitoring and evaluation of all agency activities relevant to the delivery of services provided including interpretation and implementation of policies and procedures.
- Monitors client/referral satisfaction.
- Monitors progress of personnel performance.
- Ensure staff development including orientation.

Employee Name: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## STAFF ORIENTATION

**Contractor/Employee Name:** \_\_\_\_\_

It is the policy of this company to make sure that every new employee is oriented before beginning work.

- Company policy and procedures: scope of services and type of clients served
- Clients rights and responsibilities
- Staff code of conduct
- Confidentiality of client files and medical information (HIPAA material)
- Proper documentation on company service forms
- Procedures on reporting client condition, progress and/or progress to supervisory nurse
- Emergency procedure information forms and usage
- Infection control
- Employee obligation to report known exposure to hepatitis and TB
- Communication skills with Alzheimer's, aphasia, dementia, and other related illnesses
- Procedures for handling complaints
- Employee job responsibilities
- Incidents and emergencies
- Transportation of clients
- Managing client funds

This is to certify that I knowledge receipt of the contents of the current orientation booklet. As a condition of my continued contract/employment, I agree to abide by the policies set forth in the orientation booklet. Any contents of the booklet that was not reviewed, I agree that I am responsible for reviewing and by no means the content and typo or errors would not be misconstrued in any form or fashion and I am holding Provider free of any liability to the effect.

\_\_\_\_\_  
Contractor/Employee Signature Title

\_\_\_\_\_  
Date