Employee Records Checklist

Employee Name:	Employee ID:

Section 1 (Application)

- ☐ Employee Document Checklist
- ☐ Emergency Contact Sheet
- ☐ Employment Application (signed & dated)
- ☐ Employee Resume (if applicable)
- ☐ Employment Agreement (w-9/w-2 employees)
- ☐ Job description (for every position held)
- ☐ Orientation Checklist
- ☐ References X 2

Section 2 (Consents)

- ☐ W-9 Employee Addendum (w-9 employees only)
- ☐ Pledge of Confidentiality
- ☐ Confidentiality Statement
- ☐ Policies and Procedures Acknowledgement
- ☐ Probationary Period Statement
- ☐ Employee Policy on Jobs
- ☐ Patient safety – Environment of Care
- ☐ Consent form to release physical-medical exam/Criminal background screening data form
- ☐ Random Testing of Alcohol/Drug Usage
- ☐ Automobile Requirements
- ☐ Infection Control Awareness Requirement
- ☐ Standard Precautions
- ☐ Employee Handbook Acknowledgement
- ☐ Compliance with Americans with Disabilities Act of 1990
- ☐ Medicaid Fraud Acknowledgement
- ☐ Laws, Rules and Regulations Acceptance
- ☐ Suspected Abuse Acknowledgement
- ☐ Tuberculosis declination/Hepatitis declination/Covid 19 policies
- ☐ Authentication for Electronic Signature
- ☐ Staff Conflict of Interest
- ☐ Attestation of Compliance with Background Screening Requirements
- ☐ Employee Evaluation – Annual/Probationary

Section 3 (Skills Assessments)

- ☐ RN/LPN Pre-employment exam (completed and scored) – RNs/LPNs Only
- ☐ Nursing Competency Evaluation - RNs/LPNs Only
- ☐ HHA Pre-employment exam (completed and scored) – HHAs/CNAs Only
- ☐ Home Health Aide Competency Evaluation - HHAs/CNAs Only
- ☐ Skills Observation Assessment

Section 4 (CEUs and licenses)

- ☐ Copy of Certificate/Transcripts from an accredited institution
- ☐ Professional License (if applicable)
- ☐ Professional License Verification
- ☐ CPR/First Aid card
- ☐ Domestic Violence
- ☐ OSHA
- ☐ HIV/AIDS
- ☐ Medical Errors
- ☐ Alzheimer's
- ☐ HIPAA
- ☐ Infection Control

Section 5 (Personal Documents)

- ☐ Copy of Driver's License
- ☐ Driver's License Verification
- ☐ Sex Offender's search
- ☐ Social Security Card (confidential)
- ☐ Copy of Passport/Resident Card (confidential)
- ☐ Level 2 Background Screening
- ☐ Annual Physical Exam
- ☐ I-9 form (signed and dated)
- ☐ W-4 or W-9 (signed and dated)
- ☐ Professional Liability Insurance
- ☐ Auto Insurance
- ☐ E-verify

Section 6 (Expired Documents)

Standard Application for Employment

It is our policy to comply with all applicable state and federal laws prohibiting discrimination in employment based on race, age, color, sex, religion, national origin, disability or other protected classifications.

Please carefully read and answer all questions. You will not be considered for employment if you fail to completely answer all the questions on this application. You may attach a résumé, but all questions must be answered.

"Employer"	Position applying for

PERSONAL DATA

Name (last, first, middle)			
Street Address and/or Mailing Address	City	State	Zip

Home Telephone Number	Business Telephone Number	Cellular Telephone Number
Date you can start work	**Salary Desired**	**Do you have a High School Diploma or GED?**
		Yes ☐ No ☐

POSITION INFORMATION

Check all that you are willing to work

Hours:	Days	Swing	Status:
Full Time ☐	Days ☐	Swing ☐	Regular ☐
Part Time ☐	Evenings ☐	Graveyard ☐	Temporary ☐
		Weekends ☐	

Are you authorized to work in the U.S. on an unrestricted basis? Yes ☐ No ☐

Have you ever been convicted of a felony? (Convictions will not necessarily disqualify an applicant for employment.) Yes ☐ No ☐

If yes, explain:

Have you been told the essential functions of the job or have you been viewed a copy of the job description listing the essential functions of the job?
Yes ☐ No ☐

Can you perform these essential functions of the job with or without reasonable accommodation? Yes ☐ No ☐

QUALIFICATIONS

Please list any education or training you feel relates to the position applied for that would help you perform the work, such as schools, colleges, degrees, vocational or technical programs, and military training.

	School Name	Degree	Address/City/State
School			
School			
Other			

SPECIAL SKILLS

List any special skills or experience that you feel would help you in the position that you are applying for (leadership, organizations/teams, etc.

REFERENCES

Please list three professional references not related to you, with full name, address, phone number, and relationship. If you don't have three professional references, then list personal, unrelated references.

Name	Address/City/State	Phone	Relationship

WORK HISTORY Start with your present or most recent employment and work back. Use separate sheet if necessary. (INCLUDE PAID AND UNPAID POSITIONS)		
Job Title #1	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

May we contact your present employer? **Yes** ☐ **No** ☐ **N/A** ☐

Job Title #2	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

Job Title #3	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

Job Title #4	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

I certify that the facts set forth in this Application for Employment are true and complete to the best of my knowledge. I understand that if I am employed, false statements, omissions or misrepresentations may result in my dismissal. I authorize the Employer to make an investigation of any of the facts set forth in this application and release the Employer from any liability. The employer may contact any listed references on this application.

I acknowledge and understand that the company is an "at will" employer. Therefore, any employee (regular, temporary, or other type of category employee) may resign at any time, just as the employer may terminate the employment relationship with any employee at any time, with or without cause, with or without notice to the other party.

_____ _____

Applicant Signature Date

Hired? ☐ Yes ☐ No Signature _____ Date _____

INDEPENDENT CONTRACTOR AGREEMENT

This Agreement is entered into as of _____between AJE NURSING SERVICES and _____.

1. **Independent Contractor**. Subject to the terms and conditions of this Agreement, the Company hereby engages the Contractor as an independent contractor to perform the services set forth herein, and the Contractor hereby accepts such engagement.

2. **Duties, Term, and Compensation**. The Contractor's duties, term of engagement, compensation and provisions for payment thereof shall be as set forth in the estimate previously provided to the Company by the Contractor and which is attached as Exhibit A, which may be amended in writing from time to time, or supplemented with subsequent estimates for services to be rendered by the Contractor and agreed to by the Company, and which collectively are hereby incorporated by reference.

3. **Confidentiality**. The Contractor acknowledges that during the engagement the Contractor will have access to and become acquainted with various trade secrets, inventions, innovations, processes, information, records and specifications owned or licensed by the Company and/or used by the Company in connection with the operation of its business including, without limitation, the Company's business and product processes, methods, customer lists, accounts and procedures. The Contractor agrees that to not disclose any of the aforesaid, directly or indirectly, or use any of them in any manner, either during the term of this Agreement or at any time thereafter, except as required in the course of this engagement with the Company. All files, records, documents, blueprints, specifications, information, letters, notes, media lists, original artwork/creative, notebooks, and similar items relating to the business of the Company, whether prepared by the Contractor or otherwise coming into the Contractor's possession, shall remain the exclusive property of the Company. The Contractor shall not retain any copies of the foregoing without the Company's prior written permission. Upon the expiration or earlier termination of this Agreement, or whenever requested by the Company, the Contractor shall immediately deliver to the Company all such files, records, documents, specifications, information, and other items in the Contractor's possession or under the Contractor's control. The Contractor further agrees to not disclose retention as an independent contractor or the terms of this Agreement to any person without the prior written consent of the Company and shall at all times preserve the confidential nature of relationship to the Company and of the services hereunder.

4. **Conflicts of Interest; Non-hire Provision**. The Contractor represents that the Contractor is free to enter into this Agreement and that this engagement does not violate the terms of any agreement between the Contractor and any third party. Furthermore, the Contractor, in rendering duties shall not utilize any invention, discovery, development, improvement, innovation, or trade secret in which there is not a proprietary interest. During the term of this agreement, the Contractor shall devote as much productive time, energy and abilities to the performance of duties hereunder as is necessary to perform the required duties in a timely and productive manner. The Contractor is expressly free to perform services for other parties while performing services for the Company. For a period of six months following any termination, the Contractor

shall not, directly or indirectly hire, solicit, or encourage to leave the Company's employment, any employee, consultant, or contractor of the Company or hire any such employee, consultant, or contractor who has left the Company's employment or contractual engagement within one year of such employment or engagement.

5. **Merger**. This Agreement shall not be terminated by the merger or consolidation of the Company into or with any other entity.

6. **Independent Contractor**. This Agreement shall not render the Contractor an employee, partner, agent of, or joint venture with the Company for any purpose. The Contractor is and will remain an independent contractor in relationship to the Company. The Company shall not be responsible for withholding taxes with respect to the Contractor's compensation hereunder. The Contractor shall have no claim against the Company hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind.

7. **Insurance**. The Contractor will carry liability insurance (including malpractice insurance, if warranted) relative to any service that is performed for the Company.

8. **Successors and Assigns**. All of the provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, if any, successors, and assigns.

9. **Choice of Law**. The laws of the state of Florida shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties hereto.

10. **Modification or Amendment**. No amendment, change or modification of this Agreement shall be valid unless in writing signed by the parties hereto.

11. **Entire Understanding**. This document and any exhibit attached constitute the entire understanding and agreement of the parties, and any and all prior agreements, understandings, and representations are hereby terminated and canceled in their entirety and are of no further force and effect.

12. **Unenforceability of Provisions**. If any provision of this Agreement, or any portion thereof, is held to be invalid and unenforceable, then the remainder of this Agreement shall nevertheless remain in full force and effect.

13. **Professional Responsibility.** Nothing in this Agreement shall be construed to interfere with or otherwise affect the rendering of services by Contractor in accordance with his independent and professional judgment. This Agreement shall be subject to the rules and regulations of any and all professional organizations or associations to which Contractor may from time to time belong and the laws and regulations governing said practice in this State. Our Agency has full responsibility over all contracted services. Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract. Both parties agree that the Employee shall submit clinical notes and progress reports to the Director of Nursing once a week (on/or before 72 hrs of service rendered) and shall conform to prescribed scheduling of visits and

periodic patient evaluation. All Patients' health information must be maintained CONFIDENTIAL as HIPAA requirements. Both parties agree that this Agency shall coordinate all job-related activities of the Employee, control all job-related activities of the Employee, and shall evaluate the Employee's job performance just as we do that of other employees.

14. **Suspension and Termination.** The initial term of this Agreement shall be for a period of ( ) months and shall automatically continue thereafter for successive terms of ( ) months unless or until terminated as hereinafter provided. Company shall have the right to terminate this agreement if Contractor fails to comply with all the rules and regulations provided to Contractor by the Company. The Company may terminate this Agreement at any time by 10 working days' written notice to the Contractor. In addition, if the Contractor is convicted of any crime or offense, fails or refuses to comply with the written policies or reasonable directive of the Company, is guilty of serious misconduct in connection with performance hereunder, or materially breaches provisions of this Agreement, the Company at any time may terminate the engagement of the Contractor immediately and without prior written notice to the Contractor.

15. **Payment Agreement.** Both parties agree that the Contractor shall be paid an hourly rate of $_____ or per visit rate of $_____.

IN WITNESS WHEREOF the undersigned have executed this Agreement as of the day and year first written above. The parties hereto agree that facsimile signatures shall be as effective as if originals.

AJE NURSING SERVICES	_____
Company's Name	Contractor's Name
By: Lazaro Alfonso / Administrator	By: _____
Authorized Representative/Position	Position
Signature: _____	Signature: _____
Date: _____	Date: _____

EMERGENCY CONTACT INFORMATION

Please complete at least two of the references below.

EMERGENCY CONTACT INFORMATION

FIRST LAST RELATIONSHIP

HOME PHONE WORK PHONE CELL PHONE

ADDRESS CITY STATE ZIP

EMERGENCY CONTACT INFORMATION

FIRST LAST RELATIONSHIP

HOME PHONE WORK PHONE CELL PHONE

ADDRESS CITY STATE ZIP

EMERGENCY CONTACT INFORMATION

FIRST LAST RELATIONSHIP

HOME PHONE WORK PHONE CELL PHONE

ADDRESS CITY STATE ZIP

STAFF CONFLICT OF INTEREST

PURPOSE:
To ensure employees avoid any personal interest that may conflict with the interests of the agency.

POLICY:
The Agency expects all of its employees to understand and be aware of potential situations where their personal interests may conflict with the business interests of the Agency.

PROCEDURE:

1. All employees will report to their immediate supervisor any interests in or employment with an entity that interacts with the Agency including, but not limited to:
    a. employee participation in any business transactions where there might appear to be a conflict between the employee's personal interest and that of the Agency.
    b. employee participation in any entity which buys services from or provides services/products to the Agency.
    c. outside employment that interferes with satisfactory performance of an employee’s duties and responsibilities for the Agency.
    d. any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an employee's duties and responsibilities for the Agency.
    e. acceptance of gifts, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence an employee in the performance of the employee's duties and responsibilities for the Agency.

2. If a conflict of interest is discovered or suspected the supervisor/manager and employee will discuss its impact with the Administrator.

3. After the above discussion, a recommendation may be made for the employee to end his/her association with the entity or the Agency within a specified period of time.

4. The failure of an employee to cease activity that management determines to be a conflict interest will subject the employee to disciplinary action up to and including termination.

5. Upon hire, agency staff will sign a Conflict of Interest Statement.

STATEMENT OF PRINCIPLE RELATING TO DISCLOSURE OF CONFLICTS OF INTEREST

No employee or member of the Board of Directors, Advisory Committee or other individual committee, or entity shall derive any profit or gain directly or indirectly by reason of their association with the Agency, without the prior knowledge and approval of the Board of Directors. All board members and/or employees, at the discretion of the board, will be required to submit a disclosure statement annually.

Full and prompt disclosure to the Board of Directors will be made of any transaction, situation, or event which may place a person(s) in a position in which his or her family, partner or business associate is in conflict with the interest of the Agency.

Full disclosure will be made of the names and addressed of individuals or corporations having a combined direct or indirect ownership or controlling interest of 5 percent or more in the Agency or in any subcontractor in which the Agency has a direct or indirect ownership interest of 5 percent or more.

Disclosure must be made of conviction of any criminal offense involving Medicare, Medicaid or Title XX programs on the part of any person on the Board of Directors and on the part of any agent or managing employee of the Agency.

Disclosure must be made of the names and addresses of any current employees in managerial, accounting, auditing, or similar capacity who were employed by the Agency's Medicare fiscal intermediary within the previous twelve months. Change of address for parent, subunits or branches must be promptly disclosed.

Purchases, sales, leases or other contractual arrangements to, from and with the Corporation shall, except as hereinafter specified, be considered as involving potential conflict, which should be disclosed.

Gifts or other favors offered, or received, shall be disclosed.

No officer, Director or employee of the Corporation shall have any personal financial interest, direct or indirect, in any contract relating to the business conducted by the Corporation, or the furnishing of supplies or equipment to the Corporation, unless authorized by the concurring vote of two-thirds of the Board of Directors.

In matters involving a conflict of interest, a board member must disclose any known significant reasons why a transaction might not be in the best interest of the Agency and a board member shall not participate in discussions unless requested by the board not vote on such transactions. The abstention and the reason for it shall be recorded in the minutes.

A director, officer or employee in a policy making position of the Corporation will not, however, be considered to have a conflict of interest with the Corporation if he/her or any member of his/her family:

1. Is an officer, director or employee of a Bank, Savings and Loan Association, or company in which the Corporation has funds on deposit or invested in shares of stock:
2. Is or has been employed (or a member of his family or partner is or have been employed) with the approval of the Board of Directors to render legal, accounting, or other professional services to the Corporation on a fee basis.

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST

I have read and am fully familiar with the Agency's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my membership on the Agency's Board of Directors or its committees or my employment. Furthermore, I agree to disclose any such interest which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the Agency's business that might result in any profit or gain, directly or indirectly, for myself.

_____
Signature

_____
Date

Direct Employee Agreement

This Agreement is entered into as of_____, between Aje Nursing Services (hereinafter referred to as "Company" and _____ _____(hereinafter referred to as "the Employee".

1. **Duties and Responsibilities.** To perform job duties as specified in the Employee's Job Description (refer to Job Description). To obey and comply with all lawful and reasonable instructions given by supervisors including duties not specifically mentioned but which may be reasonably expected within the scope of work, to devote all time, attention, knowledge and skill during working hours exclusively to the business and interests of the Company and to work exclusively for the Company during the duration of this employee contract, not to enter into any contracts or other commitments on behalf of the Company without the written consent of the Company, to observe the Policies and Procedures set by the Company from time to time in the conduct of its business, for the purpose of this employee contract the parties undertake to act in good faith and guarantee that they shall neither do or not do anything which may prejudice or detract from the assets interests or rights of either of them or others.

2. **Competency and Probation.** The Employee guarantees that he / she is competent to carry out the services for which he / she has been employed under this employee contract and that he / she is properly qualified to occupy the post envisaged herein. Any material misrepresentation shall lead to summary termination of this contract; the Employee will be required to serve a probationary period of three months during which the Company will provide ongoing training and during which the Employee's performance and progress will be monitored.

3. **Orientation, Rules, Regulations and Procedures.** Upon engagement the Employee will be required to participate in an orientation program. It is a duty of the Employee to read and understand the Company's Policies and Procedures, as well as the Grievance and Disciplinary Codes and Processes. A copy of this will be made available to the Employee. Compliance with such procedures is a term and condition of employment with the Company.

4. **Remuneration:** The Company shall pay the Employee an agreed salary every ____ weeks. You will be remunerated at the hourly rate of $_____ or per visit rate of $_____ as agreed at the time of your interview, for the hours worked as indicated. Taxes shall be deducted from the salary. The rate of remuneration will be reviewed on an annual basis.

5. **Overtime.** Should the Company's requirements for work extend to overtime, the Employee hereby agrees to work such overtime. Any hours worked will be remunerated at the following rate:

6. **Withholding of Services.** It is the Company's policy that should the Employee withhold services for whatever reason, a principle of "no work, no pay" shall apply. This policy applies if healthcare documentation is not provided as stated during Company orientation.

7. **Deductions.** The Company shall be entitled to deduct, from the Employee's remuneration any amount that the Company is legally obliged to deduct, e.g. income tax, unemployment insurance,

etc; any amount in respect of which the Employee's written authority has been given; any amount for loss or damage to the Company that the Employee has caused.

8. **Medical Suitability and Testing.** The Employee hereby declares that there is no medical condition, either physical or psychological, of which he / she is aware that would impede his / her performance on the job, or hold an actual potential risk to the health and safety of the Employee himself, herself, a fellow employee or patients. The Company may, at its discretion, require the Employee to undergo medical examinations from time to time should this appear necessary or justified. The Employee expressly agrees to submit himself / herself to alcohol and drugs tests at the Company's discretion.

9. **Confidentiality.** The Employee acknowledges that during the course of employment with the Company, the Employee will become familiar with its confidential information including commercial and technical secrets and / or the confidential information of patients of the Company. The Employee consequently agrees that during the period of employment and thereafter, the Employee will not disclose to others or make use of directly or indirectly, any confidential information of the Company or confidential information of patients of the Company or of others who have disclosed it to the Company under conditions of confidentiality, unless for a purpose authorized by the Company. If there is any doubt about whether any disclosure or use is for an authorized purpose, the Employee is to obtain a ruling in writing from the Company and is to abide by it. The Employee shall take reasonable security precautions to keep confidential all information deemed confidential and shall not make unauthorized copies. He / she further agrees to notify the Company immediately upon discovery of any unauthorized use or disclosure of confidential material and shall assist the Company in regaining such material. For the purpose of this clause, confidential information will be deemed to extend to all confidential medical records and commercial information, including, but not limited to the contents of patient records, computer records, patient lists, billing and reimbursement schedules, employee records and the like. The Employee is required to deliver to the Company whenever required to do so, or in any event when leaving the employment of the Company, all books of accounts, records, correspondence, training material, notes, computer disks, and the like concerning or containing any reference to the business of the Company or the Company's patients.

10. **Surrender of Documents.** Any documents or records or creations but not limited to written instructions, photographs, computer records, notes or memoranda relating to the business of the Company, which are made by the Employee or which come into the Employee's possession while he / she is employed by the Company, remains the property of the Company and shall be surrendered to the Company on demand and, in any event, on the date of termination of the Employee's employment with the Company. The Employee will not retain any copies thereof or any extracts there from.

11. **Copyright.** The Employee hereby assigns to the Company the total right, title and interest in and to any copyright in any existing or future works or part thereof of whatsoever nature that the Employee, individually or jointly with any other person(s) has made or created or will make or will create during the course and scope of the Employee's employment hereunder. The Employee expressly undertakes that all such works or copies thereof shall be delivered to the Company and

that possession of such works that the Employee may have from time to time will be deemed to be possession on behalf of the Company as its agent.

12. **Notice of Termination.** Termination of employment shall, under normal circumstances, be subject to one or more of the following stipulations:

- During the first six months of employment, one week written notice by either party;
- After six months of employment and within one year of employment, two weeks written notice by either party;
- After one year or more of employment, four weeks written notice by either party;
- The Company shall have the right to pay the Employee in lieu of notice;
- Failure to comply with the disciplinary rules and regulations or the policies and procedures of the Company as amended from time to time;
- Failure to sign any reasonable restraint that the Company feels necessary.
- The Company will be entitled to terminate the employment of the Employee other than the termination referred to above on, but not limited to, the following conditions:
    - In terms of the disciplinary code;
    - for justifiable and / or persistent breach of employment duties due to incapacity or poor performance;
    - abscondment;
    - is convicted of any criminal offence;
    - failure to disclose relevant material information pertinent to the job requirements, or does so incorrectly, intentionally, vaguely or falsely in regulation to his / her employment application;
    - guilty of any other conduct which will justify dismissal at common law.

13. **General.** This employee contract and any exhibit attached constitute the sole and entire agreement between the parties with regard to the subject matter hereof and the parties waive the right to rely on any alleged express provision not contained herein. No party may rely on any representation, which allegedly induced that party to enter into this agreement, unless the representation is recorded therein. No agreement varying, adding to, deleting from or canceling this agreement and no waiver of any right under this agreement shall be effective unless it is:

- In writing;
- Agreed to by both parties;
- Signed by both parties.
- No relaxation by a party of any of its rights in terms of this agreement at any time shall prejudice or be a waiver of its rights (unless it is a written waiver) and it shall be entitled to exercise its rights hereafter as if such relaxation had not taken place.
- No party may cede any of its rights or delegate or assign any of its obligations in terms of this employee contract without the prior written consent of the other parties.
- Unless inconsistent with the context, words signifying any one gender shall include the others, words signifying the singular shall include the plural and vice versa and words signifying natural persons shall include artificial persons and vice versa.

By signing below, the Employee certifies under the penalty of perjury that the name and address given is the Employee's legal name, address and signature.

14. **No Duress.** The Employee acknowledges that he / she has read this employee contract in its entirety, fully understands all clauses and is signing this contract under his / her free will.

AJE NURSING SERVICES	_____
Company's Name	Employee's Name
By:_____	Address_____
Authorized Representative/Position	_____
Signature: _____	Signature: _____
Date: _____	Date: _____

EMPLOYEE EVALUATION SHEET – PROBATION PERIOD/ANNUAL

Name of Employee: _____

Date of Employment: _____ **Position:** _____

Immediate Supervisor: _____

EVALUATION

3 = Consistently Exceeds Expectations - Consistently exceeded achieving most or all job expectations mutually agreed upon by the supervisor and employee.

2 = Meets Expectations - Achieved most or all job expectations mutually agreed upon by the supervisor and the employee.

1 = Needs Improvement - Failed to achieve most or all expectations mutually agreed upon by the supervisor and the employee. Please notify HR if an employee's performance needs improvement or is unsatisfactory. Supervisors will be asked to establish follow-up evaluations to monitor the employee's progress.

	1. JOB KNOWLEDGE: Evaluate the use of information, procedures, materials, equipment and techniques required for current job.
	2. QUALITY: Evaluate the accuracy, completeness, and follow-through of work.
	3. PLANNING/ORGANIZING: Consider effectiveness in response to varying work demands, developing efficient methods, setting goals and objectives, establishing priorities, and utilizing available resources.
	4. PRODUCTIVITY: Evaluate the volume and timeliness of work based on the resources available to accomplish department/unit goals and priorities.
	5. INITIATIVE/INNOVATION: Evaluate the self-starting ability, resourcefulness, and creativity to formulate and propose innovative solutions and improvements to the duties of the position.
	6. TEAMWORK/COOPERATION: Consider effectiveness of working relationships with other employees, students, and faculty to solve problems, improve work processes, share information and resources, and accomplish specific tasks in a professional and ethical manner.
	7. DEPENDABILITY: Consider punctuality, regularity in attendance, meeting deadlines, and performing work without close supervision.
	8. COMMUNICATION: Evaluate the clarity of ideas expressed, effectiveness of oral and written presentations, and listening to and interacting with others in a helpful, informative, and professional manner.
	9. PERSONAL APPEARANCE: Assess cleanliness of employee. Assess personal hygiene. Ability to follow policies on wearing uniform as well as hand washing policy and infection control procedures.

PART 3 - OVERALL PERFORMANCE SUMMARY

Please use this space to describe the overall performance rating. The overall rating should be a reflection of the performance factors, behavioral traits and supervisory factors.

Supervisor's Comments: (attach additional sheets if necessary)

_____
_____
_____
_____
_____

PART 4 - EMPLOYEE COMMENTS

I have been advised of my performance ratings. I have discussed the contents of this review with my supervisor. My signature does not necessarily imply agreement. My comments are as follows (optional) (attach additional sheets if necessary):

_____
_____
_____
_____
_____
_____

Supervisor's Signature: _____ Date: _____

Employee's Signature: _____ Date: _____

Original to H.R. / Copy to Employee *

W-9 EMPLOYEE ADDENDUM

_____
Initials

I hereby acknowledge that I am an Independent Contractor. Therefore, I am responsible for my social security and other taxes, and will receive an IRS 1099 Form for the preceding year by February of each year which is also sent to the Internal Revenue Service (IRS).

PLEDGE OF CONFIDENTIALITY

_____
Initials

I, the undersigned, have read and understand the policy on confidentiality of personal health information as described in the Confidentiality Policy which is in accordance with *Health Insurance Portability and Accountability Act (HIPAA)*. I also acknowledge that I am aware of and understand the Corporate Policies of the Company regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.

In consideration of my employment or association with the Company, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with the Company, or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside the Company, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and Corporate and departmental policies governing proper release of information.

I understand that my obligations outlined above will continue after my employment/contract with the Company ends. I further understand that my obligations concerning the protection of the confidentiality of personal health information relate to all personal health information whether I acquired the information through my employment/contract with the Company or within any of the healthcare facilities within the Company.

I also understand that unauthorized use or disclosure of such information may result in a disciplinary action up to and including termination of employment/contract, the imposition of fines pursuant to *Health Insurance Portability and Accountability Act (HIPAA)*, and a report to my professional regulatory body.

CONFIDENTIALITY STATEMENT

_____
Initials

As an employee of the Company, I understand that my work will involve access to medical information/records that are considered confidential. I acknowledge my responsibility to respect the confidentiality of patients and/or department records, to follow Company procedures in order to protect privacy, and to act in a professional manner, both to the public and over the phone.

I further understand that if I am found acting indiscreet with confidential material or not protecting privacy of patients and/or others through my actions, I will be dismissed from my job immediately. I understand this action to be necessary in order to maintain high professional standards of the business and integrity of the Company.

Employee Name: _____ Signature: _____

POLICIES AND PROCEDURES ACKNOWLEDGEMENT

_____
Initials

By initialing this statement, I acknowledge that I have received the Company's Policies and Procedures and the Employee Handbook. I have been given the opportunity to read and ask questions about the Policy. Furthermore, by signing this statement, I agree to abide by all the provisions contained in the Policy. I understand that this agreement is required for me to serve in any capacity as a healthcare professional, or to be employed by or volunteer for the Company. I understand that failure to comply with the Policy subjects me to the responses outlined there, including termination of employment. I hereby acknowledge receipt of the Company's Policies and Procedures and the Employee Handbook; I agree to abide by the provisions of the Policy and the Code.

PROBATIONARY PERIOD STATEMENT

_____
Initials

TO: _____

FROM: AJE NURSING SERVICES INC

SUBJECT: Acknowledgment of Probationary Period

DATE: _____

I understand that I am on probation as an employee for the first ninety (90) days of my employment which started on _____ for the purposes of the Florida "Unemployment Compensation Law." I understand that if my employer discharges me for unsatisfactory work performance under the Florida "Unemployment Compensation Law" he will not have his account charged for any unemployment benefits I might be determined eligible for in the future. I also understand that my probationary period may be extended an additional ninety (90) days.

I acknowledge that I initialed this form within seven (7) days of my employment.

EMPLOYEE POLICY ON JOBS

_____
Initials

As an employee of AJE NURSING SERVICES INC, I understand that the job I am being hired to perform belongs to AJE NURSING SERVICES INC I also understand that it is illegal for me to transfer or attempt to transfer any case to another Agency or take ownership of any job that I am employed in.

Should I act underhandedly and take over such a job so that I may be paid directly by the client, to the exclusion of my employer, or transfer any case to another Agency. I will be in violation of State, Federal and agency rules and will accordingly pay $10,000.00 to AJE NURSING SERVICES INC

Employee Name: _____ Signature: _____

PATIENT SAFETY – ENVIRONMENT OF CARE

_____
Initials

AJE NURSING SERVICES INC implements the following guidelines to be followed by all employees of this company:

As soon as the employee arrives to see the patient, he/she will make physical assessments of the safety devices found in the home such as locks, ventilation, beds/chairs used by the patient, bedding, bathroom systems, and ALL electrical devices found in the kitchen to ensure they are functioning properly. Employee shall use the "Patient Safety Checklist" provided by the agency in order to report the information as soon as possible. In accordance with the report, the agency's Director of Nursing shall take proper action to correct any possible deficiencies found.

CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM

_____
Initials

In order to be employed with this company, it has been explained to me that it is a requirement to conduct a Physical Exam and Background Screening. I understand that this information is used for verification of employment qualifications and shall be kept confidential and will not be discussed with anyone. This applies to persons inside and outside of the agency except as needed in order to function in the daily business. The information contained regarding the Physical Exam and Background Screening cannot be removed from the agency unless a "Release of Information" form has been signed by me. It is my understanding that the signed "Release of Information" form provides authorization for the agency to release my Physical/Background information to State and Federal regulatory agencies as well as Accrediting Organizations.

RANDOM TESTING OF ALCOHOL/DRUG USAGE

_____
Initials

I understand that I order to be offered employment as well as maintain employment in this Company; I cannot use drugs or consume alcohol. I further understand that if I am suspected of alcohol/drug use that I shall consent to undergo a voluntary blood and urine test. This company participates in the Drug Free Workplace Program and working under the influence shall not be tolerated and shall result in an immediate discharge of employment. It is my understanding that working under the influence of such, shall affect the quality of my work and can result in an On-the-Job Injury. Furthermore, I authorize the results of such blood/urine tests to be released to my employer.

Employee Name: _____ Signature: _____

AUTOMOBILE REQUIREMENTS

_____
Initials

It is my understanding that I am hired by AJE NURSING SERVICES INC with the condition that I have and maintain reliable personal means of transportation available to be used to perform my job duties. I further understand that the use of reliable transportation is needed to complete patient assignments. As part of my contract to continue to be employed by AJE NURSING SERVICES INC I must maintain auto liability insurance of the minimum requirement of $10,000.00/$20,000.00 for bodily injury and $5,000.00 in property damage. I also understand that it is prohibited to transport patients in my vehicle at any time.

INFECTION CONTROL AWARENESS REQUIREMENT

_____
Initials

It is the policy of this company that an infection control program be followed at all times to ensure patient and employee safety. As a condition for employment, it is my duty to follow this infection control program:

I agree to:

- Report any exposure to bloodborne/airborne pathogens to the Director of Nursing.
- Follow the hand washing technique provided at AJE NURSING SERVICES INC
- Avoid ALL contact with body fluids (i.e. blood) when working with high risk infected patients.
- Release this agency of any and ALL liability if I was to contract any virus or infectious disease (i.e. AIDS) while performing my duties.
- Report to the nearest emergency room and be seen by a physician. I shall report to work only after I am cleared of any transmittable infection.
- Read and become more aware with the requirements of the CDC and the Department of Health and Human Services

I confirm that I am aware of the agency's Policies and Procedures regarding the Infection Control Program and that I must abide by said Policies and Procedures. Shall I refuse or fail to follow the established Infection Control Program; it is grounds for immediate termination of employment.

Employee Name: _____ Signature: _____

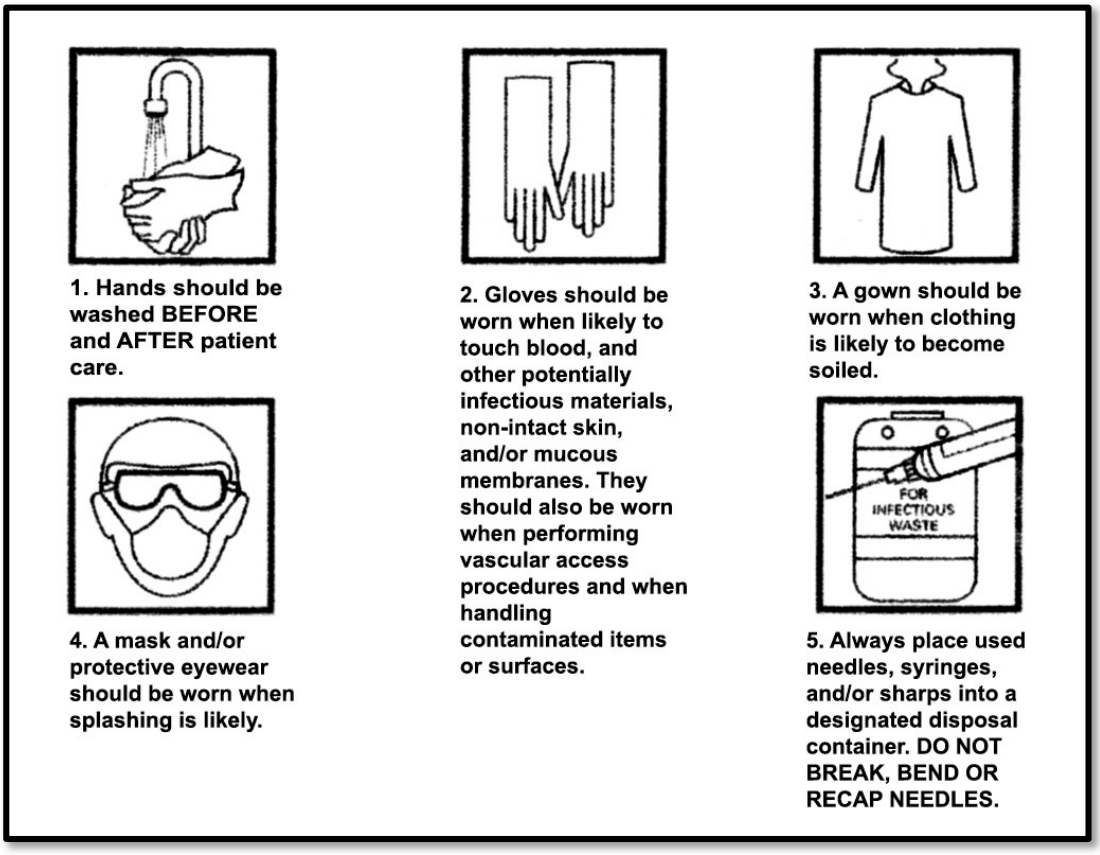
STANDARD PRECAUTIONS

_____
Initials

As an employee of this agency (direct or indirect), I agree to comply with the Standard Precautions set forth to avoid the risks of contracting and spreading transmittable diseases. I hereby agree to:

- Use gloves when providing care
- Wear an apron if exposing to bodily fluids
- Wear masks and protective eyewear when deemed necessary
- Follow the agency's hand washing procedures

I confirm that the agency's Standard Precautions was explained and it is my understanding that I do ALL of the following presented in the diagram below:



Employee Name: _____ Signature: _____

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT

_____
Initials

I hereby confirm that I have read the agency's Employee Handbook. It is expected for me to comply with following the policies stated in the Employee Handbook and if I fail to comply it is sufficient cause for immediate termination of employment. I agree to the following:

- Behave in a professional manner at ALL times
- Contact the agency shall I notice discrepancies between my job duties and performance levels in the tasks assigned
- Read and follow the job description provided and signed by me
- Follow the agency's policies in the Employee Handbook
- I shall be on time to perform job duties I have accepted and shall notify the agency if an emergency arises and causes me to be late. Not notifying the agency is grounds for immediate termination of employment
- I shall decline remuneration from Clients or other individuals and shall demonstrate work ethics. I shall receive compensation ONLY for job duties performed
- I will not make or accept personal telephone calls while performing job duties
- I will not transport a patient or family member in my personal vehicle
- I will not smoke in a patient's home or in the office

Agency maintains policies that address ethical behavior and non-smoking. I agree to abide by ALL the Policies and Procedures set forth by the agency and it is my understanding that failing to do so, shall be grounds for immediate termination of employment.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT OF 1990

_____
Initials

I understand that AJE NURSING SERVICES INC is an equal opportunity employer. It was explained to me that if hired, the decision is made solely on my job-related qualifications and does not regard to race, color, sex, religion, national origin, handicap, or marital status. Furthermore, upon hiring me, I am required to complete a medical history questionnaire and/or undergo a physical exam that will be kept confidential and in a separate file. I understand that I must be able to perform those job duties for which I am hired, and I will have to respond to whether or not I have the ability to perform the job duties for which I am hired.

PLEASE READ AND SIGN STATEMENTS BELOW:

If hired, I understand that it is conditional and shall undergo probation for the initial 90 days of employment. I understand that I cannot request unemployment benefits if terminated during this probationary period or if terminated during the initial 6 months of employment. I am aware that the Employee Handbook and agency Policies and Procedures may be amended and/or deleted at any time throughout my employment without notice to me. Furthermore, I understand that my employment can end at any moment in time shall I not be in compliance with company Policies and Procedures. I certify that ALL information provided for gains of employment, is true and accurate to the best of my knowledge. I understand that my employer shall investigate my work history and personal history prior to offering employment. I agree to the terms and conditions set forth by my employer and understand that falsification of information is a felony and is ground for immediate termination.

Employee Name: _____ Signature: _____

MEDICAID FRAUD ACKNOWLEDGEMENT

_____
Initials

I, _____, have been instructed on Medicaid fraud during the orientation process at time of hiring. It has been made clear to me that I am not to participate in any activities that lead to or include fraudulent practices. If I am found to not be in compliance with the agency rules, this may serve as a direct cause for being dismissed from employment with this agency.

LAWS, RULES and REGULATIONS ACCEPTANCE

_____
Initials

I, _____, acknowledge the receipt of the current Laws, Rules and Regulations in place in the form of a CD. I am aware that if I do not have access to a computer to access the information, I can have the information available for access at the business location.

SUSPECTED ABUSE ACKNOWLEDGEMENT

_____
Initials

I, _____, have been instructed on incidents that lead to patient abuse, neglect, or exploitation during the orientation process at time of hiring. It has been made clear to me that I am not to participate in any activities that lead to any and all forms of patient abuse, neglect or exploitation. If I am found to not be in compliance with the agency rules, this may serve as a direct cause for being dismissed from employment with this agency.

Employee Name: _____ Signature: _____

Tuberculosis Clearance Form

All staff members must complete this form to certify that they have been tested for and show no evidence if tuberculosis.

Name: _____

Address: _____

City/State/Zip _____

Phone#: _____

Test was administered on _____ and reveals no evidence of tuberculosis.

Remarks: _____

_____

Physician's Name: _____

Physician's Contact Information, including address and phone number:

_____

_____

Physician's Signature and Date: _____

Please return this form to:

AJE NURSING SERVICES INC
99 NW 183 ST STE 224-A5
MIAMI GARDENS, FL 33169

DENIAL OF TB

Employee health release for denial of TB signs and symptoms for persons who have had BCG or a positive TB test in the past.

The early signs and symptoms of tuberculosis are as follows:

Cough
Night Sweats
Loss of Weight
Loss of Appetite
Coughing Blood

I have read the above information and do not now have these symptoms. If these symptoms develop I will contact my supervisor immediately and follow up.

_____ _____/_____/_____

Employee Name and Signature Date

HEPATITIS B DECLARATION FORM

Hepatitis B is a major infectious occupational health hazard in the Health-Care industry. The critical risk for health personnel is contact with blood and other body fluids. Persons previously infected with hepatitis B virus are immune to the disease, for persons who have not had the disease, Hepatitis B it vaccine will provide immunity. The vaccine is given in three separate doses and failure to receive all doses may cause the vaccine to be ineffective and not result in immunity. Clinical studies have shown that 85 to 96 percent of those vaccinate evidence immunity. Periodic testing of vaccinated persons for antibody to Hepatitis B will confirm immune status. I understand that due to my risk or occupational exposure to blood or other potentially infectious material I may be at risk of acquiring Hepatitis B virus (HBV) infections, I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself.

I have read the above information and have received verbal and written instructions regarding the efficacy, risk and complications of receiving the vaccine. Any questions I had have been answered. I acknowledge that I am aware of tine availability of tine Hepatitis B vaccine and the benefit that such vaccination provides in the prevention of infection with Hepatitis B virus.

- ☐ I decline Hepatitis B vaccination at this time because I have been previously immunized with a complete series (three injections) of the Hepatitis B vaccine or I have been diagnosed as having tine Hepatitis B virus disease and I am immune.

- ☐ I decline Hepatitis B vaccination at this slate. I understand that by declining this vaccine, I continue to be at risk or acquiring Hepatitis B. If in the future I continue to have occupational exposure to blood or other potentially infectious material and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

- ☐ I accept vaccination with time hepatitis B vaccine.

_____	_____	_____
Employee	Signature	Date

1st injection: _____ 2nd: _____ 3rd: _____

AJE NURSING SERVICES INC

EMPLOYMENT ORIENTATION CHECKLIST

ADMINISTRATIVE ORIENTATION (for office personnel and service providers)	
➢ History of the organization	
➢ Organizational structure	
➢ Introduction to agency philosophy, policies and employee resource CD	
➢ Job description	
➢ Geographical service area	
➢ Strategic priorities, goals and objectives	
➢ Summary of the programs and services	
➢ Lines of communication / Supervisor	
➢ Confidentiality / HIPAA	
➢ Introduction to office personnel	
➢ Tour of office departments	
➢ Mileage	
➢ Infection control	
➢ Emergency management plan	
➢ Continuing education / In-services	
➢ Alzheimer's training	
➢ Safety management	
➢ Ethical issues (insurance fraud, reporting suspected abuse, neglect or exploitation of patients)	
➢ Illegal remuneration	
➢ Personnel Policies	
➢ Review responsibility in Quality Assurance & Performance Improvement Initiatives	
➢ Review Payroll Procedures (schedule of pay, time and hours)	
➢ Employee grievance policies and procedures	
➢ Dress code	
➢ Evaluation policy	
➢ Hepatitis consent / declination	
➢ In the job injury	
➢ On-call	
➢ Progressive discipline	
➢ Non-discrimination	
➢ Communicating with visually, hearing, and speech impaired persons	
CLINICAL ORIENTATION (for service providers only)	
➢ Coordination of services	
➢ Dress code	
➢ Reporting illness	
➢ Time slips for services provided / Daily report / Clinical Notes	
➢ Developing POC / Treatment	
➢ Visits defined / Field assignments days and types of patient services	
➢ Case conference	
➢ Patient / Client grievance policies and procedures	

➢ Criteria of admissions of patients to nurse registry	
➢ Charting	
➢ Supervision of Care	
➢ Role of the Supervisor / Methods for evaluating performance and identifying needs	
➢ Patient Teachings	
➢ Nursing bag technique	
➢ Skilled care vs. Non-skilled care	
➢ Safety / Incident (OSHA) reporting	
➢ Standard precautions / hand washing technique	
➢ Community resources	
➢ Advanced directives	
➢ Patient care responsibilities	
➢ Storage and handling of drugs	
➢ Referral guidelines	

I have been oriented to AJE NURSING SERVICES INC and have a complete understanding of the company's general information, my roles and responsibilities, policies and procedures governing AJE NURSING SERVICES INC, current State & Federal laws, and other information pertinent to my position.

_____

Employee Name

_____ _____

Employee's Signature Date

_____

Supervisor's Name

_____ _____

Supervisor's Signature Date

Rest easy with our 6 steps of COVID-19 protocol for caregivers:

1. Required to take their temperature daily
2. Complete Fitness for Duty / Lack of Exposure questions before each visit
3. Wash hands upon entering client's home
4. Wear face masks when working around clients
5. Wear gloves when touching clients
6. Sanitize frequently-touched surfaces

_____

Signature

_____ _____

Name Date

AJE NURSING SERVICES INC
AUTHENTICATION FOR ELECTRONIC SIGNATURE

(please complete bellow to verify the entries, and that they are appropriately authenticated and date.)

Name/Title: _____ Address: _____
_____

Since the beginning of written language, individuals have affixed their signatures to writings of both establishing the source of the writing and memorializing their assent, or adoption, of its contents. According to Wikipedia,

The traditional function of a signature is evidential: it is to give evidence of:

1. The provenance of the document (identity)
2. The intention (will) of an individual with regard to that document

In the context of documents either received, filed with or generated by our Agency, and received by our staff, the signed person had, until recently, been that such documents were required to bear an original signature of the person who originated the document.

Our Agency is authorized to "adopt rules pertaining to the use of electronic records and electronic signatures" Any signature on electronically transmitted documents shall be considered that of the physician, staff or party it purports to be for all purposes. If it is established that the documents were transmitted without authority, the Agency shall order the filing stricken.

Statement of Purpose and Intent

The purpose of this standard is to establish minimum authentication requirements for the use of electronic signatures in electronic records by our Agency. This standard prescribes minimum requirements for the creation of electronic signatures and for security procedures associated with the use of electronic signatures in electronic records.

The goal of the standard is to assure the authenticity of electronic signatures either received or generated by our Agency so that those who utilize electronic records in which an electronic signature is associated will have confidence that the signature is authentic; i.e., that the electronic record will be unassailable as the traditional pen on paper model or that the electronic signature is a reliable as an ink signature as a means to validate the signer's identity and intent.

"Authentication" – the process of assuring signature is that an electronic signature is that of the person purporting to sign a record or otherwise conducting an electronic transaction.

"Electronic" – relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities. For the purposes of this standard, "electronic" is not meant to encompass activities involving facsimile transmission.

Electronic record" – a record created, generated, sent, communicated, received, or stored by electronic means.

"Electronic signature" – an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record.

"Electronic transaction" – an action or set of actions occurring between two or more persons or entities relating to the conducting of patient care affairs by electronic means.

"Security procedure" – a procedure employed for the purpose of verifying that an electronic signature, record, or performance is that of a specific person or for detecting changes or errors in the information in an electronic record. "Security procedure" includes a procedure that requires the use of algorithms or other codes, identifying word or numbers, encryption, or callback or other acknowledgment procedures.

By signing below, I authenticate that all electronic records signed by me, was reviewed, entries verified using secured process, and are signed electronically by me.

Signature: _____ Date: _____

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **Section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:	
Health Care Provider/ Employer Name:	AJE NURSING SERVICES INC
Address of Health Care Provider:	99 NW 183 ST STE 224-A5 MIAMI GARDENS, FL 33169

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached**.

Purpose of Prior Screening: EMPLOYMENT

Screening conducted by: Date of Prior Screening: _____

- ☑ Agency for Healthcare Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Elder Affairs
- ☐ Department of Financial Services
- ☐ Department of Children and Families

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature	Title	Date

REFERENCE VERIFICATION

(THIS SECTION TO BE COMPLETED BY APPLICANT)

Reference Name: _____
Facility Name:_____
Telephone: (_____)_____

I have applied to **AJE NURSING SERVICES** for a position as a _____ _____. I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

Applicant's Signature: _____
Print Applicants Name:_____

I worked for you from _____ to _____ as a _____

NOTE: Please fax back to our office at (866) 329-5776

To be completed by former employer if faxed **OR** by human resource staff if verified via phone:

Would you rehire? YES_____ NO_____
Is the above information correct? YES_____ NO_____
If no please explain: _____
_____

Job Skill	Excellent	Very Good	Good	Poor
Job knowledge				
Initiative				
Attendance				
Ability to Work with others				
Judgment				
Honesty				
Ability to Accept Direction				
Grooming and Appearance				
Time Management				

Comments:_____
_____
_____

Signature: _____ **Title:** _____

Date: _____

REFERENCE VERIFICATION

(THIS SECTION TO BE COMPLETED BY APPLICANT)

Reference Name: _____
Facility Name:_____
Telephone: (_____)_____

I have applied to **AJE NURSING SERVICES** for a position as a _____ _____. I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

Applicant's Signature: _____
Print Applicants Name:_____

I worked for you from _____ to _____ as a _____

NOTE: Please fax back to our office at (866) 329-5776

To be completed by former employer if faxed **OR** by human resource staff if verified via phone:

Would you rehire? YES_____ NO_____
Is the above information correct? YES_____ NO_____
If no please explain: _____
_____

Job Skill	Excellent	Very Good	Good	Poor
Job knowledge				
Initiative				
Attendance				
Ability to Work with others				
Judgment				
Honesty				
Ability to Accept Direction				
Grooming and Appearance				
Time Management				

Comments:_____
_____
_____

Signature: _____ **Title:** _____

Date: _____

Form W-4 (2019)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

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

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

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.