INTERVIEW REVIEW

Applicant Name: _____Date_____

Days and Hours available Mon Tue Wed Thurs. Fri Sat Sun

Review:

Personality:	friendly	average	quiet
Verbal skills:	excellent	average	poor
Communicates:	clear	somewhat clear	not very clear
Flexibility:	very flexible	somewhat	not flexible
Skill level:	higher skilled	moderately skilled	lower skilled
Appearance:	professional	semi-professional	not professional

Good Candidate for employment: yes no

Overall Interview:_____

_____ _____

Interviewer Date

ANVIENT HOME HEALTHCARE SERVICES, LLC JOB APPLICATION

PLEASE NOTE: It is important that you complete all parts of the application. If your application is incomplete or does not clearly show the experience and/or training required, your application may not be accepted. If you have no information to enter in a section, please write N/A.

Name and Address	
Name (First, MI, Last)	Social Security Number
Mailing Address	
City, State, and Zip Code	
Telephone	Alternate Phone
If under 18, please list age	Email

Job Type							
Days/hours available to work							
D I have no preference.	D Mon.	D Tues.	D Wed.	D Thurs.	D Fri.	D Sat.	D Sun.
I am seeking a:		D Full-time job		D Part-time job		D Full- or Part-time	
How many hours can you work weekly?				Can you work nights?		Date available to begin	

Additional Information		
Have you ever been employed by this organization in the past?	D Yes	D No
I certify that I am a U.S. citizen, permanent resident, or a foreign national with authorization to work in the United States.	D Yes	D No
Have you ever been convicted of, or entered a plea of guilty, no contest, or had a withheld judgment to a felony?	D Yes	D No
If Yes, please explain:		

Do you have a driver's license? D Yes D No	Driver's license number	Issued in what state?
Have you had any accidents during the past three years?		How many?

Have you had any moving violations during the past three years?	How many?

Education				
School	Location (mailing address)	Years Completed	Major	Degree or Diploma
High School				
College or Business/Trade School				

Military			
Have you even been in the Armed Forces?	D Yes	D No	Date entered
Are you now a member of the National Guard?	D Yes	D No	Discharge date
Specialty			

ANVIENT HOME HEALTHCARE SERVICES, LLC

Work Experience (continued)		
Company	Name of last supervisor	Hrs/week
Address	Start Date	Starting Salary
City, State, and Zip Code	End Date	Final Salary
Phone number	Your last job title	
Reason for leaving (be specific)		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.		
May we contact this employer? D Yes D No		

References
Please include name, phone number, and circumstances of your acquaintance. Exclude relatives and former employers.
1.
2.
3.
4.

I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that, should this application contain any false or misleading information, my application may be rejected or my employment with this company terminated.

Signature	Date

ANVIENT HOME HEALTHCARE SERVICES, LLC

Name: _____Position: _____

ITEM	DESCRIPTION	INITIALS
EMPLOYEE ACKNOWLEDGEMENT OF PROBATION	I UNDERSTAND THAT I AM ON PROBATION AS AN EMPLOYEE FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STARTED ON _____ I UNDERSTAND THAT MY EMPLOYER MAY DISCHARGE ME FOR UNSATISFACTORY WORK PERFORMANCE. I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.	
NOTICE TO APPLICANTS	We comply with Disabilities nondiscrimination. During the interview process, you may be asked questions concerning your ability, to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. If required, all entering employees in the same job category will be subjected to the same medical questionnaire and/or examination and all information will be kept confidential and in separate files. We are an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, national origin, handicap, or marital status. We assure you that your opportunity for employment with us depends solely upon your qualifications. PLEASE READ AND SIGN STATEMENT BELOW I understand that I will be placed on a 90 day probation period. I further understand that if I am terminated for unsatisfactory work performance within the 90 day probationary period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination. I understand and agreed that all policies, procedures, and the Employee Handbook may be modified, amerced, or deleted by my employer with or without notice to me of such amendment, modification or deletion; that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and that my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president. I certify that all information given on this employment application, any resume that I submit to the company, and any related papers and answers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such information requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation of any derogatory information discovered as a result of this investigation my-subject-me – to –immediate-dismissal. I hereby release from liability all persons who provide information to my employer during the course of any such investigation	
SAFETY RESPONSIBILITY CONTRACT	It has been explained to me that I am being offered employment by Anvient Home Healthcare Services, LLC with the understanding that I have personal protective equipment (PPE) to use, such as mask, gloves, goggles, gown, etc. I also agree to use available PPE to provide care to any patient	

ANVIENT HOME HEALTHCARE SERVICES, LLC

Employee/Contractor Signature: _____Date_____

Name: _____Position: _____

ITEM	DESCRIPTION	INITIALS
CONFIDENTIALITY STATEMENT	I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF THE MEDICAL RECORDS AND UNDERSTAND THAT THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE, EITHER INSIDE OR OUTSIDE THE AGENCY (EXCEPT AN NEEDED TO CONDUCT THE BUSINESS OF THE DAY). I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE HOME HEALTH AGENCY UNLESS A "RELEASE OF INFORMATION" FORMS HAS BEEN COMPLETED AND SIGNED BY THE PATIENT. IT IS IN MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL. I HAVE BEEN FORMALLY INSTRUCTED IN THE POLICIES AND PROCEDURES OF ANVIENT HOME HEALTHCARE SERVICES, LLC, ALSO INFORMED REGARDING THE AGENCY'S POLICY FOR CONFIDENTIALITY COMPLIANCE, AND I HAVE READ AND SIGNED A JOB DESCRIPTION FOR MY SPECIFIC CLASSIFICATION.	
PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY _____ SIGNATURE OF INDIVIDUAL MAKING PLEDGE _____ SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE	I, the undersigned, have read and understand Anvient Home Healthcare Services, LLC, (hereinafter refer to policy on confidentiality Policy which is in accordance with relevant legislation. I also acknowledge that I am aware of and understand the policies of Abik Health Services, 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 Anvient Home Healthcare Services, LLC, 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 Anvient Home Healthcare Services, LLC, or after my employment or association within or outside Abik Healthcare Services, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation and Anvient Home Healthcare Services, LLC, policies governing proper release of information. I understand that my obligations outlined above will continue after my employment/contract/association appointment with Anvient Home Healthcare Services, LLC, ends. I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with Anvient Home Healthcare Services, LLC, or with any of the entities, which have an association with Anvient Home Healthcare Services, LLC. If for any reason I must complete any clinical documentation for any of my patient at later time, or at my residence, I assure that no Protected Health Information will be left unattended in any vehicle. In my residence, it will be placed in a secure location where children or any family member will not have access to it at any time. All family members will be alerted about the Confidentiality status of such records. I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant legislation, and a report to my professional regulatory body.	
POLICY ON JOBS	As an employee of Anvient Home Healthcare Services, LLC, I understand that the job I am being hired to perform belongs to this Agency. 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 Emirates and agency rules and will accordingly pay a determined fee to Anvient Home Healthcare Services, LLC.	

Employee/Contractor Signature: _____Date_____

ANVIENT HOME HEALTHCARE SERVICES, LLC

Name: _____Position: _____

ITEM	DESCRIPTION	INITIALS
NON DISCRIMINATION POLICY ANTI HARASSMENT POLICY	Anvient Home Healthcare Services, LLC does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by our Agency directly or through a contractor or any other entity with which our Agency arranges to carry out its programs and activities. In case of question please contact the Agency's Administrator. Our Agency strives to maintain a work environment that is free of discrimination, intimidation, hostility, or other offenses that might interfere with work performance. In keeping with this desire, we will not tolerate any unlawful harassment of employees by anyone, including any supervisor, co-worker, vendor, client, or customer. What Is Harassment? Harassment consists of unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's protected status, such as color, disability, gender, national origin, race, religion, age or other legally protected status. We will not tolerate harassing conduct that affects tangible job benefits, that interferes unreasonably with an individual's work performance, or that creates an intimidating, hostile, or offensive working environment. Harassment can take many forms, including, but not limited to: words, signs, jokes, pranks, intimidation, physical contact, or violence	
UNIVERSAL PRECAUSTIONS	It is the policy of our Agency that home health care providers will adhere to the following, when delivering care to all patients. By adhering to the following universal precautionary measures, the risk of transmission of disease is decreased when the infection status of the patient is unknown. Gloves must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids. Gloves or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes. Gloves are to be worn when handling all specimens to prevent contamination from body specimen fluids or blood. Mask and protective eyewear or face shield must be worn during procedures that are likely to generate droplets of body fluids, blood or when the patient is coughing excessively. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood and after all patient care activities. Home Health Care providers, who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.	
CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM	I have been formally instructed that my Physical Examination Form, and any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency (except an needed to conduct the business of the day). I understand that no medical data are to be removed from the agency unless a "Release of Information" form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Agency to	

	release my Physical/Background Information data to surveyors at their request if needed for conduct the annual survey or any necessary investigation. I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.	

Employee/Contractor Signature: _____Date:_____

Name: _____Position: _____

ITEM	DESCRIPTION	INITIALS
INFECTION CONTROL	For your wellbeing, and the wellbeing of your patient, we outline the following procedures to guard against infection. 1. Please wash your hands before and after each procedure. 2. In the event of an exposure to a pathogen please make an immediate report to the Director of Nursing. This office must be notified immediately and the staff involved must report to the nearest hospital emergency room and will return to work only after a physician has cleared him/her of any communicable infection. 3. When working with high risk infection's patient, remember to avoid any and all contact with the patient's body fluids, especially blood and blood products. Read and be familiar with the attached pamphlet on how to prevent catching the infections or any other virus. 4. This agency is not liable for our health care worker who contracts virus in the course of performing his/her professional duties. For more policies on infection control our agency asks all of its employees to read the accompanying scripts which are summaries from the World Health Organization and Medicaid. I hereby acknowledge that I have read and understand the Infection Control Policy contained in the Field Employees Procedure Manual. I am familiar with the procedure appropriate to my position as a field employee	
USE OF PERSONAL PROTECTIVE EQUIPMENT	I, the undersigned, understand and agree that as a condition of employment I am required to wear/use the following personal protective equipment supplied and/or required by my employer: Company Supplied: _____ Company Required (Supplied by Employee/Contractor): _____ I agree to inform my employer immediately upon the failure of any of the above listed equipment so the same can be promptly repaired or replaced. In the event I sustain an on-the-job injury as a direct result of my failure to wear/use the personal protective equipment listed above, my worker's compensation benefits could be substantially reduced.	
WAIVER OF RIGHTS	I, the undersigned, understand that the hazards of my job, have been fully explained to me by my supervisor: _____ I further acknowledge that my employer has supplied me and/or I have supplied the following Personal Protective Equipment: _____ I understand that it is necessary for me to use this Personal Protective Equipment to fully protect myself from the hazards of my job. I realize that in the event I do not use all of this Personal Protective Equipment and I sustain a personal injury caused by my failure to use/wear said Personal Protective Equipment, I may be denied up to 25% of the indemnity portion of my claim	
PERSONNEL POLICIES SAFE AND ADEQUATE CARE OF THE PATIENT (SAFETY OF THE PATIENT'S	Anvient Home Healthcare Services, LLC, hereby sets forth the following guidelines to be adhered to by all employees of this agency: *Upon arrival at a patient's home, the nurse/employee shall make physical checks of the essential safety devices such as proper locks on doors, proper ventilation, proper beds/chairs, proper bedding, adequate bathroom systems, and adequate kitchen with all electrical devices; to be sure they are in good working condition.	

ANVIENT HOME HEALTHCARE SERVICES, LLC

IMMEDIATE ENVIRONMENT)	*The employee shall also check the appropriate boxes on our "Patient Safety Checklist" and make the appropriate report to our offices as soon as possible. *Upon receipt of such report, the Director of Nursing shall take necessary action to ensure that any safety deficiencies are corrected. I have received, read, (or it has been read to me) and understand the "Company Policy and Safety Rules and Regulations", and agree to abide by them. I further understand that failure to do so could result in disciplinary action or termination	

Employee/Contractor Signature: _____Date: _____

Name: _____Position: _____

ITEM	DESCRIPTION	INITIALS
EMPLOYEE STATEMENT OF COMMITMENT	I have read and understand The Agency, Personnel Policy Manual. In compliance with those policies, I agree to conform to the following: - I will always maintain professionalism in the home to which I am assigned. - I will immediately contact The Agency, regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by The Agency. - I have read and understand the Agency, job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by The Agency. - I will abide with the Agency Standard Code of Dress as described in the Personnel Policy Manual. - I will arrive in time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the Agency, office of the situation and expected arrival time. - I will not accept any money or gifts from the Agency's Clients. I will receive payment for services rendered directly from The Agency. - I will not accept any money or gifts from The Agency's Clients. I will receive payment for services rendered directly from The Agency - I will notify The Agency, immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand the Agency; office will then contact the client. I also understand that not calling The Agency, office when I am unable to meet my assignment commitment will be grounds for immediate termination. - I will not make or accept personal telephone calls on the client's home. - I will not transport a patient or family member in my personal vehicle	
VOLUNTARY TESTING	In order to protect myself and my employer, I _____ Voluntarily authorize blood and urine testing as required. I agree to allow such samples and testing to be completed at a time and place to be chosen by my employer. I further authorize the results of samples/testing to be released to my employer.	
POLICY ON PATIENT'S PROGRESS NOTES	It is the policy of The Agency that weekly Progress Notes shall be written on each of our patients, preferably each Friday. Such a Progress Note, to be written on our standard "Progress Notes" form, shall be written by a Skilled Nurse/Professional/field staff, who also should supervise the case in review, together with Supervisor RN/Staff if applicable. Completed progress notes, along with other pertinent patient records, shall be submitted to the Director of Nursing (at the office) once every week (Tuesday before 5:30pm). During that period a note faxed from employee may be used in place of the original, until the regular 1 week delivery time frame, progress note is received in the office. Home health care staff members will ensure complete concise documentation of services, issues and conditions occurring during the period of services rendered to the client. It is our Policy that we allow	

	the use of automotive mechanism to help our staff to complete their Progress Notes report like typing by Typewriter, Word Processor, or Computer Software, in compliance with the following steps: 1-Ensure the compliance of confidential regulations and guidelines, including the care of the Patient's Privacy Rights. 2-Don't allow another person access to any Patient Information needed to complete the work, if necessary finish the Notes at the staff's residence. 3-Destroy all Patient Information after completing the Progress Notes 4-Inform immediately to the Agency's Privacy Officer if any breach of confidential guidelines for Patient's Privacy Rights is suspected. 5-In the use of Computer Software or any electronic device to help complete the progress note, the staff cannot save any Patient Information in the Staff Personal Computer/tablet, is the patient's information is used, the Staff must delete the information, immediately after completing their work.	

Employee/Contractor Signature: _____Date:_____

Independent Nurse Contractor Agreement

This Agreement is made this _____day of _____, 200___, by and between Anvient Home Healthcare Services, LLC hereinafter called the "corporation" having its principal place of business in 4500 Forbes Blv, Suite W200, Lanham, 20706 and _____ residing at _____City of _____, State of _____, a nurse, and public independent contractor of his/her nurse services to the health care field, hereinafter called the "contractor, by which the parties intended and agree, that their relationship shall be one of corporation and independent contractor respectively and that said contractor shall enjoy all rights and

privileges, and be obligated and responsible to corporation, for all the duties normally assumed and/or incurred by those commonly referred to, accepted as, and holding themselves to the public as independent contractor in commerce and general business.

Whereas corporation and contractor desire to enter into an agreement whereby corporation will contract with third party clients, hereinafter referred to as "clients", to utilize the services of certain independent nurse contractors from time to time, and whereby said corporation herein will make available his/her services to said client(s) by, from time to time, offering compensation to contractor for his/her services whereby contractor will supply his/her services to third party client(s).

Corporation and contractor will always be and remain in a relationship of corporation and independent nurse contractor, therefore, corporation and contractor herein agree further, that each shall be governed during said arrangement, and for purposes of this contract, by the provisions set out herein below:

DESCRIPTION OF SERVICES

a) The corporation hereby agrees that it has and will contract with certain hospitals, nursing homes, health institutions, (clients), to provide the availability of independent contract nurses to said client(s). The corporation further hereby agrees to utilize contractor, on an independent contractual basis, in providing said services to said client(s), whenever, wherever, and however, said client(s) requires; provided that contractor is competent with regard to, and familiar with the services requested by client(s).

b) Should contractor agree to provide his/her services to client(s) for a designated shift and/or designated time, contractor is bound by this agreement to provide said services. Should contractor not be able to fulfill his/her obligations to the client(s), he/she shall notify corporation not less than four (4) hours prior to the beginning of said nursing shift. In the event contractor is absent for a shift which he/she agreed to fulfill, and should contractor fail to notify corporation four (4) hours prior to start of said shift, corporation shall have the option of immediately terminating this agreement, without regard to circumstances or reason leading to contractor's absence and/or failure to notify corporation

c) While contractor is performing said nursing duties, he/she is representing himself/herself and utilizing professional judgment as an independent

nurse contractor. This professional judgment is in the sole discretion of the contractor, and is to include all routines, practices and subjective decisions necessary to fulfill the contracted service. Contractor also agrees not to perform duties outside of his/her scope of practice/licensure

d) The corporation will provide forms for the contractor to systemically document proof of school, licensure, knowledge, skills, and experience to enable the client(s) to place the contractor in the proper area to be serviced. The corporation and the client(s) will keep a record of this information, if client(s) so desires

e) The contractor will not, under any circumstances, act as an agent of the corporation. The contractor shall be solely responsible for his/her own professional training and cost of such training. The contractor shall also be solely responsible for maintaining his/her licenses and for costs of such. The corporation should have no right and shall not direct, supervise, oversee, or control or be responsible for the supervision, direction, or control of the contractor while said contractor is performing services for the client(s), either as to the result to be accomplished. The contractor is responsible for furnishing his/her own uniforms, transportation, tools, instruments, and written material of a professional nature required in the practice of professional nursing.

f) Corporation and contractor hereby agree that the client(s) has the authority to direct, supervise, oversee and/or control contractor and can prohibit contractor from working in its facility, if it deems contractor is unfit, renders inadequate service. In this event, the contractor's then existing contract with the corporation shall be automatically terminated, and shall become null and void as of the end of the last day of work by contractor for client(s). Contractor shall be entitled to charge corporation for the time and services actually rendered to the client

TERMS OF AGREEMENT

aa) The corporation and contractor herein, shall mutually agree upon services to be provided on a daily, weekly, or monthly basis, depending on the corporation's client(s) requirements and the contractor's desired work volume and availability. Subject to any pre-existing work commitments to others, which contractor shall be permitted to engage in under the terms of this agreement, contractor hereby agrees to make available his/her services to corporation's client(s), in not less than four and not more than sixteen hour increments per day, at any of corporations client location mutually agreed upon by corporation and contractor herein, during the terms of this agreement. Unless otherwise provided

herein, the terms of this agreement will be valid for a period of one year from date of execution, and will renew each year automatically

NOTICE OF TERMINATION

bb) Either party upon thirty (30) days advance written notice to the other party may terminate this agreement, contractor understands that during that 30 day period he or she can be considered inactive in status

FEES FOR SERVICE

cc) The contractor shall be compensated for services rendered to client(s) on a bi-weekly basis. The corporation shall advance to the contractor full payment subject to the collection and/or reimbursements from the client(s), for the corporation's charges covering the contractor's service fees. In the event the corporation's client(s) fail or refuse to make payment to the corporation for any services previously rendered by the contractor herein, the contractor hereby agrees to reimburse the corporation for any such fee payments previously advanced.

dd) Contractor agrees that he/she shall be paid _____per hour of services provided to corporation's clients.

TAXES AND WITHHOLDING

Contractor hereby states his/her rights and intention to represent himself/herself as an independent nurse contractor to the general public, and to operate his own independent business, as an independent nurse contractor. Furthermore, contractor understands, acknowledges and agrees that he/she shall be solely responsible for complying with all Federal and State Income Tax and Payroll Tax Laws, requirements, and payments, resulting from his/her services. Contractor understands, acknowledges, and agrees that he/she may be required to pay quarterly estimated taxes, or pay a penalty for failing to do so. Said contractor shall complete an Internal Revenue Service Form W-9 (Request for Tax Payer's Identification Number and Certification).

PROFESSIONAL LIABILITY INSURANCE

All of the corporation's clients demand proof of professional liability coverage on all nurse contractors, therefore, contractors shall be responsible for obtaining his/her own professional liability insurance at his/her expense. The limit must be $1,000,000 each person, $3,000,000 aggregate. The corporation will provide for its own professional liability insurance at its expense.

GENERAL LIABILITY INSURANCE

Contractor shall be responsible for obtaining his/her own general liability insurance at his/her own expense. The corporation will provide for its own general liability insurance at its expense.

WORKER'S COMPENSATION INSURANCE

Contractor agrees to waive his/her claim to Worker's Compensation Insurance from Corporation.

COMPLIANCE

a) Contractor shall be responsible for compliance with the policies and procedures of the client(s), as set forth by Joint Commission on Accreditation of Hospitals, HIPAA, and the State Board of Nursing in the state where he/she is working. Contractor is also responsible for complying with current education requirements as indicated by the State Board of Nursing in the state that said continuing education is required.

b) The corporation recognizes and agrees that contractor may provide its services to any other person or entity, and contractor hereby agrees to use his/her best good faith efforts to perform under the condition of this agreement.

IN WITNESS WHEREOF, the parties hereto have executed this agreement on this _____day of, _____, 20____, the effective date of this agreement is to be as herein above first indicated.

_____ _____

Contractor Name Representative of Corporation

_____ _____

Signature/Date Signature/Date

HOME CARE AND ALZHEIMER. Alzheimer disease is a progressive, degenerative disorder that attacks the brain's nerve cells, or neurons, resulting in loss of memory, thinking and language skills, and behavioral changes. Alzheimer's disease is the most common cause of dementia, or loss of intellectual function, among people ages 65 and older. Home care is a very helpful choice for both the person with Alzheimer's disease and their families because it provides the very kind of care that is most important-services in the comfort and familiarity of the patient's own place of residence. Criteria for home care admission, for persons with end stage dementia, may not always be well known-issues of mobility, nutrition and weight, verbal communication, problems with infection and overall decline are evaluated. The psychological and physical support provided by home care teaching and supportive equipment can greatly relieve the family caregiver. Caring for a person with Alzheimer's disease (AD) is a challenge that calls upon the patience, creativity, knowledge, and skills of each caregiver. Anvient Home Healthcare Services, LLC treats patients with every kind of terminal condition and many different forms of dementia, including persons with ADRDs. A proper assessment of a patient addresses the needs of the person and his or her caregivers and family in a comprehensive fashion. This is especially important to the family of a person suffering from ADRSs, since this person may have difficulty communicating his or her needs to family members. More than those with other diseases, these patients spend a long period at her needs to family members. More than those with other diseases, these patients spend a long period at the end of their lives bed bound, mostly unresponsive, and in need of total care. As with all of our patients, it is the goal of our home care program to care for ADRDs. Patient while supporting and comforting family and loved ones regardless of the setting or the patient's daily abilities. These communication challenges become part of the task of you, the caregiver. It's common for people with Alzheimer's disease to have trouble with language. Perhaps the individual may try describing an object rather than using its name because of difficulty thinking of the correct word. For example, the person might refer to the telephone as "the ringer" or "that thing I call people with". It takes much patience to communicate with individuals who forget names, struggle for the words they want to use, never finish a sentence, or repeat the same phrase over and over—all problems that may be experienced by people with Alzheimer's disease. To facilitate communication, try these strategies: *Relax. People with Alzheimer's communicate better when they do not feel pressured. *Keep distractions to a minimum. Turn off the radio and television. If others are in the room, find a quite spot. *When the person has trouble expressing a though, guess what may be meant by asking questions they can answer with a yes or no. For example, "Do you mean..? Or "Do you want to go..."? *Sometimes people forget what they are saying and stop in the middle of a sentence. To help them start again, calmly repeat the last few words they said. If they can't continue, ask a question that relates to what they had been saying.

*Make sure you understand what they have said. Question like, “You want to leave now, is that right?” or “You want some milk, don’t you”? Will verify what’s been said.
*You may have to decipher a meaning from a few words. The person’s tone of voice and body language may also help you figure out what they mean. For example, a shaky voice and fidgeting behavior may convey fear more than their words can. May people have limited access to the words they want to use? “Walk now” may mean a person is uncomfortable and wants to leave the room.

_____ _____
Employee Date

Employee Name: _____

STAFF CODE OF CONDUCT/ETHIC

To outline a standard of conduct for all employees, contractors and members of the Board of Directors. To establish and retain the highest possible of public confidence.

CODE OF ETHICS:

- The Code of Ethics contains standards of ethical behavior and practices that impact all dealings with colleagues, patients, the community and society as a whole.
- The Code of Ethics also incorporates standards governing personal behavior particularly when that conduct directly relates to the role and identity of the organization.
- The Code of Ethics outlines principles focused on maintaining and enhancing excellence within OUR AGENCY
- The Code of Ethics serves as notice government officials that OUR AGENCY expects its personnel to abide by all applicable laws and regulations.
- OUR AGENCY has an ethical responsibility to the patients and the community it serves, and fulfills their responsibility through ethical care, treatment, services and business practices.

- Whenever possible, patients/families/legal guardian are included in decisions about the patient’s care, treatment and services, including ethical issues
- Should the patient require or request care, treatment or services not available or inconsistent with the organization’s mission, an offer to refer/transfer the patient to an organization that can fulfill this need will be made and if in agreement, the patient will be referred /transferred appropriately.
- The patient/family will be notified of any financial benefit, if any, to OUR AGENCY s a result of the referral/transfer process.
- Contracted providers/staff of healthcare services must meet and adhere to the quality and ethical standards of this organization.
- Billing practices of OUR AGENCY shall adhere to and be compliant with usual and acceptable standard ethical and legal business practices.
- The effectiveness and safety of care, treatment and services provided by OUR AGENCY is consistent for all patients and is not dependent on the patient’s ability to pay

STAFF MEMBERS'AND BOARD OF DIRECTORS' RESPONSIBILITY TO THE ORGANIZATION:

- Uphold the values, ethics and mission of the organization.
- Conduct all personal and professional activities with honest, integrity, respect, fairness and good faith in a manner that will reflect positively upon the organization and in the best interest of the patient population and community served.
- Comply with all applicable local, laws and regulations in the conduct of organizational or personal activities.
- Respect confidences including confidential business information.
- Assure that no conflict of interest exists in any dealings involving the organization.
- Provide healthcare services consistent with available resources and assure the existence of a resource allocation process that considers ethical ramifications.
- Respect of the customs and practices of those served, consistent with the organization's philosophy.
- Be truthful in all forms of communication, including receivables and avoid information that would create unreasonable expectations.
- Assure the existence of a process to evaluate the quality of care or services rendered.
- Avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices.
- Advice patient of rights, responsibilities and risks regarding care and services provided.

VIOLATIONS: Employees, Manager and volunteers who violate this code shall be subject to disciplinary action, up to and including termination of employment.

Employee/Contractor Signature: _____Date: _____

AGENCY ZERO FRAUD TOLERANCE POLICY

PURPOSE:

To ensure employees participate in the Agency's effort to avoid/prevent any FRAUD activity that may Conflict with the interests of the agency, and any Emirates programs.

POLICY:
The Agency expects all of its employees to understand and be aware of potential situations where the

FRAUD will not be tolerated.

PROCEDURE:

1. All employees will report to their immediate supervisor and actions/omission in/or employment, services that interacts with the Agency Fraud prevention Policy, 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's effort to prevent fraud.
b. Employee participation in any activity/cover for services not provided.
c. Outside employment that interferes with satisfactory performance of an employee 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/giving of gifts kick back, 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. (Illegal remuneration)
f. Participated in any action to Alter Costs.
g. Use un-licensed person to perform their duties, or licensed without authorization (misrepresentation)
h. Not report any sign of Abuse, verbal, physical, economical or any other form.
i. Participate in any act of Identity/Insurance ID theft.
j. Permit unnecessary or duplicate services.
k. Altering Claims, Billing Forms, Invoices, Expenses, or any other accounting related issue. (Over – billing)
l. Non-compliance with approved/ordered scheduled of visits, and Reporting Guidelines, including technically corrected transcribing services if used.

m. Participate in fraudulent Records, Notes, Signature, and Reports.
2. If a fraud action is discovered or suspected the supervisor/manager and employees will discuss its impact with the Agency's 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, including the correspondent report to any Regulatory Agencies.
4. The failure of an employee to cease activity that management determines to be a fraud action will subject the employee to disciplinary action up to and including termination.
5. Upon hire, agency staff will sign Agency's Zero Fraud Tolerance Statement.

Employee Name & Title: _____Employee Signature: _____Date_____

Employee Name: _____

STAFF CONFLICT OF INTEREST

PURPOSE:

To ensure employees avoid any personal interest that may conflict with the interest 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 interact 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/giving 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 Agency's Manager.
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 of 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.

Explain any possible conflict of interest (Example working for another Agency, Hospital, etc):

_____

_____

_____ _____

Staff Signature Date

JOB DESCRIPTION – CAN/GNA

Position Overview:

Certified nursing assistant is an individual who has completed a board-approved Certified Nursing Assistant training program and certified as Certified Nursing Assistant. (CNA). The position is responsible for providing a high quality of in home health care to adults and children with various medical needs under the supervision of registered nurse. Certified nursing assistant would be able to give written account of all services provided to clients as well as pertinent medical information necessary to provide care. Position must be committed with deep sense of pride in a client's progress and wants to make a difference

Essential Job Functions:

- Provides direct patient care as defined in the State Nurse Practice Act., and in accordance with Anvient Home Healthcare Services, LLC policy and procedure which includes:
- Activities of daily living, (a) Eating, or being fed (b) Grooming, bathing, (C) Oral hygiene including brushing teeth, (D) Shaving, and Combing hair.
- Mobility transferring, ambulation, and access to the outdoors, when appropriate.
- Toileting and dressing in clean, weather-appropriate clothing.
- Responsible for safe and effective delivery of care personal hygiene, etc.
- Communicate with RN Supervisor to provide, and evaluate patient care in a manner that maximizes safe and effective delivery of home nursing services.
- Implement care to prevent or reduce risk and to achieve expected outcomes.
- Report and document nursing care given and patient response, recognizing any alterations in patient needs and intervening accordingly.
- Serve as a patient and family advocate, demonstrating respect for the privacy and rights of the patient and family in the implementation of the care plan.
- Prepare and utilize medical equipment and materials efficiently and effectively.
- Demonstrates personal and professional accountability.
- Attend at least 12 nursing education in-services annually

Requirements:

• 1 year of adults and Pediatric Nursing Experience (within the last 2 years)
• Must be certified from Maryland State Board of Nursing.
• Must have a High School Diploma or GED equivalent
• Completed application for employment
• Current, unrestricted nursing license in the jurisdiction in which you are working
• Valid Driver's License or photo ID
• Social Security card or valid US Passport
• Current Healthcare Provider CPR and First Aide certification
• Physical Exam within the last 12 months (without limitations)

• PPD or Chest X-Ray and Hepatitis B Vaccination within the last 12 months (with negative results) or signed waiver
• Background check (with no criminal history)
• Employment and Character references that can be verified.

(**Vaccination will be provided at no cost to employee).**

Note: Note: The entire job to be performed by designated is not inclusive herein; however, staff may perform other related duties as may be directed by nurse supervisor or the director of nursing services to meet the Patient's needs

Employee Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

JOB DESCRIPTION

Tittle of position: Certified Medication Technician (CMT)

Position Summary

Certified medication technician is an individual who has completed a board – approved medication technician training program and certified by the board as a medication technician. The CMT may perform nursing functions that are routinely delegated and supervised by registered nurse and must clearly understand the legal and ethical limits of their position. CMT would be able to give written accounts of all services provided to client by the agency as well as all pertinent medical information necessary to provide care. Medication aides must read and understand the rights and routes of all medication. Registered nurses will train, delegate, and supervise the administration of all medications by CMT/Aides, and shall verify and document the requisite education, training and competency before assignment of duties

- To provide safe and accurate medication administration and promote self-care
- To inform the patient/caregiver of the therapeutic regime
- To report to Registered nurse of patient response to medication and refusal of medication
- To document the medication's name, dosage, route, frequency of medication and administration as appropriate on the medication record (MAR)
- Report to the supervisor and document medication errors
- Remind patients of their medications when appropriate

Primary Duties

The medication aide's role is providing routine daily medications, either prescription or non-prescription, to patients whose condition and drug regimen are stable. The aide must administer medications in the indicated dosage at the correct time, routes and frequency. The aide must ensure the patient actually swallows the medications, which can be an issue with rebellious patients or those with dementia. A warm and encouraging manner can be useful to win the patient's willing compliance. If the medication aide observes a change in the patient's vital signs or behavior, or any other indication of adverse effects from a medication, it must be reported to the RN supervisor immediately

POSITION QUALIFICATIONS

A CMT must obtain formal training and have passed the certification exam by Maryland Board of Nursing as a Certified Medication Technician/Aide in Medication Administration. The CMT must be able to read,

and write clearly and have strong communication skill. Must understand and follow the physician's order before administering medication
Qualifications: Certified by the Board of Nursing as Certified Medication Technician Experience: Two or more years in Home Health care, nursing home or Hospital setting. Home health experience preferred currently licensed as: Certified Medication Technician
Valid Driving License and Social Security Card or valid US Passport
Current CPR/First Aide Cards
Physical Exam within the last 12 months (without limitations)
PPD or Chest X-Ray within the last 12 months (with negative results)
Background Check (with no Criminal Records) and employment/character references
Proof of Hepatitis B Vaccination or a signed declination (**Vaccination will be provided at no cost to employee).**

REFERENCE

Date: _____

TO: Company Name: _____

Supervisor Name: _____

Telephone #: _____

Dear Sir or Madam,

Employee First and Last Name_____is applying to our office as _____ until we have thoroughly checked her/his cooperation in completing the information requested.

I authorize Anvient Home Healthcare Services, LLC, to gather any information - concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

_____
APPLICANT SIGNATURE

To be completed by Previous Employer:

Position _____Date from _____to_____

Reason for leaving: _____

_____

Would you rehire? Yes____ No ____If no please advise why: _____

_____

PLEASE ADVICE IF: ABOVE AVERAGE, SATISFACTORY. BELOW AVERAGE OR COMMENTS.

Punctuality & Attendance _____

Appearance (Grooming)_____

Judgment _____

Performance _____

Ability to Perform_____

Organization of Time_____

Compatibility_____

Accepts Direction _____

Signed _____Title _____Ph_____

APPLICANT CHARACTER REFERENCE CHECK

To Whom It May Concern:

The applicant named below has submitted an application for employment with Anvient Home Healthcare Services, LLC. Please verify character information to the best of your knowledge. Your feedback will be kept confidential. Thank you

To be completed by applicant:

Name of Applicant: _____Date of Application: _____

Applicant Signature: _____ Date: _____

REFERENCE INFORMATION

Colleague, Friend, or Employer: _____ Tel: _____

Address: _____City:_____

How long have you known applicant: _____how you know the applicant (example; Friend, neighbor, relation, etc.)

Signature of reference: _____ Date: _____

Please check the most appropriate box regarding applicant's abilities;

Communication Skills	Excellent	Very Good	Good	Don't know	Poor
Work quality					
Attitude					

Reliability					
Maturity					
Helpfulness					
Ability to work with others					

Please brief descriptions why you think the applicant would be suitable for the position:

_____

_____

Please provide any additional comments that can facilitate the hiring process:

_____

_____

Thank you

Criminal Background Check Authorization/Consent

Please read and complete this form in its entirety and sign in the space provided below. Your written consent is necessary for completion of the employment application process. Thank you

Name: _____ Other Name Used: _____

DOB: _____ SEX____ Height____ Weight ____eye color ___ hair color _____ Race____

Citizenship: _____ SS#: _____ Phone: ( ) _____ _____

Driver's License #: _____ State: _____ Expiration _____

Current Address: _____ City _____ State: _____ Zip Code: _____

I, _____, hereby authorize Anvient Home Healthcare Services, LLC to conduct my background check and qualifications for purpose of evaluation whether I am qualified for the position for which I am applying. I understand that Anvient Home Healthcare Services, LLC will utilize an outside firm or Grand Mission Consult located at 7515 Annapolis Road Suite 203, Hyattsville MD 20784 to assist in checking such information.

I specifically authorize such an investigation and also consent that Anvient Home Healthcare Services, LLC may use any company of their choice to obtain such information. I also understand that I may withhold my permission and in such a case, no investigation will be done, and my application for employment will not be processed further.

APPLICANTS REQUIRED TO MAKE DISCLOSURE MUST COMPLETE THE STATEMENT BELOW

I, _____, Hereby declare or affirm under penalty of perjury, that I (check one) _ have __ have not, been convicted, received a probation before judgement, received a not criminally responsible disposition and that I (check one) __ am __am not, the subject of any pending criminal charges

ANVIENT HOME HEALTHCARE SERVICES, LLC

Applicant Signature: _____ Date: _____

---------- For Office Use ----------

Authorized Personnel: _____ Date: _____

Position Applied for: _____ Authorization #:

CRIMINAL HISTORY CHECK, EMPLOYEE MISCONDUCT REGISTRY
NURSE AIDE REGISTRY NOTIFICATION AND STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by Anvient Home Healthcare Services, LLC, LLC. that a criminal history check will be performed on my name. I have informed Anvient Home Healthcare Services, LLC, LLC. of all names (for example, maiden name, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the criminal history check. I also understand that if I have been convicted of the following offenses, that I may not be employed by Anvient Home Healthcare Services, LLC, LLC. I also understand that Anvient Home Healthcare Services, LLC, LLC. will search the Employee Misconduct Registry and the Nurse Aide Registry (if applicable) to determine whether any acts of abuse, neglect or exploitation have occurred and whether my name is designated on either registry. If my name is designated on either registry I understand Anvient Home Healthcare Services, LLC, LLC. must deny me employment.

Offenses which constitute a bar to employment and for which an administrative review is not available, are offenses under:

- Criminal homicide
- Kidnapping and unlawful restraint
- Indecency with a child
- aggravated assault
- injury to a child, elderly individual, or disabled individual
- abandoning or endangering a child
- Agreement to abduct from custody
- Solicitation of a child
- Sale or purchase of a child
- Arson
- Robbery
- Aggravated robbery or

A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice of an offense containing elements that are substantially similar to the elements of an offense listed under the

above Subdivision.

I understand that all information obtained by Anvient Home Healthcare Services, LLC, LLC. regarding any criminal history will remain confidential. By signing this form, I certify that the information on this form contains no willful misrepresentation and that the information is true and complete to the best of my knowledge.

_____ _____ _____

Applicant Signature Printed Name Date

GNA/CNA COMPETENCY ASSESSMENT SKILLS CHECKLIST

NAME:_____

DATE OF EMPLOYMENT:_____DATE COMPLETED:_____

Do you have experience with skill?		Do you have skills to perform the following:		Competency for GNA/CNA Indicate years of experience with each skills	Proficiency Required	Evaluation Method	Competency Validation by RN. Initials and Date
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1. Temperature:			
				a. Oral			
				b. Rectal			
				c. Axillary			
				d. Digital Thermometers			
				2. Pulse(radial)			
				3. Respiration			
				4. Blood pressure			
				5. Bed bath			
				6. Shower/tub bath			

ANVIENT HOME HEALTHCARE SERVICES, LLC

Do you have experience with skill?		Do you have skills to perform the following:		Competency for GNA/CNA Indicate years of experience with each skills	Proficiency Required	Evaluation Method	Competency Validation by RN. Initials and Date
YES	NO	YES	NO				
				7. Nail care–None Diabetic patient			
				8. Skin care			
				9. Oral care			
				10. Shampoo			
				11. Toileting/Elimination			
				a. Urinal			
				b. Bedpan			
				12. Transfer techniques:			
				a. Bed to chair			
				b. Chair to standing			
				c. Assist with ambulation			
				d. Other			
				13. Assists with exercises program range of motion per MD's order			
				14. Assistive devices:			
				a. Walker			
				e. Cane			
				15. Positioning			
				16. Other Skills:			
				a. Dry dressings			
				b. Medication reminders			
				c. Urinary catheter care			
				d. Observe/record intake and output			

ANVIENT HOME HEALTHCARE SERVICES, LLC

Do you have experience with skill?		Do you have skills to perform the following:		Competency for GNA/CNA Indicate years of experience with each skills	Proficiency Required	Evaluation Method	Competency Validation by RN. Initials and Date
YES	NO	YES	NO				
				e. Hoyer lift			
				17. Documentation Skills: (legible, timely, accurate and complete)			
				a. Progress notes, flow charts			
				b. Incident reporting			
				c. Relates to plan of care			
				18. Observation and reporting to:			
				a. RN/Supervising Nurse			
				19. Adheres to plan of care			
				a. Review POC prior to care			
				b. Performs services as ordered			
				c. Report vital information to RN supervisor			
				20. Infection Control			
				a. Hand washing			
				b. Proper bath technique			
				c. Protective equipment			
				d. Exposure plan			
				e. Equipment Care			
				f. Other			
				21. Emergency procedure			
				22. Document on equipment log			
				23. Making Errands for patient			
				24. Submits written summary of incident reports			

ANVIENT HOME HEALTHCARE SERVICES, LLC

Do you have experience with skill?		Do you have skills to perform the following:		Competency for GNA/CNA Indicate years of experience with each skills	Proficiency Required	Evaluation Method	Competency Validation by RN. Initials and Date
YES	NO	YES	NO				
				25. Attends in-service orientation			
				26. Patient safety/falls risk			
				27. Meal preparation:			
				a. Oral feeding per MD's order			
				b. Diabetic diet			
				c. Low sodium per MD's order			
				d. Low cholesterol/fat per MD's order			
				28. Light housekeeping			
				29. Linen change/wash clothing			
				d. Ostomy care			
				e. Assist patient with dysphagia			
				f. Other			

COMMENTS:

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

ACTIVITIES ASSESSMENT CHECKLIST

CMT COMPETENCY SKILLS ASSESSMENT CHECKLIST

Name: _____ Date: _____

Please review the following list of topic and circle a rating on a range of 1 to 4 to indicate your level of experience. Also indicate the approximate date you last performed each task.

Skill level

1. None – Never used; No experience
2. Limited - Below expected standard
3. Average – Fully meets standard
4. Advanced – well above standard , work independently

PRACTICAL SKILL ASSESSMENT	SKILL LEVEL	DATE LAST PERFORMED

ANVIENT HOME HEALTHCARE SERVICES, LLC

Medication administration		
Identifies correct medication, patient dose, time, and route before administering medication.	**1 2 3 4**	
Administers medication by the route ordered according to appropriate dose ● Oral ● Topical ● Rectal ● Eye, ear, and nose	**1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4**	
Documentation of medication administration	**1 2 3 4**	
Reporting and documentation of medication error	**1 2 3 4**	
Assess vital sign: ● Temperature ● Heart rate ● Respiration	**1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4**	
Measurement of blood pressure	**1 2 3 4**	
Describe proper actions for medication refusal	**1 2 3 4**	
Check expiration date on label	**1 2 3 4**	
Use medication terminologies , symbols and abbreviation	**1 2 3 4**	
Demonstrate the knowledge , skills, attitudes and behavior to be able to take history and examine patient and keep an accurate and relevant medical record		
a. Documentation of care provided	**1 2 3 4**	
b. Medication record –keeping	**1 2 3 4**	
Demonstrate appropriate time management and organizational decision making	**1 2 3 4**	
Use infection control techniques ● Hand washing ● Use of gloves ● Use of sanitizer	**1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 4**	
Respond to medication allergies	**1 2 3 4**	
Demonstrate the knowledge , skills, attitude and behaviors to reduce the risk of cross infection	**1 2 3 4**	
Demonstrates the knowledge, skills, attitudes and behaviors to evidence and guidelines that will benefit patient care	**1 2 3 4**	

Name employee: _____ Signature: _____ Date_____

ANVIENT HOME HEALTHCARE SERVICES, LLC

Director of Nursing: _____ Date _____

Employee Influenza Vaccination Policy Acknowledgement of Receipt

Please print your name, title and then sign and date the form to indicate that you have received a copy of the Anvient Home Healthcare Services, LLC policy for the administration of Influenza vaccine to Adage Healthcare employees, dated _____. You are responsible for reading and adhering to the policy.

_____ _____

Print Name Signature

Please send signed Acknowledgement of Receipt to: Office of Human Resources. Anvient Home Healthcare Services, LLC, LLC.

I am aware of the influenza policy and have a chance to have my questions answered about influenza vaccination. I understand the benefits and risks of the vaccine and:

• I agree to have the influenza vaccine for the _____ influenza season. If you have already received the influenza vaccine for this influenza season, please specify the date _____

• I decline vaccination for the _____ influenza season. I understand that I may rescind this declination at any time. Please specify reason (s) for the declination (optional) _____

Signature_____ Date_____

_____ _____

Print Name Title

Did you receive the influenza vaccine during last year's influenza season? • yes •no
For questions for the influenza vaccination, please call **CDC Hotline: 1800-232-4636**

Administration of Vaccine:

• LAIV

• TIV

_____

Vaccine Type Date (RN) Signature

ANVIENT HOME HEALTHCARE SERVICES, LLC

HEPATITIS B VACCINATION DECLINATION FORM

In accordance with OSHA requirements, employers must make hepatitis B vaccinations available at no cost to employees who have occupational exposure to the hepatitis B virus (HBV). Body art practitioner is required to submit evidence of current hepatitis B immunity in conjunction with registration materials. This includes records of hepatitis B vaccinations and booster shots. If a practitioner declines to be vaccinated against HBV, he/she must submit signed declination agreement from his/her employer. A sample declination statement is provided below. Contact Occupational Safety & Health Administration (www.osha.gov) for additional information.

Waiver of Hepatitis B Vaccine.

I _____ understand that due to my occupational exposure to blood or other potentially infectious materials OPIM, I may be at risk of acquiring Hepatitis B Virus (HBV) infection, I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with hepatitis B vaccine; I can receive the vaccination series at no cost to me.

☐_____ Request to receive Hepatitis B vaccine

☐_____ Refused Hepatitis B vaccine and hold harmless Anvient Home Healthcare Services, LLC, LLC.

☐_____ Provide written proof of immunity (attach)

☐_____ Provide written proof of previous hepatitis B vaccination (attach)

☐_____ Provide written proof of medical contraindication (attach)

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Date Employee (Print Name) Employee's Signature

--------- ---------- ----------

Date Employer Representative (Print name) Employer Representative's Signature

ANVIENT HOME HEALTHCARE SERVICES, LLC

Job Description Acknowledgment

The duties of have been explained to me in details. I have read and fully understand the duties and work history requirements as outlined in the Anvient Home Healthcare Services, LLC policy and procedure and acknowledge the receipt of the job description as stated.

I have received a copy of the job description, and understand that failure to strictly implement assigned duties / directives may result in termination of my appointment with Anvient Home Healthcare Services, LLC Inc.

Employee Signature Date

Administrator Signature Date

JOB ACCEPTANCE STATEMENT

I _____have read, understand and agree to the

terms and conditions specified in this job description for the (RN)__ (PT)__ (OT)__

(LPN)__ (PTA)__ (CNA/CMT)__ position I presently applied for. A copy of this job

description has been given to me.

I further understand that this job description may be reviewed at any time and

that I will be provided with a revised copy.

Employee Signature_____Date_____

ANVIENT HOME HEALTHCARE SERVICES, LLC