



Welcome to Caring Hearts! We do not train our people to be caring, we hire caring people. We are happy to have you as a part of our team.

Below you will find important information relating to your new position. Please take a few minutes to read through, and know that you can call if you have any questions.

We treat our Patients Just Like family:

- It is often a difficult decision for families to bring strangers into their homes to care for their loved ones. We are confident that you will have great respect for your patients and their families, and will treat your patients as well as you would treat your own family.
- Your patients are counting on you. If you are scheduled to be there at 8am, you absolutely must be there on time! Very often they are watching the clock and are anxiously waiting to get to the bathroom, or to eat, or take their medication. If, for any reason, you know you are going to be late, call your patient so they will know. Unfortunately when caregivers are consistently late, the patients commonly ask them not to return. So, it is not only courteous to be on time, it is also job security for you.
- patient binders. Each home will have a patient binder that will have timesheets in it, as well as a description of what your duties are at their home. This binder is often in the kitchen (usually on top of the fridge). If it is your first day with a patient, make a point to go a little early to review the care notes, or contact other caregivers who help that patient, to get information from them as well.
- Go to caringutahemployees.blogspot.com to find copies of all OSHA, Safety Plan, Policies and Procedures, Drug Free Workplace program, and all other employee information.

Payroll:

- A work week runs from Sunday-Saturday
- Checks are sent out every other Friday, and a pay period ends the Saturday before payroll
- In order to be paid you have to have your time sheets turned in every Saturday by midnight

PCS notes/Timesheets: it is critical to your pay that you **turn in your timesheets as soon as you are finished with that client for the week.**

- Be sure you fill out all of the information on the timesheets, including the top section
- Have the patient initial each day before you leave (If the patient is sleeping when you leave, you can make a note explaining, in place of the initials)
- Get the client signature at the bottom of the timesheet on your last day of the week (again, if the client is sleeping when you leave, you can make a note explaining, in place of their signature).
- How to turn in timesheets:
 - **text:** you can text a picture of the timesheet to 801-750-2980 (send each timesheet separately)
 - **email:** you can scan and email, or take a picture and email it to caring.utah@gmail.com
 - be sure to send a separate email for each patient timesheet
 - the "subject" line should be: client's name and date of last shift on the timesheet
 - **fax:** 877-372-0056
 - no cover sheet
 - send each page as a separate fax
- How to report 24 hour shifts: Instead of filling in the "time in" and "time out" on your timesheet, you will put "1 shift" in the "total hours" section for the day you arrived on shift.
 - ie: if you arrived on Tuesday and left on Wednesday, you would write "1 shift" in the Tuesday column.



New Employee Checklist

Here are the items needed in order to make the next payroll

- Completed Criminal Background Screening
- Fingerprints (this form will be emailed to you after you submit all other paperwork)
- Evidence of TB testing being completed (Need to be tested? Contact local health department for details)
- Evidence of First Aid Training
- Completed W-4 form
- Completed I-9 form
- Contract of Employment
- Pre-Health Screening Questionnaire
- Health Insurance Information
- Shift Work Agreement
- Abuse Investigation Reporting
- Drug-Free Workplace Program
- Copy of driver's license & Social Security Card
- All current licenses and certifications (i.e., CNA, CPR)
- Direct Deposit Authorization Form (if you would like your checks directly deposited to your bank account)
- On-Site Evaluation Form

Submit all of the above to caring.utah@gmail.com, or fax to 877-572-0056, or mail to P.O. Box 184; Riverton UT 84065, or deliver to administrator



Criminal Background Screening Authorization Form

First Name _____ Last Name: _____ Application# _____

I hereby authorize the Caring Hearts to submit my Direct Patient Access Application to the Bureau of Criminal Identification (BCI) for processing in accordance with Caring Hearts policy. I authorize BCI to access and review State and Federal criminal history records and provide that information to the Caring Hearts to be used to make a clearance determination. I do hereby release Caring Hearts and BCI, all information. I have been provided with a copy of this form.

I have read and understand the foregoing and my certification is true and correct to the best of my knowledge and belief.

Applicant Signature: _____ Date: _____

Company Representative: _____ Date: _____

Name: First _____
Middle _____
Last _____

S.S.N. _____

Date of birth _____

Race _____

Gender _____

eye color _____

hair color _____

height _____

weight _____

US citizen _____

place of birth _____

primary phone _____

phone type _____

secondary phone _____

phone type _____

email address _____

Prior addresses in the last 7 years
(State and dates only)

*all information contained in this authorization shall be kept confidential and shall only be used for the purpose
of submitting information for a background check

Employee's Withholding Certificate

OMB No. 1545-0074

- Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
 ► Give Form W-4 to your employer.
 ► Your withholding is subject to review by the IRS.

2020

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); or (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ► □
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TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ► \$ _____ Multiply the number of other dependents by \$500 ► \$ _____ Add the amounts above and enter the total here 3 \$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income 4(a) \$ _____ (b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here 4(b) \$ _____ (c) Extra withholding. Enter any additional tax you want withheld each pay period 4(c) \$ _____

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete. ► Employee's signature (This form is not valid unless you sign it.) ► Date		
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)



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 <table border="1"><tr><td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td></tr></table>				-			-				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):

- | |
|---|
| <input type="checkbox"/> 1. A citizen of the United States |
| <input type="checkbox"/> 2. A noncitizen national of the United States (See <i>instructions</i>) |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____ |
| <input type="checkbox"/> 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 <i>instructions</i>) |

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)
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Preparer and/or Translator Certification (check one):

- | | |
|--|---|
| <input type="checkbox"/> I did not use a preparer or translator. | <input type="checkbox"/> 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



Employer Completes Next Page





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

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				
Document Title	OR	List B Identity	AND	List C Employment Authorization
Issuing Authority		Document Title	Document Title	
Document Number		Issuing Authority	Issuing Authority	
Expiration Date (if any) (mm/dd/yyyy)		Document Number	Document Number	
Document Title		Expiration Date (if any) (mm/dd/yyyy)	Expiration Date (if any) (mm/dd/yyyy)	
Issuing Authority				QR Code - Sections 2 & 3 Do Not Write In This Space
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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)
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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
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Contract of Employment

This contract is entered into on this _____ of _____ year of _____ by and between Caring Hearts of Utah (hereinafter called Employer) and _____ (hereinafter called Employee) (together, "Parties"). The use of the masculine gender shall be interpreted to include the feminine.

WHEREAS, employee has been offered at-will employment or is a current at-will employee with the company where employee will be or is currently providing companionship services to a client(s) ("client") of the company while living in the client's home;

WHEREAS, the parties desire to enter into a "reasonable agreement" as these terms have been interpreted by the United States Department of Labor ("DOL") for purposes of the Fair Labor Standard Act ("FLSA")

WHEREAS, employee will be or is a domestic service worker residing in the client's home and will be provided with private quarters in a homelike environment

WHEREAS, the parties desire to set forth the terms and conditions upon which employee agrees to provide companionship services to company's client(s) as described herein;

WHEREAS, employee has been informed and is aware that the execution of this agreement is a necessary term and condition of employee's employment; and

WHEREAS, the employee understands the extreme importance to the company in keeping its operations, techniques, business plans, financial information, and information related to its customers proprietary and confidential.

NOW, THEREFORE, in consideration for employee's employment and/or continued employment at the company and the mutual promises set forth herein, the company and employee agree as follows:

1. Employee-Employer Status. In the performance of this agreement, the employee is in all respects an employee of the company, on "at will" basis, and as a result such employment relationship may be terminated by either the company or employee at any time, for any reason, with or without cause. Employee understands and agrees that he/she is not an agent with authority to bind the company.
2. Effective Date of Companionship Care
 - a. Employee is a current employee of the company and is subject to a live-in caregiver contract. This agreement supersedes and replaces such contract. For purposes hereof,



the date on which Employee began providing "Companionship Care" (as defined in this contract) for the company is the "effective date".

- b. Employee is a new employee of the company. The date this agreement has been signed by the parties is the "effective date".

3. Companionship Care

- a. Employee understands and agrees that he/she will live at the client's home for an extended period. Employee will be provided private quarters in the client's home, with a sleeping space that is separate from the client. Employee will be provided with bed, lighting, and a dresser and/or closet in which to store clothing or other belongings. In addition, employee will have access to facilities for cooking and eating, a bathroom, and a space for recreation. These additional facilities may be shared by employee and/or other household members of the client.
- b. Employee shall provide companionship care to client. For purposes hereof, "Companionship Care" is fellowship (engaging client in social, physical, and mental activities such as conversation, reading, games, crafts, accompanying client on walks, errands, to appointments or to social events) and protection (being with client in their home or outside the home to monitor their safety and well-being). Employee shall assist client with activities of daily living (such as dressing, grooming, eating, bathing, toileting and transferring), as well as instruments of daily living (tasks that enable them to live independently at home such as meal preparation, driving, light housework, and assisting them with the physical taking of medications). Employee shallot perform general household work , such as caring for family members other than client, or medically related tasks (services that require training by medical personnel, including invasive or sterile procedures or procedures that otherwise require the exercise of medical judgment).
- c. Maintain open communication between families and health care professionals regarding client's medical and emotional condition
- d. Document and report any changes in client's health status
- e. Ensure highest client safety and well-being
- f. Employee agrees to provide proof of First Aid training. If no training exists, employee agrees to complete training prior to their 6 month review.
- g. Employee agrees to be tested for Tuberculosis prior to working with clients. If employee has been tested within 6 months of hire date, the results of that test may be submitted, but the cost of that test will not be reimbursed. The cost of a new test will be reimbursed by Company upon submission of results of the TB test to Company. Results must be submitted within 7 days of hire date.
- h. Employee acknowledges regarding employment policy : "No Call, No show, No Job" is in effect and a Notice of Neglect will be forwarded to both the Utah Department of Health and Welfare and the Background Check Program.



- i. Employee agrees to use his/her best efforts to serve the employer. Employee agrees that he will at all times respect the rights of the patients they serve.
- j. Employee recognizes and fully realizes that employer is a Personal Care Agency, staffing pattern may be varied. Employer has the sole right to make work schedule changes and Employee agrees to abide by such changes.

4. Compensation

- a. Employee shall document companionship care on the "PCS Notes" form provided by company and shall document all hours worked on PCS Notes form.
 - b. Employee understands and agrees that he/she will not be compensated for eight (8) hours of sleep time, generally from 11pm to 7am. Employee shall document on the PCS Note form whether or not he/she was able to have eight (8) hours outside of caregiving, where a minimum of five (5) hours of which employee was uninterrupted rest. In the event that employee was not able to have eight (8) hours outside of caregiving or did not have a minimum of five (5) uninterrupted hours for rest, employee may be entitled to compensation, to be determined by the company, in its sole discretion.
 - c. Employee shall be paid a daily rate of not less than \$120.00 per day, based on a forty (40) hours a week at the national minimum wage of \$7.25 and seventy-two (72) hours a week at time and a half, and taking into account a deduction of \$33.34 per day for room and board expenses in connection with living in the home of the client.
5. Confidential Information: Employee acknowledges and agrees that, in the course of employee's employment, employee may become acquainted with confidential information belonging to the company, its clients, customers and accounts. Employee shall not, during or after the term of employee's employment, use or disclose said confidential information, or any part thereof, to any person, firm, corporation, association, limited liability company, joint venture, or other entity, for any reason or purpose whatsoever, without the prior written consent of the company. Confidential information may be kept in any form, including, but not limited to, computer files, papers, documents, contracts, letters, communications and other things, tangible and intangible. Upon the conclusion or termination of employment, the employee shall immediately return to the company all confidential information and other property of the company in employee's possession or subject to employee control. For purposes of this agreement, "confidential information" shall include, but not be limited to, information concerning:
- a. Current and prospective clients, customers, and accounts of the company, including methods of soliciting and retaining clients, customers, and accounts of the company, including methods of soliciting and retaining clients, customers, and accounts, as well as the identity of all such current and prospective clients, customers, and accounts;
 - b. Information deemed confidential or proprietary by the clients, customers and accounts of the company;
 - c. Advertising strategies, techniques and processes;



- d. invoicing/billing information and any other information reflecting the company's pricing practices;
 - e. Company techniques, methods and processes, to fellowship and provide caregiving services to the company's clients;
 - f. Client information which employee learned in the course of providing companionship care, and would not otherwise know about the client.
6. Remedies and Breach: this agreement creates rights which cannot solely be protected by an award of money damages and that specific performance shall lie for any material breach of this agreement. Employee agrees, in the event of any breach of this agreement, material or immaterial, that the company will suffer irreparable harm and will not have an adequate remedy at law, that the company may pursue and obtain preliminary and permanent injunctive relief, in addition to any other remedy to which the company may be entitled at equity or law, and that the company shall be entitled to a judgement from a court of competent jurisdiction to enjoin any further breach of this agreement. Employee agrees to reimburse the company for any and all of its reasonable attorneys' fees and costs arising from its good faith effort to enforce this agreement, including any and all reasonable attorneys' fees and costs necessary to establish a right to fees and costs under this paragraph.
- a. Employee agrees to pay \$5,000 to company, should employees choose to leave their employment at Company to work directly for a client, either former or current, of Company.
7. Severability/Reformation: It is the intention of the parties that the terms of this agreement shall be construed to be separable and severable. No provision of this agreement found invalid or unenforceable shall invalidate or render unenforceable any other provision of this agreement. It is the intention of the parties that if any provision of this agreement is found invalid or unenforceable in any part or degree, it shall be interpreted, if possible, so as to render it enforceable on a limited and reasonable basis.
8. Entire agreement: This agreement sets forth the entire understanding of the parties with respect to the subject matters, and shall not be modified or amended except by a further written document signed by all parties.
9. Employee's Continuing Obligations: Employee's obligations under this agreement shall continue following the conclusion or termination of Employee's employment with the company.
10. Assignment: The company's rights under this agreement shall insure to the benefit of and shall be subsequent assigns of this agreement to a parent, subsidiary or affiliate, or successors or assigns by reorganization, merger or consolidation or sale of substantially all of the company business or assets. This Agreement shall not be assignable by the employee without the written consent of the company.



11. Choice of Law: This agreement shall be governed by and construed and interpreted in accordance with the laws of the State of Utah without reference to principles of conflict of laws. Each of the Company and the Employee hereby submits for itself or himself, as applicable, to the excluding general jurisdiction of the courts of the State of Utah for any dispute arising out of this Agreement.

IN WITNESS WHEREOF, the parties have entered into this Agreement and knows the contents thereof, accepts this agreement as written and signs of his or her own free will, as of the date first written below.

Employee Signature

date

Company Administrator or Designee

date



Employee Health Evaluation

Name: _____ SSN: _____

Address: _____ Phone# _____

Job Title: _____ Physician: _____

Emergency Contact: _____ Relation: _____

Address: _____ Phone# _____

Do you have any allergies to (circle all that apply):

Latex or Vinyl Chemicals/household products soaps/personal care products
Foods Pollens/dust Certain types of clothing/gloves

Circle the response that describes the communicable diseases, vaccinations, or antibody titers you have had. Please include the date(s) of vaccinations or titer completion.

<u>Disease</u>	<u>Vaccine</u>	<u>Date</u>	
Yes No	Yes No	_____	Rubeola (red measles - 7 day)
Yes No	Yes No	_____	Rubella (German measles - 3 day)
Yes No	Yes No	_____	Mumps
Yes No	Yes No	_____	Hepatitis B
Yes No	Yes No	_____	Chicken Pox
Yes No	Yes No	_____	Tetanus/Diphtheria
Yes No	Yes No	_____	Polio
Yes No	Yes No	_____	Pneumococcal
Yes No	Yes No	_____	Tuberculosis

If you have had a positive TB skin test, date of skin test conversion: _____

Last chest X-ray date: _____ Result: _____

Please note that if you are pregnant or planning pregnancy, please discuss the occupational risks particular to your position (such as exposure to communicable diseases, exposure to cleaner/disinfectant fumes, lifting) with your physician. If you have any conditions that may prevent you from performing assigned duties satisfactorily, these must be discussed with your employer. All information will be kept confidential. The information on this health evaluation is complete and accurate to the best of my knowledge. I hereby certify that I am free of any physical, mental or emotional condition that would be detrimental to the well being of those in my care.

Employee Signature _____ Date _____

Administrator or designee Signature _____ Date _____



Dear Employee,

The Affordable Care Act includes a requirement for most individuals to have health insurance or potentially pay a penalty for noncompliance. This penalty will apply to the individual and their dependents unless they have "Minimum Essential Coverage". If you and your dependents have health insurance under certain government sponsored plans, an employer sponsored plan, a plan in the individual market, or any other health benefit recognized by Health and Human Services, then you are exempt from the mandate or the penalty.

Caring Hearts of Utah LLC does not currently offer health insurance at this time to our employees. If you would like more information on obtaining health insurance in Utah, you can go to:

www.healthcare.gov

"I understand that Caring Hearts of Utah LLC does not offer health insurance to their employees at this time. I have been given information regarding where to learn more about obtaining health insurance on my own, as well as form OMB No. 1210-0149 explaining my health insurance marketplace coverage options."

(Employee signature)

(Date)



Abuse Investigation

All reports of patient abuse, neglect, misappropriation or patient property, and injury of an unknown source shall be promptly and thoroughly investigated.

1. When an incident or suspected incident of patient abuse, neglect, misappropriation of patient property, or injury of an unknown source is reported, the Administrator or appointed designee will investigate the incident.
2. The administrator will provide to the person in charge of the investigation a copy of the patient abuse report form and any supporting documents relative to the incident.
3. The investigation shall consist of:
 - a. A review of the completed Resident Abuse Report Form¹
 - b. an interview with the person(s) reporting the incident;
 - c. Interviews with any witnesses to the incident¹
 - d. an interview with the patient
 - e. An interview with the patient's attending physician and review of the patient's medical record;
 - f. An interview with the staff members (on all shifts) having contact with the resident during the period of the alleged incident¹
 - g. Interviews with the patient's family members, and visitors, or others who provide care to the patient.
4. Witness reports shall be reduced to writing. Witnesses will be required to sign and date such reports. (Note: A copy of such reports must be attached to the Abuse Investigation Report Form.)
5. The Person In charge of the abuse investigation will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the investigation process.
6. Should the Ombudsman decline the invitation to participate in the investigation, a notation of such data will be entered into the investigation record. The Ombudsman will be notified of the results of the investigation.
7. While the investigation is being conducted, accused individuals not employed by the Agency will be denied unsupervised access to the patient. Visits may be made in designated areas approved by the Administrator.
8. Employees of the Agency who have been accused of resident abuse will be reassigned to non patient care status or suspended from work until the Administrator has reviewed the results of the investigation.
9. The person in charge of the investigation will consult with the Administrator daily concerning the progress of the investigation.
10. the Administrator will keep the patient and his/her family/representatives informed of the progress of the investigation
11. the results of the investigation will be recorded on the Patient Abuse Investigation Report Form

12. A copy of the completed Patient Abuse Investigation Report Form will be provided to the Administrator within five (5) working days of the reported incident.
13. The Administrator will inform the resident and his/her family/representative of the results of the investigation and corrective action taken.
14. Should the investigation reveal that the abuse occurred, the Administrator will report such findings to the local police department, the ombudsman, and the state-licensing agency within twenty-four (24) hours of the results of the completion of the investigation.
15. The results of all investigation shall be reported to the state survey and certification agency within five (5) days of the completion of the investigation.
16. All reports of abuse are investigated by a state licensed agency. Should the licensing agency determine that abuse occurred; state officials will forward the appropriate notices to the accused individual and to the Agency Administrator.
17. Should the investigation reveal that a false report was made/filed, the investigation will cease. Patients, family members, ombudsman, state agencies, etc. will be notified of the findings. (Note: Disciplinary actions concerning the filing of false reports are outlined in the Agency's personnel manual).
18. Policies governing abuse reporting are outlined in a separate policy entitled "Abuse Reporting"
19. Inquiries concerning abuse reporting and investigation should be referred to the Administrator or to the director of patient services.

Abuse Reporting

All personnel must promptly report an incident or suspected incident of abuse, including injuries of an unknown source and misappropriation of resident property.

1. Our Agency will not condone patient abuse by anyone, including staff members, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals.
2. Any alleged violations involving mistreatment, neglect or abuse, including injuries of an unknown source and misappropriation of resident property, must be reported to the Administrator.
3. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the Agency Administrator, or his/her designee will notify the following persons of agencies, of such incident within specified timeframe. The Agency must report such information within four (4) hours, unless otherwise specified to the appropriate law enforcement agency, which is the Commission of Ageing or its area agencies.
 - a. Adult Protective Services (Immediately)
 - b. Law Enforcement Officials
 - c. Agency Representatives
 - d. Health and Welfare
 - e. Adult Protection
 - f. Child Abuse
 - g. Local law Enforcement (911)
4. All personnel, patients, visitors, etc., are encouraged to report incidents of abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff.
5. To assist our agency staff members in recognizing incidents of abuse, the following definitions of abuse are provided:

- a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.
 - b. Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging a derogatory terms to patients or their families or within their hearing distance, to describe patients, regardless of their age, ability to comprehend, or disability.
 - c. Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
 - d. Physical abuse is defined as hitting, slapping, punching, kicking, etc. It also includes controlling behavior through corporal punishment.
 - e. Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services
 - f. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
6. The person(s) observing an incident of patient abuse or suspected patient abuse must immediately report such an incident to the Administrator. The following information should be reported to the Administrator:
 - a. The name of the resident(s) involved
 - b. the date and time that the incident occurred
 - c. Where the incident took place
 - d. The name(s) of the person(s) committing the incident, if known
 - e. the type of abuse that was committed (i.e.: verbal, physical, sexual, neglect, etc.)
 - f. And other information that may be requested by the Administrator or designee.
 7. Upon receiving reports of physical or sexual abuse, the Administrator shall immediately examine the patient. Findings of the examination must be recorded in the patient's PCS notes. (Note: If sexual abuse is suspected, DO NOT bathe the patient or wash the patient's clothing or linens. Call the police immediately.)
 8. The Administrator or designee must complete a Patient Abuse Report Form and obtain a written, signed, and dated statement from the person reporting the incident.
 9. A completed copy of the Patient Abuse Report Form and written statements from witnesses, if any, must be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator within five (5) working days of the occurrence of such incident.
 10. When an incident of patient abuse is suspected or determined, such incidents may be reported to the Administrator regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy.

Employee Signature

Date

Caring Hearts Administrator or Designee Signature

Date



PERSONAL CARE AIDE ON-SITE EVALUATION

Personal Care Aide Name: _____

Date of Evaluation: _____

Name of Client observed: _____

Does the Aide?	Yes, No, N/A and Comments
Have knowledge of policy and procedures?	
Have first aid training?	
Document observations/services inpatient record?	
Exceed personal care service levels?	

Demonstrates competency in personal Care areas?

Self-administration of medications by: reminding and/or opening containers for the client	
Transferring Client	
Personal Grooming and Dressing	
Eating and meal preparation	
Oral hygiene and denture care	
Toileting and toilet hygiene	
bathing	
Taking and recording temperatures and/or weights	
Administers emergency first aid	
Provides transportation	

Signature of Supervisor / Title

date

Print name



NEW EMPLOYEE INFORMATION FORM

(PLEASE FILL OUT FORM COMPLETELY)

Employer Company Name _____

Employee Name _____ Birth Date _____
(First Middle Last) (MM/DD/YYYY)

Social Security Number: _____ Home Telephone Number: _____

Address _____ Apt/Unit# _____ City _____

State _____ Zip _____ E-mail Address: _____

First Day of Employment: _____ Job Title: _____ Rate of Pay: \$ _____ Hourly _____ Salary
(MM/DD/YYYY)

Male/Female: _____ Job Location: _____ Department: _____ Division: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone Number: _____

Employment Status per week:

Full Time (30+ hours) _____ Part Time (less than 30 hours) _____ Seasonal FT _____ Seasonal PT _____ On Call/Temp _____

Disabled/Veteran Classification:

Disabled _____ Vietnam Era Veteran _____ Disabled Veteran _____ (30% plus disability) I am not a Vet _____

Race/Ethnic Data (Select One):

Two or more races	White	Asian
Hispanic or Latino	Black or African American	American Indian or Alaskan Native
Native Hawaiian/other Pacific Islander	Some Other Race	Decline to State

I understand and acknowledge that any employment with Zamp HR will be on an "at-will" basis, which means that any employment relationship can be severed by Zamp HR at any time for any reason or for no reason. It also means that I may sever the employment relationship at any time for any reason or for no reason. I further agree that any disputes that may arise from employment with Zamp HR will be settled first through Mediation and then Arbitration according to the policies and practices of Zamp HR.

I testify that any and all information that I have provided is true to the best of my knowledge. I also understand that providing any false information on this form may be grounds for termination.

X _____
(Employee Signature)



DIRECT DEPOSIT FORM

All deposits have electronic pay stubs. View at www.zamphr.com

PLEASE NOTE: WE CANNOT DEPOSIT FUNDS INTO PRE-PAID DEBIT CARD ACCOUNTS

Company Name _____

Employee Name _____ Social Security # _____

Action to be taken

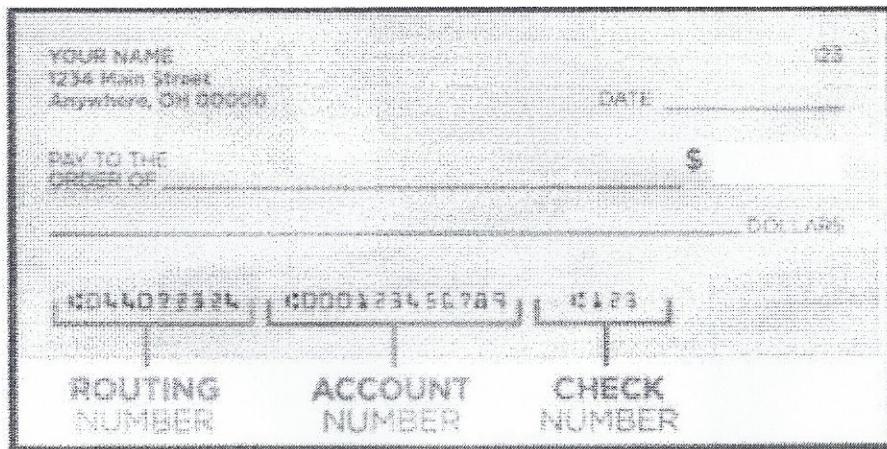
Enroll in a Pay Card _____ Add New Bank Account(s) _____ Delete Bank Account(s) _____ Change Bank Account(s) _____

	Account 1	Account 2	Account 3
New Account / Delete Account / Change Account?			
Bank Name			
Checking or Savings Account?			
Routing Number			
Account Number			
Amount of Net pay to be Deposited (\$ or %)			

I hereby authorize Zamp HR to transfer electronic debits or credits to the bank account(s) noted above. I authorize the institutions named to accept and process the debit or credit entries initiated by Zamp HR. Zamp HR shall have no liability if the information listed above is not correct. This agreement may be terminated at any time by written notification to Zamp HR with Zamp HR being allowed reasonable time to act. I certify that I have legal right to conduct any, and all business on the accounts listed above. Zamp HR reserves the right to stop this transfer if sufficient collected funds are not available. I grant Zamp HR the right to correct any erroneous overpayments by debiting my account to the extent of such overpayment. I understand that Zamp HR reserves the right to refuse any direct deposit request.

Signature

Date (MM/DD/YYYY)



Zamp HR (And Its Entities) Employee Acknowledgment Form

Employee Name: _____ ("Employee")
Subscriber / Company Name: _____ ("Subscriber")

1. Professional Employer Organization, Licensing Act Recitals.

Professional Employer Organization Contact Information:
Zamp HR (And Its Entities) ("Zamp HR" or the "Company")
Craig Allred, President
(801) 377-1190

2. Employee Acknowledgement. I, the employee, understand that my employer (the "Subscriber") has entered into a written agreement with Zamp HR whereby Zamp HR will provide professional employer services to Subscriber and employees working at Subscriber's location (the "Subscriber Agreement"). I understand that this Acknowledgement Form serves as notice to me that pursuant to the Subscriber Agreement, I will become a co-employee of Zamp HR and the Subscriber. Pursuant to the Subscriber Agreement, Subscriber will continue to direct and control my day-to-day work activities, and will continue to be responsible for my terms and conditions of employment, including, but not limited to, my wages and/or salary. I will continue to receive the same wages and/or salary as previously agreed upon between the Subscriber and me. I accept the conditions of the co-employment relationship between Zamp HR, Subscriber and me. I also confirm that I have received a copy of the Zamp HR Employee Handbook, and that I agree to abide by its terms and conditions. I further agree and understand that in the event Subscriber fails to provide funds to Zamp HR as required under the Subscriber Agreement and I fail to receive my wages as previously agreed between Subscriber and me, I agree that my recourse for such wages or other compensation alleged to be due is against the Subscriber, and that I waive any and all claims to wages, salary, or other compensation ("Compensation") from Zamp HR. I further agree that Zamp HR does not pay, and has no obligation to pay, severance pay, accrued PTO, or other payments other than the amounts described above.

3. At Will Employment. Except with respect to paragraph 6 below, I understand that I am an "employee at will". I have entered into this employment relationship with the Company/Subscriber, voluntarily and for no specified length of employment. This means that the Company and/or Subscriber may discharge me at any time for any reason, with or without notice, and that I may terminate my employment at any time for any reason, with or without notice. Any oral or written representations to the contrary, by either the Company or the Subscriber, are invalid and may not be relied upon by me. In the event my employment is terminated by Subscriber or Zamp HR, I agree to contact Zamp HR within 48 hours of such termination and request from Zamp HR an opportunity for employment as another Subscriber Client of Zamp HR. I understand and agree that my failure to provide such notice to Zamp HR and to seek other employment through Zamp HR may adversely affect my ability to collect unemployment benefits.

4. Confidential and Proprietary Information. I, the employee, will preserve the secrecy of all trade secrets and other proprietary and confidential information belonging to the Subscriber or Zamp HR during employment and after termination of employment, and I will not take or misuse any such confidential information at any time. I agree on the request of the either Subscriber or Zamp HR, or upon termination of employment, I will promptly return to the appropriate party all its property, specifically including all documents, disks, or other computer media or other materials in my possession or under my control that contain ideas, processes, concepts or other trade secrets or proprietary and confidential information belonging to the either party.

5. Workers Compensation, Medical Treatment, Modified Duty, Designated Provider Policy. I, the employee, understand in accordance with state law, a Medical Provider has been designated for purposes of Workers Compensation Insurance, and that my Workers Compensation benefits may be reduced if I fail to be seen by the Designated Medical Provider for treatment of any work related injury. I also understand that work-related injuries must be reported to the Subscriber immediately following the injury and if I do not report the injury within a reasonable time frame, Workers Compensation benefits may be reduced.

6. Position and Duties. I further understand that I shall be subject to the Subscriber's direct supervision and shall perform the tasks assigned by the Subscriber, subject to the Subscriber's practices, policies and procedures. Subscriber may modify my position and duties at Subscriber's sole discretion, with or without notice to me. I further agree to comply with the Company's established instructions, practices and procedures, when and if Company has provided or assisted in providing such instructions, practices and procedures. I shall remain the employee of Subscriber for purposes of determining whether any of Subscriber's employees are entitled to or eligible for incentive stock options.

7. Place of Performance. I, the employee, shall be based at the Subscriber's address.

8. Compensation, Benefits and Related Matters.

a. **Compensation.** The Company shall issue pay checks to me in accordance with the agreement as to wages or salary between the Subscriber and me. The amount of salary/wages may be unilaterally changed from time to time at the discretion of Subscriber and/or Company.

b. **Benefits.** If eligible, I shall be entitled to the benefits that I applied for on the Benefits Enrollment Form, which, by my signature on this form, I acknowledge I have received.

9. **Mediation and Arbitration.** I agree to abide by the Mutual Arbitration Agreement between Zamp HR, Subscriber and me that is included with the enrollment documents received today.

10. **Drug-Free Workplace Policy.** I understand that Zamp HR and the Subscriber maintain a drug-free workplace, and I agree to the terms and conditions of the Drug and Alcohol Policy of Zamp HR and/or Subscriber. I understand and acknowledge that I can be required to undergo a drug test as a condition of employment, following a work-related accident, and/or upon reasonable suspicion of impairment. Failure to comply with a drug testing request or a positive test result will result in discipline up to and including termination.

11. **Harassment, Sexual Harassment, Work Place Violence and Reporting Policy.** I understand that harassment in any form and violence in the workplace is a direct violation of the Company's policy and that Zamp HR and/or subscriber will investigate all reported incidents of harassment, sexual harassment and workplace violence. I understand that substantiated incidents of this type will lead to disciplinary action up to and including immediate termination. I understand that if I believe that I have been the subject of harassment or sexual harassment, or have been harmed by violence or threatened with violence, or have witnessed anyone else connected with my employment, experience or commit such conduct, I must promptly notify my immediate supervisor, a member of Management of the Subscriber or the VP of Human Resources for Zamp HR at 1-888-810-8187. In such an event, Zamp HR and the Subscriber will make every reasonable effort to preserve the confidentiality of all persons involved.

12. **Release of Information.** I hereby consent to the release of my name, city, phone number, job skills, and other applicable information to partnering staffing agencies, and other potential employers, to be used for the purpose of unemployment management. I further consent to the disclosure by the partnering staffing agencies of all pertinent information relevant to my employment, and details pertaining to compensation to enable a quick return to the work place.

13. **Release of Information for References.** I understand that my employer will provide references to potential employers upon my written request only. I understand that my employer will release information concerning employment when presented with a written release. I understand that with this written release that I release Zamp HR and the subscriber from liability and hold them harmless concerning any information they may give about my job performance to potential employers, so long as they provide the information in good faith.

14. **Acknowledgment.** I acknowledge that I have received, read and understand this Employee Agreement Form, and that I understand that I am an at-will employee and that as such I may quit employment at any time, for any reason, with or without notice, just as my employment may be terminated by Subscriber or Company at any time, for any reason, with or without notice.

ZAMP HR (AND ITS ENTITIES):

EMPLOYEE:

By: _____
(Print Name)

By: _____
(Print Name)

Name: _____
(Signature)

Name: _____
(Signature)

Title: _____

Title: _____

Date: _____

Date: _____

Client Company Name: _____ herein referred to as "Company."

This policy provides Company employees with guidelines pertaining to drug and alcohol abuse during the normal course of employment.

Scope:

This policy applies to all employees of the Company and all affiliated companies at all locations.

Policy Statement:

Company provides a safe and productive work environment for all employees. It is the policy of the Company that employees shall not be involved with the unlawful use, possession, sale, or transfer of drugs or narcotics of any type, including the misuse of prescription drugs, or engage in any conduct that may impair their ability to perform assigned duties or otherwise adversely affect the Company's business. The use or possession of illegal drugs or alcohol on premises owned, controlled, or leased by the Company or otherwise during working hours (regardless of the place) is strictly prohibited. Further, employees shall not misuse prescription or legal drugs such that the effect of such misuse places the employee or any other person in danger or jeopardy. The specific purpose of this procedure is to outline the methods for maintaining a work environment free from the use of alcohol, illegal drugs, and misused legal drugs and medications. In order to provide reliable and safe service to the Company's customers and a safe work environment for its employees, employees must be physically and mentally fit to perform their duties safely and efficiently.

Introduction:

- A. Employees are expected to report for work and remain at work in a condition to perform assigned duties free from the effects of alcohol and drugs.
 1. The use of alcohol or illegal drugs and the misuse of legal drugs along with the physiological effects of such conduct represent a threat to the well-being and security of employees and could cause extensive damage to others as well as the Company's reputation and community standing.
 2. Any conduct in violation of this drug and alcohol policy will not be tolerated.
 3. Off-the-job illegal drugs activity, alcohol consumption, or misuse of legal drugs that adversely affects an employee's job performance or that could jeopardize the safety of other employees, the public, Company equipment, or the Company's relations with the public will also not be tolerated.
- B. Illegal drugs are those drugs defined as illegal under federal, state, or local laws. They include, but are not limited to:

• Marijuana	• Cocaine
• Heroin	• Hallucinogens
• Methamphetamines	• Alcohol
• Hashish	• Prescription drugs used in an unlawful manner

Drug Testing:

Drug and alcohol tests may be conducted as a routine part of the pre-employment physical examination for applicants and co-op students prior to employment. Applicants must satisfactorily pass the drug screen prior to reporting to work as a condition of employment. Offers of employment may be made, contingent upon satisfactorily meeting these requirements. If the drug screening procedures indicate the presence of illegal drugs or controlled substances, the applicant will not be considered further for employment. An applicant who fails a pre-employment drug test may not re-apply for employment for a period of one-hundred and twenty days.

In addition, the Company reserves the right, consistent with applicable law, to conduct tests for reasonable suspicion and post-accident occurrences. Random testing may also be conducted at any time. An employee may be suspended pending the outcome of any drug test required.

Drug and alcohol tests will be conducted as a routine part of all employees being considered for positions for certain vendors as part of their requirements due to restrictive policies or government regulations.

***Any employee who refuses to submit to any of the above mentioned drug tests will be considered a positive result from an alcohol/drug test and will subject to disciplinary action, up to and including termination of employment.*



DRUG AND ALCOHOL POLICY - CONTINUED

Consequences of Violating the Drug & Alcohol Policy

A. Drugs

The use, sale, transfer, or personal possession (e.g., on the person or in a desk, or vehicle) of illegal drugs while on the job, including rest periods, meal periods and work at locations other than Company premises, or on Company property is a dischargeable offense that will be subject to disciplinary action, up to and including termination of employment and may also result in criminal prosecution. Any illegal drugs found will be turned over to the appropriate law enforcement agency. In addition, impairment due to the misuse of a legal drug shall also be a violation of the Drug and Alcohol Policy, and constitute a dischargeable offense that will be subject to disciplinary action, up to and including termination of employment.

B. Alcohol

For all employees, alcohol consumption is prohibited during the workday, including rest period and meal periods. The use or personal possession (e.g., on the person or in a desk/vehicle) of alcohol during work time or on Company property is a dischargeable offense that will be subject to disciplinary action, up to and including termination of employment.

Company Drug & Alcohol Policy and Testing Consent Form

I have read and understand the Drug and Alcohol Policy of the Company, and I agree to submit to all of its requirements, including submitting to drug or alcohol tests as required. I understand that compliance with this policy is a condition of my employment with the Company. I also understand the disciplinary actions that the Company may take against me if I violate the Drug and Alcohol Policy.

Employee signature _____

Print name _____ Date _____

Witness _____ Date _____



Zamp HR is committed to providing a work environment that is free of discrimination and unlawful harassment. Zamp HR complies with federal and state equal employment opportunity laws and strives to keep the workplace free from all forms of illegal harassment, including, but not limited to, harassment based on:

- Sex
- Religion
- National Origin
- Age
- Disability, and
- Race

Some examples of conduct that might be considered harassment include ethnic slurs and racist remarks. In addition, sexual harassment includes any unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature where tolerance of such actions is made a condition of employment, interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment.

It is illegal and against Zamp HR company policy for any worker, male or female, to harass another worker or create a hostile working environment by committing or encouraging:

- Physical assaults on another employee, including rape, sexual battery, molestation, or attempts to commit these assaults;
- Intentional physical conduct that is sexual in nature, including touching, pinching, patting, or brushing up against another employee's body;
- Unwanted sexual advances, propositions, or sexual comments, including sexual gestures, jokes, or comments made in the presence of any employee who has indicated that such conduct is unwelcome, sexual in nature, or pornographic;
- Posting or displaying pictures, posters, calendars, graffiti, objects, or other materials that are sexual in nature or pornographic.

The creation of an intimidating, hostile, or offensive working environment includes such actions as persistent sexual comments or the display of obscene or sexually oriented photographs or drawings. Illegal harassment on the job is unlawful whether it involves co-workers, supervisors, or persons not employed by Zamp HR or its customers. In addition, retaliation against another person who objects to conduct that he or she deems to be objectionable or offensive, or who has threatened to or made a complaint of harassment, will not be tolerated.

Employees subjected to sexual harassment should immediately report the harassment to their supervisor or any member of management. If the harassment is being caused by one's supervisor, the employee should report the harassment to another member of management or to the **Zamp HR Human Resources Department, toll-free at 1-888-819-5952**. Our policy strictly prohibits retaliation of any kind against an employee that reports an incident of illegal harassment.

Supervisors and managers who receive a sexual harassment complaint should immediately follow the required steps for investigating the allegations and shall protect the employee from retaliation.

Anyone engaging in sexual or other unlawful harassment will be subject to disciplinary action, up to and including termination of employment. Moreover, such persons could also be responsible for monetary damages caused by their conduct.

I have been informed of Zamp HR's policy regarding sexual and other unlawful harassment and agree to abide by its terms.

Employee signature _____

Print name _____ Date _____



MUTUAL ARBITRATION AGREEMENT

This Mutual Arbitration Agreement is entered into among _____ (print employee name) (referred to as "Employee") and Zamp HR and _____ (the "Worksite Employer"). Zamp HR, the Worksite Employer and the Employee are referred to in this Agreement together as the "Parties", "we" or "us", or individually as a "Party".

1. NO EMPLOYMENT AGREEMENT / EMPLOYMENT AT-WILL. Neither this Agreement nor any other agreement between any of the parties is an employment agreement, and to the extent you are employed, it is at-will, you may be terminated with or without cause at any time, and without advance notice, procedure or formality, for any reason not otherwise prohibited by law.

2. EMPLOYMENT IN RETURN FOR THIS AGREEMENT. The Employee is either a new employee or is an existing employee of the Worksite Employer who is receiving new or additional benefits or other consideration, or is working under new policies as a result of the new relationship between the Worksite Employer and Zamp HR. The decision to employ the Employee and/or to offer the new benefits and policies was in return for the Employee's good faith agreement to comply with the spirit and terms of this Agreement.

3. ARBITRATION. To the maximum extent permitted by law, each party to this Agreement shall have the right to elect to arbitrate if Employee files a complaint, demand, or claim against Zamp HR or the Worksite Employer relating to Employee's employment by any party to this Agreement (a "Claim"). Any Party may elect to submit the Claim to binding arbitration in accordance with the procedures stated herein. If a Party makes an election to arbitrate, all parties named in the Claim shall be compelled to arbitrate the Claim as set forth herein.

Any Claim a Party elects to arbitrate must be brought by the complaining party within six (6) months of the event or act which gave rise to the dispute. Any Claim brought after six (6) months will be of no effect and void. In the event a dispute gives rise to damages, the parties specifically agree that no punitive damages will be sought or awarded. The arbitration shall be filed with the American Arbitration Association and the venue of such an arbitration proceeding shall be _____ (County of Worksite Employer) in the State of _____. The rules of the American Arbitration Association shall apply. The parties shall mutually agree on an arbitrator; however, if the parties are unable to agree on an arbitrator within thirty days after the election to arbitrate, then the complainant shall select one arbitrator and the respondents shall select one arbitrator, and the two selected arbitrators shall select a third arbitrator who will arbitrate the Claim. The prevailing Party, as determined by the arbitrator, will be awarded reasonable attorneys' fees, expert witness fees and costs, including arbitration fees, in addition to any relief order or award that enters for the prevailing Party.

THE EMPLOYEE UNDERSTANDS THAT THIS AGREEMENT TO ARBITRATE ALL ARBITRABLE DISPUTES MEANS THE EMPLOYEE IS AGREEING TO WAIVE, TO THE MAXIMUM EXTENT PERMITTED BY LAW, ANY RIGHT IT MAY HAVE TO ASK FOR A JURY OR COURT TRIAL IN ANY DISPUTE WITH THE COMPANY.

4. ENTIRE AGREEMENT, ENFORCEABILITY; INTERPRETATION. This Agreement expresses our entire understanding about its subject matter. The only way this Agreement may be amended, changed or waived will be through a written document that each party executes. This Agreement is enforceable by and against each of us and anyone else who has or who obtains rights under this Agreement from any Party. This Agreement will be interpreted and enforced under Utah law. Any unenforceable provision of this Agreement will be modified to the extent necessary to make it enforceable or, if that is not possible, will be severed from this Agreement, and the remainder of this Agreement will be enforced to the fullest extent possible.

Each Party has read and considered this Agreement carefully, believes that each Party understands each provision and has conferred or has had the opportunity to confer with the Party's own attorney before executing this Agreement.

IN WITNESS OF OUR AGREEMENTS, Zamp HR, the Worksite Employer, and the Employee have executed this Agreement on the date(s) indicated below.

The Employee

The Worksite Employer

Zamp HR

By:

By:

By:

Title:

Title:

Title:

Date:

Date:

Date: