The below information MUST ACCOMPANY YOUR DRIVER'S APPLICATION

CURRENT DRIVER'S LICENSE OR STATE ISSUED ID CARD _____

DRIVER'S RECORD (5 YEARS)

SOCIAL SECURITY CARD _____

CURRENT CPR _____

CURRENT FIRST AID _____

TB TEST (WITHIN 12 MONTHS)

Employment Application

Date: _____

Full Name: _____ D.O.B._____ SSN: _____

Current Address: _____ City: _____ State: _____

Zip Code: _____ County: _____ Cell Phone: _____

Position Applied for: _____Salary Desired: $_____ C.N.A ____ PCA ___ LPN___ RN___ Med Tech____

☐ Full Time ☐ Part Time When are you available to begin work? _____

Type of School	Name Of School	Years Completed	Diploma/ Degree
High School			
College or Trade			
Professional			
Other			

Do you drive? ☐ Yes ☐ No Do you have a car? ☐ Yes ☐ No

First Aid: ☐ Yes ☐ No CPR: ☐ Yes ☐ No Current TB Test: ☐ Yes ☐ No

Employment History:

Name Of Company	Company Address	Job Title:	Salary:	Phone Number	Supervisor	Can we contact this employer as a reference? If not, please explain why

References:

Name Of Reference	Phone Number	Relationship

I certify that all statements in this application and any attached documents are true, complete and accurate. I understand that false information may result in rejection or termination of my employment.

Signature: _____ **Date:** _____

AUTHORITY FOR RELEASE OF INFORMATION
State Access Only
Name Check Access

I authorize the North Carolina Department of Public Safety through the State Bureau of Investigation to perform a North Carolina name-based criminal history record information check in connection with my application for employment, my employment or volunteer services with COMMUNITY HEALTH CARE INC pursuant to DHHS-LONG TERM - STATE AND FED - NCGS 122C-80B/131D-40A A1/131D-40A A1.

(Type or print clearly)

Last Name	First	Middle	Maiden

Social Security Number (Optional*)	Date of Birth	Sex	Race

I understand that the North Carolina State Bureau of Investigation, officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the above named agency cannot provide a HARD COPY of the results of this criminal history record check to me.

*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.

Applicant's/Employee's/Volunteer's Signature

_____

Date

_____

This form must be maintained on file with the above named agency for one year. UPON COMPLETION OF THIS FORM, MAIL A PHOTOCOPY TO THE ADDRESS INDICATED BELOW:

State Bureau of Investigation
Criminal Information and Identification Section
Attn: Applicant Unit
Post Office Box 29500
Raleigh, North Carolina 27626-0500

ORI # HCPCA1887 - COMMUNITY HEALTH CARE INC

HCPCA1887

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

By this document, Community Health Care discloses to you that a consumer report, including an investigative consumer report containing information as to your character, general reputation, personal characteristics and mode of living, may be obtained for employment purposes as part of the pre-employment background investigation and at any time during your employment. Should an investigative consumer report be requested, you will have the right to request a complete and accurate disclosure of the nature and scope of the investigation requested and a written summary of your rights under the Fair Credit Reporting Act. Please sign below to acknowledge the receipt of this disclosure.

Applicant's/Employee's Signature _____

Date _____

AUTHORITY FOR RELEASE OF INFORMATION

I authorize BackgroundChecks.com to release criminal history and consumer report in connection with my application for employment with Community Health Care.

(Please print clearly)

Last Name	First	Middle	Maiden
_____	_____	_____	_____
Social Security Number	**Date of Birth**	**Sex**	**Race**
_____	_____	_____	_____

Applicant's/Employee's Signature _____

Date _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **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.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) **Social security number**
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **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 . . . . . ▶ ☐

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)

COMMUNITY HEALTH CARE, INC.

MEDICAL TRANSPORTATION DRIVER

DATE: April 7, 2020

POLICY:

Medical Transportation Driver will provide auto mobility of clients to and from hospitals, convalescent facilities, dialysis centers, rehabilitation centers, medical offices and their private residence in a safe, secure and professional manner. Medical Transportation Driver also may provide rides to clients who have been pre-approved for non-medical trips, such as grocery shopping, pharmacy, church and other social gathering.

PURPOSE:

Transportation is provided in a safe, timely and professional manner for individuals needing auto mobility by an approved commercial carrier.

I. QUALIFICATIONS:

A. Must be 18 years of age
B. High School Diploma
C. CPR Certification / First Aid
D. Current Criminal Record Report
E. Valid NC Driver's License
F. Pass a drug screening
G. Provide a current 2-year DMV Printout

II. KNOWLEDGE, SKILLS AND ABILITIES:

A. Must comprehend and comply with Employee Handbook, Driver Manual and Driver Training outline
B. Must be able to understand and operate GPS devices and cell phones
C. Must communicate with dispatch regarding schedule progress and receive instructions effectively

III. DUTIES:

A. Transport clients in company vehicles in a safe and professional manner
B. Maintain a professional image and attitude with clients, visitors and co-workers
C. Complete daily vehicle pre-trip and post trip logs and inspections
D. Maintain cleanliness of vehicle
E. Must be able to physically step up and down steps
F. Safely secure clients for transport, lift up to 50 lbs and transport wheelchair clients on paved and unpaved surfaces

IV. LINE OF AUTHORITY – Medical Transportation Driver is guided by the Transportation Dispatcher

V. HOURS

VI. SALARY

VII. OVERTIME STATUS – Non-exempt

Signature: _____

Date: _____

OSHA Declination Form

The Federal Occupational Safety and Health Administration (OSHA) which addresses occupational exposure to bloodborne pathogens requires that vaccinations for Hepatitis B be made available to all employees or volunteers to receive the Hepatitis B vaccination. Community Health Care, Inc. will incur all costs for employees or volunteers to receive the Hepatitis B vaccination. Prior approval is needed by the Agency director before an employee takes the vaccination.

I have been informed of OSHA requirements and understand the need or purpose of the vaccination but I decline to take the Hepatitis B vaccination.

Employee Signature: _____

Date: _____

Statement of Acknowledgement

This is to acknowledge that I have received a copy of Community Health Care, Inc.'s personnel policies and procedures. I understand that it provides guidelines and summary information about Community Health Care, Inc.'s personnel policies, procedures, benefits and rules of conduct. I also understand that it is my responsibility to read, understand, become familiar with and comply with the standards that have been established. I further understand that Community Health Care, Inc. reserves the right to modify, supplement, rescind, or revise any position, benefit, or policy from time to time, with or without notice, as it deems necessary or appropriate.

Employee Signature: _____
Date: _____

Transportation Liability Waiver

I consent and agree transporting of clients and family caregivers during work hours and for completing required task activities will be my sole responsibility for assuring that proper liability insurance is kept current on all the vehicles used for this purpose. Further, I accept full risk of liability for any expense, damage, loss of property or injury that may occur while transporting clients and family caregivers during approved work hours: and that the agency, Community Health Care, Inc. will not be liable for such aforementioned conditions involving accident liabilities.

Employee Signature: _____
Date: _____

Employee Non-Compete Clause

I _____, understand when a client recruited by Community Health Care is assigned to me and I later terminate the assignment from the Agency, I cannot be placed with the client for 90 days under another working relationship. If another working relationship outside of Community Health Care is formed, a finder's fee of $500.00 will be charged by deducting money owed from my pay.

Employee Signature: _____
Date: _____

WAIVER OF LIABILITY FOR WORK PERFORMED AFTER CLIENT SCHEDULED HOURS AND VOLUNTEER SERVICES

I understand any work activities or visits performed by me after completing authorized hours according to my Work Schedule for clients receiving official home care/health services through Community Health Care is my sole responsibility regarding any type of risk of liability that may be incurred after approved hours. Therefore, I agree that any expense, damage, accident or loss is not the liability of Community Health Care.

I further agree that if I am assisting clients through Community Health Care in a volunteer capacity, the agency also is released from any expense, damage, accident or loss that may be incurred at any time with work, activities, or visits.

Employee Signature: _____
Date: _____

NOTICE OF NO SMOKING IN CLIENTS' HOMES

According to the Division of Health Service Regulations, a bill was issued in effect October 1, 2007 which prohibits the smoking by employees in homes of their clients. As employees of Community Health Care, you are, hereby, notified of this bill and required to follow this "No Smoking in Client's Homes" notice. Violators will be subject to disciplinary action.

Employee Signature: _____
Date: _____

NOTICE OF NON-PAYMENT OF SERVICE HOURS PROVIDED TO CLIENT WHEN DENIAL OF CLAIM BY MEDICAID

I am hereby notified of non-payment of service hours provided by me to clients who are denied claim reimbursement from Medicaid to the agency due to hospitalization, ineligible for services due to Medicaid expiration, inpatient skilled nursing facility service, adult care home or any other conditions described by Medicaid to be non-reimbursable for Personal Care Services.

Employee Signature: _____
Date: _____

Use of Confidential Information by Employee

I as an Employee of Community Health Care do hereby acknowledge that I must comply with a number of State and Federal Laws which regulate the handling of confidential and personal information regarding both customers/clients of this company and its other employees. These laws may include, but not be limited to- FACTA, The Privacy Act, Gramm-Leach-Bliley, and ID Theft Laws (where applicable). I understand that I must maintain the confidentiality of ALL documents, credit card information, and personal information of any type and that such information may be used only for the intended business purpose. Any other use of said information is strictly prohibited. Additionally, should I misuse or breach, any personal information of said clients and/or employee; I understand I will be held fully accountable both civilly and criminally, which may include, but not limited to Federal and State fines, criminal terms, real or implied financial damages incurred by the client, employee, or this company.

Employee Signature: _____
Date: _____

Property Damages and Bodily Injuries Responsibility

I _____ consent and agree that property damages to the structure of the client's dwelling inside and outside which includes such things, and is not limited to frame, windows, furniture, lawn, trees and shrubberies are my responsibilities. I further accept full responsibility and liability for any expenses, damages, losses of personal properties of client, family, friends, and whosever is present inside or outside the home for which I am involved during approved work hours. It is also my responsibility to be accountable for any bodily injuries that may occur on my behalf to client, family, friends and whoever is present inside and outside the home during approved work hours.

Community Health Care Inc. will not be liable for such aforementioned conditions involving negligence or accidents that are not covered under the company's General Liability insurance client.

Employee Signature: _____
Date: _____

Required Drug Testing

To ensure the well being of our clients and the proper use of techniques by our employees, we are enforcing safety within the work environment. Therefore, in case of an injury or any type of accident involving you and/or the client, you are required to submit a drug test within 24 hours of the occurrence from a reputable facility such as a hospital, doctors office, Urgent Care, and Laboratory Centers.

My signature below indicates that I have been made aware of this required personnel procedure.

Employee Signature: _____
Date: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employer Completes Next Page

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

INFECTION CONTROL / BLOODBORNE PATHOGENS

Bloodborne Pathogens

HBV: Hepatitis means "inflammation of the liver." Hepatitis B virus (HBV) is the major infectious bloodborne hazard you face on the job.

If you become infected, symptoms can include flu-like symptoms so severe that you may require hospitalization. **You may feel no symptoms at all but your blood, saliva and other body fluids may be infectious.** There is a vaccine available to prevent infection.

HIV: The human immunodeficiency virus (HIV) attacks the body's immune system, causing the disease known as AIDS, or Acquired Immune Deficiency Syndrome. Currently there is no vaccine to prevent infection . A person infected with HIV may carry the virus without developing symptoms for several years. Symptoms may include flu-like symptoms, fever, diarrhea and fatigue. HIV is transmitted primarily through sexual contact, but may also be transmitted through contact with blood and some body fluids.

Infection Control

Infection control, also known as Universal precautions, is a way of treating all people's blood and other potentially infectious materials as if they are infected. Universal precautions treats all people, no matter their sex, race, occupation, sexual orientation, etc. as if they are infected. You will "Over-treat" the majority of persons that you come into contact with but, those who are infected you will be prepared to treat them properly.
Infection control procedures are taking active measures to prevent illnesses from being spread from them to you or from you to them.

The best way to reduce occupational risk of infection with HIV, HBV (hepatitis B), and other pathogens is to follow universal precautions. apply **Professionals assume all clients are infected with BBP (blood borne pathogens)** and take adequate nondiscriminatory precautions to protect themselves. Universal precautions should apply to blood, body fluids containing visible blood, semen, vaginal secretions, bodily tissues, and amniotic fluid.

In 1991 the Centers for Disease Control (CDC) issued guidelines describing procedures to help professionals to protect themselves from a variety of possible infections. In general, these precautions include the use of an appropriate barrier (such as gloves, masks, or goggles) to prevent exposure to infected blood, semen, and vaginal secretions. Recommendations include standard sterilization and disinfection procedures and procedures for the disposal of infectious waste. Universal precautions are designed to supplement rather than replace routine infection control practices.

- Don't handle contact lenses or smoke in such areas.

Wash your skin immediately after accidental contact with body fluids that might be contaminated. If soap and running water are not available:

- Use antiseptic toweletts or hand cleansers.
- Wash with soap and running water as soon as you can.
- If you think that you have been exposed to a bloodborne pathogen, follow proper reporting procedures, and arrange to have blood tests and counseling. (Both are confidential.) Don't donate blood in order to be tested.

Then, report the incident immediately!

Use required Personal Protective Equipment (PPE)

Wear Gloves if contact with blood, other body fluids or contaminated objects is likely. If you have a cut or scrape, bandage it before putting gloves on.

- Never re-use disposable latex or nylon gloves. (Workers allergic to latex or nylon can use hypo allergenic gloves, glove liners, or powderless gloves.)
- "Utility" gloves of vinyl, leather, etc. may be re-used after proper decontamination. Examine gloves for tears, cracks, and tiny "pin holes" before, and during use. Replace damaged gloves as soon as possible.

Remove gloves properly.

1. Grasp a glove near the cuff and pull down until it comes off inside-out. Cup it in the palm of your hand.
2. Insert 2 fingers of your bare hand inside the glove of the remaining glove.
3. Pull down so this glove also comes off inside-out, with the first glove tucked inside..

- Don't handle contact lenses or smoke in such areas.

Wash your skin immediately after accidental contact with body fluids that might be contaminated. If soap and running water are not available:

- Use antiseptic toweletts or hand cleansers.
- Wash with soap and running water as soon as you can.
- If you think that you have been exposed to a bloodborne pathogen, follow proper reporting procedures, and arrange to have blood tests and counseling. (Both are confidential.) Don't donate blood in order to be tested.

Then, report the incident immediately!

Use required Personal Protective Equipment (PPE)

Wear Gloves if contact with blood, other body fluids or contaminated objects is likely. If you have a cut or scrape, bandage it before putting gloves on.

- Never re-use disposable latex or nylon gloves. (Workers allergic to latex or nylon can use hypo allergenic gloves, glove liners, or powderless gloves.)
- "Utility" gloves of vinyl, leather, etc. may be re-used after proper decontamination. Examine gloves for tears, cracks, and tiny "pin holes" before, and during use. Replace damaged gloves as soon as possible.

Remove gloves properly.

1. Grasp a glove near the cuff and pull down until it comes off inside-out. Cup it in the palm of your hand.
2. Insert 2 fingers of your bare hand inside the glove of the remaining glove.
3. Pull down so this glove also comes off inside-out, with the first glove tucked inside..

Name_____

Date _____

BLOODBORNE PATHOGENS TEST

True or False

1._____Hepatitis B is the major infectious bloodborne hazard you face on the job.

2._____Universal precautions means treating people 16- 28 years old as if they are infected with bloodborne pathogens.

3._____Report exposure to bloodborne pathogens within 48 hours of the incident.

4._____Masks should be worn when splashing or splattering of blood or other body fluids is likely.

5._____It is okay to reuse disposable latex gloves.

6._____A vaccine is available to prevent HIV.

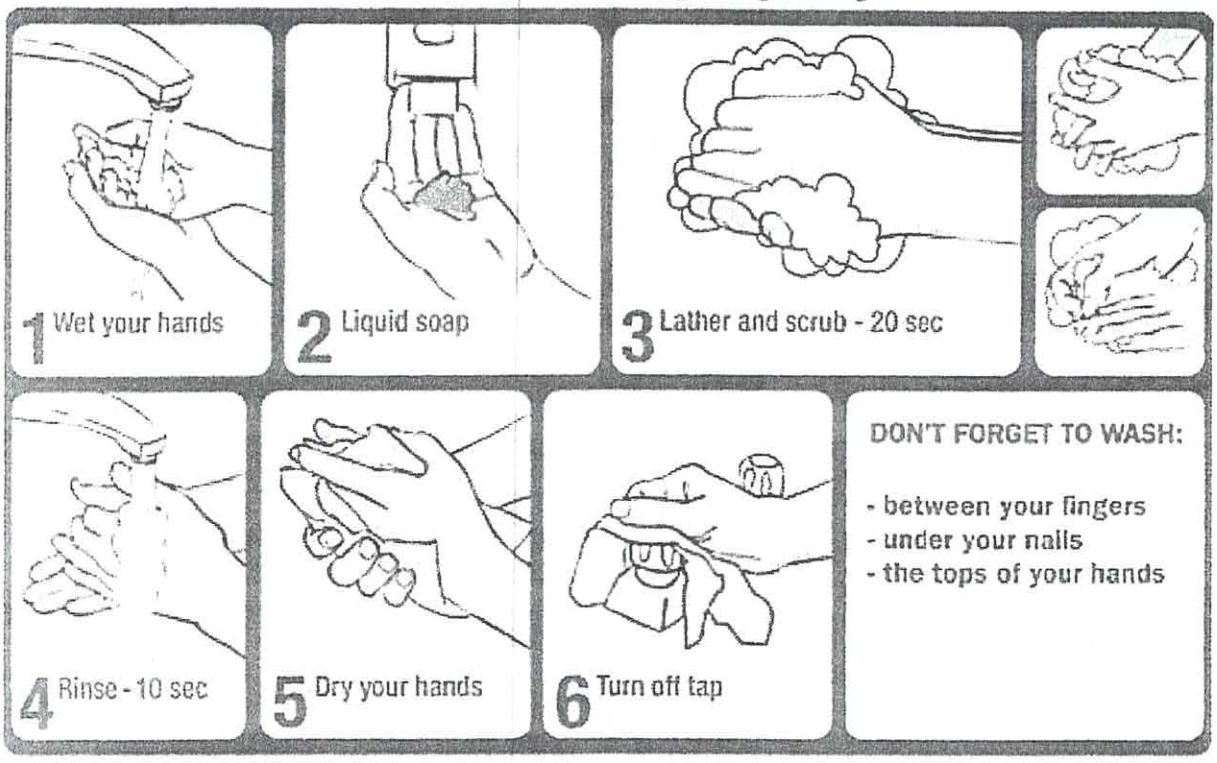
7._____Wash your hands before putting on gloves and after removing gloves.

8._____HIV is only transmitted through contact with blood and some body fluids.

9._____HIV stands for hepatitis immune virus.

10._____A person with hepatitis B infection always has severe flu-like symptoms when they become infected.

How to wash your hands properly



By signing this form, you confirm that you have completed and understand the procedures for washing your hands. If you have questions or concerns, please contact the office at 301-341-2273 (Maryland location) or 335-285-7001 (North Carolina location).

_____

Employee Signature

iSolved

New Hire/Change Form

Company Information

Employer Name | Client/Company ID

City | State | Zip

o New Hire | o Re-Hire | o Employee Change

Employee Information

Last Name | **First Name** | **Middle**

Street Address

City | State | Zip

Social Security No.

Gender o Male o Female

Date of Birth

Home Phone | Cell Phone

Personal E-mail

Employment Information

Hire Date

Employee Type o Full Time o Part Time

Employee Pay Type o Hourly o Salary Exempt o Salary Non-Exempt

Division

Department

Position

Worker's Comp Code

Hourly Rate

Salary (Per Pay Period)

Exempt from OT? o Yes o No

Zip Code of EE's Work Location

Federal Filing Status (from W-4 Form) o Single o Married o Head of Household

Claim Dependents Amount

$ Amount of Additional Fed W/H

State Filing Status o Single o Married

Number of State Allowances

$ Amount of Additional State W/H

iSolved | HCM

DIRECT DEPOSIT AUTHORIZATION FORM

Employer Name _____

Employee Name _____ Social Security Number _____

Direct Deposit #1	O Checking	O Savings	Specify One
Bank Name			% of Net Pay
Routing #			$ of Net Pay
Account #			
Direct Deposit #2	O Checking	O Savings	Specify One
Bank Name			% of Net Pay
Routing #			$ of Net Pay
Account #			
Direct Deposit #3	O Checking	O Savings	Specify One
Bank Name			% of Net Pay
Routing #			$ of Net Pay
Account #			

I authorize iSolved, on behalf of my employer, to direct deposit funds to my account(s) at the financial institution(s) listed above each pay period. If funds to which I am NOT entitled are deposited in my account(s), I authorize iSolved to initiate a debiting entry to collect any overpayments.

Employee Signature _____ Date _____

To ensure accuracy please attach a voided check or a copy of a check for each financial institution.
Important Note: Deposit tickets generally are not imprinted with the bank's required external ACH routing number and can NOT be used for setting up an employee pay check direct deposit.

Attach a copy of a VOIDED CHECK here with your financial institution's ACH routing and Account number