

# Human Resource Documents

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**Confidential Employee File Record**

Tuberculosis Testing

Hepatitis B Vaccination

For unlicensed personnel with face-to-face patient contact:

Printed copy of initial and annual nurse aide registry (NAR) and employee misconduct registry (EMR)

Verification of Employability

Criminal History Check

# EMPLOYEE APPLICATION

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

POSITION DESIRED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

STATE LICENSE #: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

AVAILABLE: Full Time: \_\_\_\_\_ Part Time/Per Visit \_\_\_\_\_ Contract: \_\_\_\_\_

ARE YOU LEGALLY ELIGIBLE TO WORK IN THE U.S.A.? Yes \_\_\_\_\_ No \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DRIVERS LICENSE # \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A CRIME? Yes \_\_\_\_\_ No \_\_\_\_\_

Conviction of a crime is not an automatic bar to employment, other factors such as the nature and date of the crime will be taken into consideration.

IF YES, GIVE DATE AND DETAILS: \_\_\_\_\_

## EDUCATION

Type of School:	Name & Location	Major	Degrees Obtained & Date
High School			
College			
Other Education or Special Training			
Other Education or Special Training			

See Resume Attached

EMPLOYMENT HISTORY

DATES		EMPLOYER & FULL ADDRESS LAST OR CURRENT POSITION	TYPE OF BUSINESS	POSITION HELD	
FROM	TO			POSITION	WORK PHONE
					STARTING PAY
				SUPERIOR & TITLE	FINAL PAY
DESCRIBE DUTIES/RESPONSIBILITIES:					
DATES		EMPLOYER & FULL ADDRESS LAST OR CURRENT POSITION	TYPE OF BUSINESS	POSITION HELD	
FROM	TO			POSITION	WORK PHONE
					STARTING PAY
				SUPERIOR AND TITLE	FINAL PAY
DESCRIBE DUTIES/RESPONSIBILITIES:					
DATES		EMPLOYER & FULL ADDRESS LAST OR CURRENT POSITION	TYPE OF BUSINESS	POSITION HELD	
FROM	TO			POSITION	WORK PHONE
					STARTING PAY
				SUPERIOR AND TITLE	FINAL PAY
DESCRIBE DUTIES/RESPONSIBILITIES:					

PERSONAL REFERENCES

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I certify that the information on this application is correct and I understand that any misrepresentation or omission of any information will result in my disqualification from consideration for employment. The agency is an equal opportunity employer and does not discriminate in its recruiting, selecting and hiring procedures because of race, color, gender, religion, national origin, age, sexual orientation or disability status nor does it discriminate with regard to Veteran status.

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_

**INSERT:**

Verification of Professional License (insert)

Copy Driver's License (insert)

Copy Social Security Card (insert)

Copy Automobile Insurance (insert)

**CONFIDENTIALITY STATEMENT**

I, \_\_\_\_\_, understand while performing my duties as an employee of the agency, I may have access to and/or be involved in the processing of patient care data, medical records, policy, procedure and other proprietary information, including computer files and electronic mail.

I understand I must maintain the confidentiality of this information at all times, both during and after working hours and after termination of employment for any reason.

I also understand any violation of this confidentiality may result in disciplinary action up to and including termination of my employment. Furthermore, I understand I may be subjected to legal action.

I certify with my signature below I have been informed of this policy above and have participated in an orientation and training session concerning the confidentiality of patient care data, medical records, policy and procedures and other proprietary information. I agree to comply fully with the confidentiality requirement.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

### CODE OF ETHICS

Agency staff is expected to conduct themselves and their business in a manner consistent with the ethics policy and procedure. This includes, but not limited, to the following:

1. Agency recognizes its obligation to provide care, treatment or services to its patients and employees through ethical medical, clinical and business practices.
2. Ethical issues involving the patient will be resolved in a collaborative manner which includes the patient and all appropriate health care staff.
3. All admissions, transfers, discharges, marketing and billing procedures are conducted in an ethical manner.
4. Agency establishes and distributes a Code of Ethics. This code considers:
  - Rights of patients and employees
  - Provision of personnel meeting the highest of standards
  - Billing practices and procedures
  - Integrity of sales and marketing materials
  - Fairness in completion
  - Compliance with all applicable laws and regulations

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date



**BACK AND LIFTING SAFETY FORM**

By signing this document, I acknowledge I have received training on proper lifting techniques, body mechanics, and back safety including, but not limited to:

- Good posture
- Good physical condition
- Proper body mechanics
- Correct lifting

I understand if I need additional equipment or assistance in performing any of my employment duties, I must inform my supervisor immediately of such requests. My signature below signifies I have all safety equipment and assistance necessary to perform my employment duties in a safe manner. I understand I am not to attempt to perform any employment duties in an unsafe manner. I understand if I think an unsafe condition or practice exists in the office or at the patient's residence, I must inform my supervisor immediately. I also understand injuries sustained while performing the duties of my job must be reported to my supervisor immediately.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

RECEIPT OF PERSONAL PROTECTIVE EQUIPMENT (OSHA KIT) FORM

I have received the following Personal Protective Equipment (PPE):

- Gloves
- Gown
- Goggles/Protective Eye Wear
- Resuscitation Device
- Biohazard Bag
- Back Support

OTHER: \_\_\_\_\_  
\_\_\_\_\_

I decline issuance of PPE equipment as I already have this equipment.

PLEASE NOTE:

REPLACEMENTS OF THE ABOVE ARE AVAILABLE AT THE AGENCY OFFICE. I HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE PERSONAL PROTECTIVE EQUIPMENT AND UNDERSTAND THAT IF I TERMINATE MY EMPLOYMENT OR IT IS TERMINATED ALL UNUSED ITEMS MUST BE RETURNED TO THE AGENCY.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

NOTICE REGARDING WORKER'S COMPENSATION

This is to notify you that our agency does not provide Worker's Compensation insurance. Please sign below indicating that you have read this information.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

INSERT:

Certificates for CE Contact or Clock Hours of Continuing Education

## C & M HEALTH SERVICES

### STATEMENT OF EMPLOYABILITY/CONSENT FOR CRIMINAL HISTORY CHECK - PG 1 OF 2

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

**By execution of this document, I acknowledge that I have been informed by the Agency, that a criminal history check will be performed on my name.**

I have also been informed that if I am an unlicensed person with direct patient contact, the Nurse Aide registry and the employee misconduct registry will be called.

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the criminal history check.

I have not been convicted of the following crimes:

- \*An offense under Chapter 19, Penal Code (Criminal homicide);
- \*An offense under Chapter 20, Penal Code (Kidnaping and unlawful restraint);
- \* An offense under section 21.08 Penal Code (Indecent exposure)
- \*An offense under Chapter 21.11, Penal Code (Indecency with a child);
- Section 21.12 Penal Code (Improper relationship between educator and Student)
- Section 21.25 Penal Code (Improper photography or visual recording)
- \*An offense under Chapter 22.011, Penal Code (Sexual Assault);
- \*An offense under Chapter 22.02, Penal Code (Aggravated Assault);
- \* An offense under section 22.021, Penal Code (Aggravated sexual assault)
- \*An offense under Chapter 22.04, Penal Code (Injury to a child, elderly individual, or disabled individual);
- \*An offense under Chapter 22.041, Penal Code (Abandoning or endangering a child);
- \* An offense under section 22.05, Penal Code (Deadly conduct)
- An offense under section 22.07, Penal Code (Terroristic threat)
- \*An offense under Chapter 22.08, Penal Code (Aiding Suicide);
- \*An offense under Chapter 25.031, Penal Code (Agreement to abduct from custody);
- \*An offense under Chapter 25.08, Penal Code (Sale or purchase of a child);
- \*An offense under Chapter 28.02, Penal Code (Arson);
- \*An offense under Chapter 29.02, Penal Code (Robbery);
- \*An offense under Chapter 29.03, Penal Code (Aggravated robbery)
- \*An offense the Agency determines to be a contraindication to employment with the consumers the Agency serves.
- \*An offense that is a conviction under the laws of another state or the uniform code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed under subdivisions (1) - (13)

A person may not be employed in a position the duties of which involve direct contact with a consumer in a facility before the fifth anniversary of the date the person is convicted of:

- \*An offense under Chapter 22.01, Penal Code ( Assault); that is punishable as a class A misdemeanor or as a felony
- \*An offense under Chapter 30.02 Penal Code (Burglary);

## C & M HEALTH SERVICES

### STATEMENT OF EMPLOYABILITY/CONSENT FOR CRIMINAL HISTORY CHECK - PG 2 OF 2

- \*An offense under Chapter 31 Penal Code (theft); that is punishable as a felony
- \*An offense under Chapter 32.45, Penal Code (Misapplication of fiduciary property or property of a financial institution), that is punishable as a class A misdemeanor or a felony
- \*An offense under Chapter 32.46 Penal Code (securing execution of a document by deception), that is punishable as a class A misdemeanor or a felony
- \* An offense under section 33.02, Penal Code (Online solicitation of a minor)
- \*An offense under section 34.02, Penal Code (Money laundering)
- \*An offense under section 35 A.02, Penal Code ( Medicaid Fraud);

OR

An offense under section 420.9, Penal Code (Cruelty to animals)

In addition according to Health and Safety code 250.006 (b), persons may not be employed by HCSSAs in a position where duties involve direct contact with a consumer before the fifth anniversary of the date the person is convicted on the following offenses:

Section 37.12, Penal code (false identification as a peace officer); and

Section 42.01 (a) (7) (8), or (9), Penal code (Disorderly conduct), in addition to an offense under chapter 31, penal code (theft), that is punishable as a felony.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment.

I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

---

Signature of Applicant

---

Date

**APPLICATION FOR EMPLOYMENT** Page 1 of 4

Position(s) you are applying for: (List all positions) \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle/Maiden

Social Security Number: \_\_\_\_\_ DOB \_\_\_\_\_

TX DL# or TX ID # \_\_\_\_\_

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

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Pager # \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_  
Street

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

Are you legally authorized to work in the U. S? \_\_\_\_\_ Yes \_\_\_\_\_ No

\*\*\* You will be required to show proof of eligibility to work in the U. S, if hired.

Are you eighteen (18) years old or older? \_\_\_\_\_ Yes \_\_\_\_\_ No

Willing/Able to work: Weekends \_\_\_\_\_ Yes \_\_\_\_\_ No Holidays \_\_\_\_\_ Yes \_\_\_\_\_ No

How did you hear about us? Newspaper Ad \_\_\_\_\_ Individual \_\_\_\_\_ Other \_\_\_\_\_

Have you ever been convicted of a felony? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, give details: \_\_\_\_\_

**EMERGENCY CONTACT**

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

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

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

LICENSURE FOR SKILLED STAFF

List all the states in which you are currently licensed, certified or have been licensed or certified. Please attach copies of all current licenses and certificates where applicable.

RN/LVN TX License #: \_\_\_\_\_ Expiration: \_\_\_\_\_

List any inactive licenses you currently have \_\_\_\_\_

Has your professional license ever been suspended, revoked, or investigated? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Other Specialty Courses/special skills which may enhance your chances of getting this job: \_\_\_\_\_

\*\*\*\*\*

CERTIFICATION FOR CNAs AND HHAs

CNA or HHA TX Certificate. # \_\_\_\_\_ Expiration: \_\_\_\_\_

\*\*\*\*\*

PAS PROGRAM ONLY: \_\_\_\_\_ GED FOR ATTENDANTS/PROVIDERS

\*\*\*\*\*

EDUCATION

1. High School: \_\_\_\_\_ Name of school/City, State \_\_\_\_\_ Mo./Yr. Graduated \_\_\_\_\_

If not high school graduate, GED obtained? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes: where? \_\_\_\_\_ Year obtained: \_\_\_\_\_

2. CNA/HHA or other Training: \_\_\_\_\_ Name of school/City, State \_\_\_\_\_ Mo./Yr. Graduated \_\_\_\_\_

3. Vocational Nurse Training: \_\_\_\_\_ Name of school/City, State \_\_\_\_\_ Mo./Yr. Graduated \_\_\_\_\_

4. College/Professional Nursing/Graduate Training: \_\_\_\_\_ Name of school/City, State \_\_\_\_\_ Mo./Yr. Graduated \_\_\_\_\_



EMPLOYMENT HISTORY

List your most recent or current employer first

1. Company Name \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Address \_\_\_\_\_

Name of Supervisor/Title \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Duties \_\_\_\_\_

Reason for leaving \_\_\_\_\_

May we contact employer? \_\_\_\_\_ Yes \_\_\_\_\_ No If No, explain: \_\_\_\_\_

2. Company Name \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Address \_\_\_\_\_

Name of Supervisor/Title \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Duties \_\_\_\_\_

Reason for leaving \_\_\_\_\_

May we contact employer? \_\_\_\_\_ Yes \_\_\_\_\_ No

If No, explain: \_\_\_\_\_

3. Company Name \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Address \_\_\_\_\_

Name of Supervisor/Title \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Duties \_\_\_\_\_

Reason for leaving \_\_\_\_\_

May we contact employer? \_\_\_\_\_ Yes \_\_\_\_\_ No

If No, explain: \_\_\_\_\_

# APPLICATION FOR EMPLOYMENT

Please circle applicable skill level:

<b>Filing</b>	No Experience	Some Experience	Experienced
<b>Sorting</b>	No Experience	Some Experience	Experienced
<b>Telephones</b> How many lines? _____	No Experience	Some Experience	Experienced
<b>Typing</b> WPM _____	No Experience	Some Experience	Experienced
<b>Computer</b>	No Experience	Some Experience	Experienced
<b>Software/Programs</b>	No Experience	Some Experience	Experienced

Please list computer software or programs that you know:

\_\_\_\_\_

**Basic Office Skills:**

Making copies	No Experience	Some Experience	Experience
Faxing	No Experience	Some Experience	Experience
10-Key	No Experience	Some Experience	Experience

Please list any other languages besides English that you speak:

\_\_\_\_\_ Fluently? \_\_\_\_\_

\_\_\_\_\_ Fluently? \_\_\_\_\_

\_\_\_\_\_ Fluently? \_\_\_\_\_

I certify that the information on this application is correct and true to the best of my knowledge.

**I realize that falsification of information on this job application is grounds for withdrawal of offer of employment and/or termination of employment.**

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

\_\_\_\_\_  
Date

# CONFIDENTIAL REFERENCE VERIFICATION

Applicant's full Name / Title while at this place of employment \_\_\_\_\_

The above named applicant has indicated that he/she is or was previously employed by you. Your evaluations of him/her will be sincerely appreciated, and will be held in complete confidence. Both the applicant and I will benefit from an early reply, since his/her employment is pending.

I hereby authorize the facility/institution named below to release all information requested on this confidential reference request.

Name of Facility \_\_\_\_\_

Name of Supervisor/Title \_\_\_\_\_

Telephone Number \_\_\_\_\_ Dates of employment: \_\_\_\_\_ To \_\_\_\_\_

Applicant's Signature

Date

\*\*\*\*\*Agency may do verification via telephone\*\*\*\*\*

Check this box if Previous Employer will only verify Dates of Employment and position held by Applicant while employed at that facility or Agency

Position(s) or Title(s) held \_\_\_\_\_

Reason for leaving \_\_\_\_\_

Would you re-hire? \_\_\_\_\_ Yes \_\_\_\_\_ No If no, why not \_\_\_\_\_

Please provide further information if possible, regarding Competence, Attitude, Initiative, Attendance, Punctuality, Cooperation, Adaptability to work situations:

Signature of Agency representative

Date

# Form W-4 (2018)

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

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

**Exemption from withholding.** You may claim exemption from withholding for 2018 if both of the following apply.

- For 2017 you had a right to a refund of all federal income tax withheld because you had no tax liability, and
- For 2018 you expect a refund of all federal income tax withheld because you expect to have no tax liability.

If you're exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to find out if you should adjust your withholding on Form W-4 or W-4P.

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

## Specific Instructions

### Personal Allowances Worksheet

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

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

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

**Line F. Credit for other dependents.** When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <b>2018</b>	
▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.					
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."		
City or town, state, and ZIP code			4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>		
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption.					
• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.					
If you meet both conditions, write "Exempt" here. ▶ 7					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶					
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)				Date ▶	
9 First date of employment			10 Employer identification number (EIN)		

# Request for Taxpayer Identification Number and Certification

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

Print or type  
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
2 Business name/disregarded entity name, if different from above
3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶ _____
4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <small>(Applies to accounts maintained outside the U.S.)</small>
5 Address (number, street, and apt. or suite no.)
6 City, state, and ZIP code
7 List account number(s) here (optional)
Requester's name and address (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> </tr> </table>				
or				
Employer identification number				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> </tr> </table>				

## Part II Certification

Under penalties of perjury, I certify that:

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

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

**Sign Here**

Signature of U.S. person ▶

Date ▶

## General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at [www.irs.gov/fw9](http://www.irs.gov/fw9).

### Purpose of Form

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

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

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

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

# Texas Employer New Hire Reporting Form



Submit within 20 calendar days of new employee's first day of work to:  
**ENHR Operations Center, P.O. Box 149224**  
**Austin, TX 78714-9224**  
**Phone: 1-800-850-6442 FAX: 1-800-732-5015**  
**Online: www.employer.texasattorneygeneral.gov**

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C
---	---	---

1	2	3
---	---	---

## Employer Information

1. Federal Employer ID Number (FEIN):  
*Please use the same FEIN that appears on quarterly wage reports.*
2. State Employer ID Number (Optional):
3. Employer Name:
4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):
5. Employer City (if US):  6. State (if US):  7. ZIP Code (if US):  -
8. Province/Region (if foreign):  9. Country (if foreign):  10. Postal Code (if foreign):
11. Employer Telephone (Optional):
12. Employer FAX (Optional):
13. New Hire Contact Person (Optional):

## Employee Information

14. Social Security Number (SSN):
15. Date of Hire (MM/DD/YYYY):
16. Employee First Name:
17. Employee Middle Name:
18. Employee Last Name:
19. Employee Home Address:
20. Employee City (if US):  21. State (if US):  22. ZIP Code (if US):  -
23. Province/Region (if foreign):  24. Country (if foreign):  25. Postal Code (if foreign):
26. State Where Employee Was Hired (Optional):
27. Employee DOB (MM/DD/YYYY) (Optional):
28. Employee's Salary (Dollars and Cents) (Optional):
29. Salary Frequency (Check One ONLY) (Optional):  
 Hourly  Weekly  Biweekly  Semi-Monthly  Monthly  Annually



**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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions)	
<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 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



## 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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:                             <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                                     <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:                             <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</li> <li>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</li> <li>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>5. Native American tribal document</li> <li>6. U.S. Citizen ID Card (Form I-197)</li> <li>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>8. Employment authorization document issued by the Department of Homeland Security</li> </ol>

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



**NURSING SKILLS VALIDATION IV THERAPY**

Employee Name: \_\_\_\_\_ Completion Date: \_\_\_\_\_

Discipline:  RN  LPN Position: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Activity	Self Assessment				Skill Validation		Independent Practice		Evaluator Initial/Date
	NA	Never	< 5x	>5x	Home	Lab	Yes	No	
Peripheral IV Start									
Site Care									
Discontinue IV									
Central Lines									
Site Care, Flush, Maintenance									
Implanted Portacath Access									
Groshong									
Blood draw (CVC)									
TPN									
Administration									
Monitoring									
Dose Monitoring									
Med Admin									
Infusion Pumps									
CADD									
Other:									

Initial \_\_\_\_\_ Evaluator Signature \_\_\_\_\_

Initial \_\_\_\_\_ Evaluator Signature \_\_\_\_\_

Initial \_\_\_\_\_ Evaluator Signature \_\_\_\_\_

TUBERCULOSIS (TB) TESTING

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

Position: \_\_\_\_\_

Date \_\_\_\_\_

Date of last TB skin test: \_\_\_\_\_ Result of last TB test:  Positive  Negative

Date of last chest x-ray? \_\_\_\_\_

Have you ever had a positive TB skin test?  Positive  Negative

Have you ever had a positive chest x-ray?  Positive  Negative

Have you ever been treated for TB?  Positive  Negative

Have you ever been vaccinated with BCG serum?  Positive  Negative

It is the employee's responsibility to have TB testing. You may visit your local public health facility to have TB testing performed and to submit a copy of testing results. Please bring a copy of your TB testing results to orientation. This copy will be retained in your Confidential Personnel file. All health information is confidential

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

**HEPATITIS B VACCINATION**

Due to your occupational exposure to blood or other potentially infectious materials, you may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available, and the cost will be reimbursed by the Agency. Please indicate below your declination or acceptance to receive the vaccine.

Hepatitis B is a blood borne virus which can cause a range of symptoms from mild to serious, and possibly result in fatal liver damage to health care workers who become infected. The virus can be transmitted through contact with infectious fluids of a patient who has hepatitis B virus. You have been taught the concepts of Universal Precautions concerning safe patient care and the use of equipment to avoid unnecessary exposure.

Synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals (initial shot, one month later, and six months later – if any shots are not received timely, then the series of shots must be started over). It has proven to be over 80 – 90% effective in protecting against the disease. There may be hypersensitivity to the vaccine, and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of fewer than 3% of injections. Employees are instructed to go to the nearest County Health clinic to obtain the shots. A listing of locations is attached.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast or hepatitis antigen and will only be given with your personal physician's recommendations in the cases of pregnancy or presence of other infection of immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

**Acceptance:** I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the Hepatitis B vaccine.

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

**Declination:**  I have been given the opportunity to be vaccinated with hepatitis B vaccine, and understand the costs would be reimbursed. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material (OPIM) and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination serious and be reimbursed for the cost of the vaccine.

I have already received the hepatitis vaccine at an earlier date. I am  am not  providing a copy of the record to the Agency.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**INSERT**

Unlicensed employees whose duties include face-to-face contact with a patient insert:

Printed copy of initial and annual nurse aide registry (NAR) and employee misconduct registry (EMR)

Verification of Employability

Criminal History Check