Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

____

Date

Dear ______________________________

Please submit to us the following documents:

1 – Professional License
2 – Drivers License
3 – CPR
4 – Auto Liability Insurance
5 – Professional Liability Insurance (except for CHHA)
6 – Social Security Card
*7 – Physical Examination/Health Assessment

Note: Physical Examination/Health Assessment should be performed:

a) Within 6 months prior to employment or within 15 days of assuming employment with this agency
b) Should indicate that you are free from health conditions which would interfere with your ability to perform assigned duties
c) Should contain verification that you are free from signs or symptoms of infectious disease

*8 – TB/PPD Test (X-ray, if necessary)
9 – Passport, Green Card or Work Authorization (If applicable)
10 – Resume

*Provide this document if your duties will involve direct patient contact.

Beneficial Home Health Services, Inc.

Application for Employment
An equal opportunity Employer

Beneficial Home Health Services, Inc. is an Equal Opportunity Company and considers all applications for Employment equally regardless of race, color, and creed, national origin, sex, age, religion, veteran status or any disability that is not job related.

Applicant's Name (Last, First, Middle)			Today's Date
Address		Nursing License Number	Expiration Date
City State Zip Code		Certification Number	Effective Date
Social Security Number — —	CPR ☐ YES ☐ NO		Expiration Date
Home Phone Number (area code)	Cell Phone Number	Page Number	

WORK HISTORY – STARTING WITH YOUR MOST RECENT WORK EXPERIENCE, LIST LAST THREE (3) POSITIONS

Company's Name (Present or most present)	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name and Title/Department		Title of Your Position	
Describe Work Performed			
Reason for Leaving			
Company's Name	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name and Title/Department		Title of Your Position	
Describe Work Performed			
Reason for Leaving			
Company's Name	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name and Title/Department		Title of Your Position	
Describe Work Performed			
Reason for Leaving			
Have you ever been fired or asked to resign from a job for any reason? (if yes, please explain)			

Beneficial Home Health Services, Inc.

EDUCATION			
High School Name	Location	Diploma	
College Name	Location	Major Course	Degree
Graduate School	Location	Major Course	Degree

ARE THERE ANY REASONS YOU WOULD BE UNABLE OR UNWILLING TO PERFORM ANY OF THE TASK REQUIRED BY THE JOB YOU ARE APPLYING FOR? (IF YES, PLEASE EXPLAIN)

____

____

LIST THREE (3) PERSON WHO ARE FAMILIAR WITH YOUR WORK OR SCHOOL BACKGROUND (DO NOT LIST RELATIVES)

Name	Occupation	Address	Telephone No.	Relationship

HAVE YOU BEEN CONVICTED OF A FELONY WITHIN THE LAST SEVEN (7) YEARS?
(Conviction will not necessarily disqualify an applicant from employment) ☐ Yes ☐ No

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY ____________________
ADDRESS ____________________ TEL NO. ____________

AFFIDAVIT

I certify that my answers to the foregoing questions are true and correct and that I have not left out any significant information of any kind whatsoever. I understand that if I am employed, any false, incomplete, misleading or otherwise, incorrect statements made on this application form, any other company document, or during any interviews, may be grounds for my immediate discharge, regardless of when discovered.

I hereby, undertand and acknowledge that unless otherwise defined by applicable law, any employment relationship with other organization is of an "at the nature", which means that I may resign at any time and that the company may discharge me any time, with or without cause, and with or without prior notice. Further, I understand that this "at will" employment relationship may not be changed by any written document, or by conduct, unless such change is specifically acknowledged in writing by the authorized division/subsidiary Administrator/Director of Nursing of this organization, and the writing condition of this affidavit.

I hereby authorize the Company to contact any entity or individuals it deems appropriate to investigate my employment history, character, and justifications, and give my full and complete consent to the companies and individuals revealing any and all information as a part of the investigation. In addition, I hereby waive my right to bring any cause of action against these companies or individuals for defamation, invasion of privacy, or any other reason because of their release of information. Applicant authorizes the use of a photocopy of this affidavit as authorization. I agree that If I am employed, I will abide by all the rules, regulations, and safety programs of the Company, as well as instructions I receive from my supervisor(s).

This application will be used by the Company to decide if you are to be hired, but its receipt does not imply that you will be employed. If I am employed, I further understand and agree that when my employment is terminated by retirement or otherwise, I must return all Beneficial Home Health Services, Inc., property in my custody, including beeper, forms, nursing bag, and disposable patient supplies. Otherwise, the cost of any property not returned will be withheld from the amount due upon separation until the property is returned.

THANK YOU FOR YOUR TIME, EFFORT AND INTEREST IN JOINING OUR COMPANY

SIGNATURE OF APPLICANT ____________________ DATE ____________

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: ____________

OR

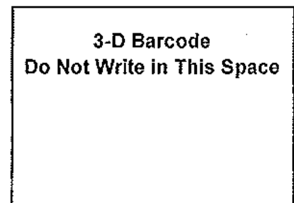
2. Form I-94 Admission Number: ____________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________

Country of Issuance: ____________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)



Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	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

Form W-4 (2013)

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. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

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 may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . **A** ______

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ______

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . **C** ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . **D** ______

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ______

F Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ______
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children.
- If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . . **G** ______

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ______

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2013

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
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 1-800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $ ______

7 I claim exemption from withholding for 2013, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ **7** ______

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

EMPLOYEE CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT is made and entered into by and between:

Employee: ____ ("Employee")

Home Health Agency: ____Beneficial Home Health Services, Inc.________ ("Agency")

Effective Date of these Terms and Conditions: ____________________________________

WHEREAS, the services of Agency performs for its patients are confidential; and

WHEREAS, by reason of employment with the Agency, Employee will have access to , will be provided with, and will, in some cases, prepare confidential and proprietary business information, such as patient services and diagnoses, employee information, financial data, and operations information, which must remain confidential for the protection of the Agency, its patients and its employees; and

WHEREAS, Employee acknowledges that he or she has received training by the Agency on all privacy policies and procedures applicable to the Employee's job function; and

WHEREAS, Employee understands that, by virtue of this Confidentiality Agreement ("Agreement"), it is hereafter a condition of employment with the Agency that all confidential information be maintained as confidential in compliance with the Agency's privacy policies and procedures as well as all applicable state and federal laws and regulations.

NOW, THEREFORE, in consideration of compensation paid in conjunction with the execution of this agreement; and intending to be legally bound hereby, the Agency and Employee agree as follows:

1. Contract Consideration. The following provision that is initialed and dated by both parties is hereby incorporated into this Agreement (initial and date only one provision, and only the initialed and dated provision is made part of theses Terms and Conditions):

In consideration of employment, Employee agrees to the Terms and Conditions as provided herein.

______________	______________
Employee Initials/Date	Agency's Initials/Date

2. Confidentiality. Employee shall not, at any time during or following employment with the Agency, disclose or use, except as required in the course of employment, any confidential or proprietary information of the Agency whether such information is in memory or embodied in writing or other physical form. Confidential or proprietary information (i) is information that is not generally available to the general public, or competitors, or ascertainable through

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217, Brea, CA 92821 Tel. (714) 256-0756 Fax (714) 256-0754

To: ______________________________

____

____

Date: ______________________________

VERIFICATION AND REFERENCE CHECK

The undersigned, having applied for a position with Beneficial Home Health Services, Inc. does hereby authorize you to provide BHHS with the information requested herein, I specifically consent to disclose in accordance with the provisions of all applicable and state laws.

Name: ______________________________ SSN: ____________ Position: ____________

Dates: From__________ To______________ Signature______________________________

Is the above information correct? Yes ☐ No ☐

Eligible for Rehire Yes ☐ No ☐

	Above Average	Average	Below Average
Dependability			
Punctuality			
Quality of Work			
Job Knowledge			
Attitude			

Comment:____

____

Overall Performance: Excellent______ Good_______ Fair______ Poor________

REASON FOR LEAVING (if applicable): ______________________________________

Printed Name:______________________ Title:______________ Date:______________

Signature:____

Beneficial Home Health Services, Inc.
770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-5054

AUTHORIZATION FOR BACKGROUND CHECK

I hereby authorize BENEFICIAL HOME HEALTH SERVICES, INC. to conduct a criminal background check, using the information provided below.

I acknowledge that in order to be employed at BENEFICIAL HOME HEALTH SERVICES, INC. this criminal background check must be conducted.

I understand that the information obtained during the criminal background check will be solely for the purpose of employment and will remain confidential.

I understand that if I am subject to a state criminal offense, I am deemed unsuitable for and may not be employed according to BENEFICIAL HOME HEALTH SERVICES, INC. policy.

However, before such determination is made, I will have the opportunity to review and challenge the factual accuracy of the criminal background result.

____ ____________________
Applicant Signature Date

First Name: ____ MI: __________

Last Name: ____

Date of Birth: ______________________________________

City: ______________________________ State: _____________

County: ____________________________ Zip Code: _____________

- If residency at above address is less than one year, please list pervious address:

City: ______________________________ State: _______________

County: ____________________________ Zip Code: ______________

Beneficial Home Health Services, Inc.
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PAY RATE AGREEMENT

Name:	Date of Hire:
Position:	Department:

Pay Rate:

☐ Rate per Visit
- Evaluation = $ ________
- Follow-up Visit = $ ________
- Recertification = $ ________
- Discharges = $ ________

☐ Rate Per Hour = $ ________

☐ Rate Per Month = $ ________

I agree to abide by BENEFICIAL HOME HEALTH SERVICES, INC. Policy and Procedures regarding Clinical Documentation and Timely Submission of Clinical notes/documents as per Management of Information Policy and Clinical Documentation. I further agree to abide by BENEFICIAL HOME HEALTH SERVICES, INC. Policy and Procedure regarding Initial and Comprehensive Assessment and Update of the Comprehensive Assessment.

Signature:	Date:
Acknowledged/Approved By:	Date:

FOR PAYROLL DEPARTMENT USE ONLY

Posted By:	Date:

BENEFICIAL HOME HEALTH SERVICES, INC.

Acceptance of Employment Form

I, ______________________________, accept the position of
(Print Name)

_________________________. I will abide by the requirements of
(Position Title)

the position description and the salary/hourly rate designated rate of

Status at Hire: ☐ Full Time ☐ Part Time ☐ Per Diem ☐ Contractual

_________________________.

_________________________ Signature

_________________________ Date

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

DOCUMENTATION TIMELINE

Field staff of Beneficial Home Health Services, Inc. agree to abide by the documentation timelines of the company concerning all patient related paperwork. Please read and review this timeline, as it is imperative that we follow it in order to remain in compliance with our company Policies and Procedures and the Medicare Conditions of Participation.

Start of Care Evaluation (SOC) / Re-Certification Evaluation (Re-Cert) / Resumption of Care Evaluation (ROC) / Discharge Evaluation

____________ (initial) Verbal Report to be given immediately to the Case Manager, not to exceed 24 hours from the Evaluation date.

____________ (initial) All paperwork to be submitted to BHHS within 48 hours of the Evaluation.

Follow-up Notes and Additional Paperwork

____________ (initial) To be submitted weekly by 5 PM on the Monday after the visit occurred.

Chart Completion for End of Certification or Discharge

____________ (initial) All notes for the patient's chart must be submitted by the Monday after the patient's End of Certification of Discharge Date. The Discussed Discharge or Re-Certification with the Case Manager shall be considered the verbal request for all paperwork necessary to complete the chart or previous certification.

____________ (initial) 2 weeks after the patient's End of Certification or Discharge Date, BHHS will send a written request to the appropriate employee(s) if the patient's chart has not been satisfactorily completed.

____________ (initial) 3 weeks after the patient's End of Certification or Discharge Date, BBHS will send a 2nd written warning and request to the appropriate employee(s).

____________ (initial) 4 weeks after the patient's End of Certification or Discharge Date, if it has been decided that attempt to complete the necessary paperwork has not been sufficient, a 3rd letter will be sent to the appropriate employee(s), stating that lacking notes will no longer be accepted and will not be paid.

TIMELINESS OF DOCUMENTATION & SUBMISSION

RATIONALE

Home Health agencies are obligated to meet very strict guidelines as specified by California Title 22 and Medicare Conditions of Participation when it comes to documentation of services rendered to its home health recipients. Agencies found out of compliance may be subject to disciplinary actions by regulatory Agencies, including revocation of privileges to provide the Medicare Home Health Benefit. The burden of the responsibility to submit medical records in a timely manner must be shared by the staff/ contractor involved.

PURPOSE

To define the timeframe that documents are expected to be completed and be included in the clinical record.

To define the actions available to the Agency in the event of non-compliance to the State and Federal regulations as well as Agency policy.

POLICY

Clinical documentation from home visits by employees and/or contract staff will be ***completed the day of the visit*** and submitted to the home health office in a timely manner meeting the requirements as specified by Title 22 and Medicare Conditions of Participation.

PROCEDURE

1. **All clinical documentation must be completed *the same day* the visit is made.** ______
2. The Contractor shall personally prepare, complete and submit the initial evaluation to the agency within 72 hours from the time of initial visit.
3. The Contractor shall personally prepare, complete and submit all pertinent documents including clinical notes and progress notes to the agency within 7 days of visit from 9:00AM to 5:30PM.

   ______
4. OASIS documentation, Clinical notes and route sheets may be faxed to the Agency within that timeframe, with the original to be submitted to the Agency by the end of the following week.

   ______
5. The contractor understands that home health visits are not complete until 1) the visit is made and 2) a BILLABLE note is submitted. Therefore, no visit will be paid unless both criteria are met. The contractor understands it is his/ her responsibility to clarify deficient notes. ______
6. It is the responsibility of the visiting staff/ contractor to confirm receipt of the clinical documentation by the Agency. ______
7. It is the responsibility of the visiting staff/ contractor to maintain a copy of both the clinical records and the route sheet in the event that submitted records are "misplaced". ______

Printed Name ____________________ Signature ____________________ Date ______________

8. Failure to submit documentation 1 week from the day of the visit could result in a verbal warning. ______

9. Failure to submit documentation 2 weeks from the day of the visit could result in the visiting professional being relieved of his/ her duties and a written warning which will be placed in the employee's personnel record. ______

10. Failure to submit documentation 3 weeks from the day of the visit could result in a written grievance form being sent to the appropriate Board (See Complaint Process Attachments 5-023.B and 5.023.C) ______

11. Documentation submitted greater than 3 weeks from the date of the visit will be accepted for processing. However, payment will be reduced to a rate equal to an hour of the State minimum wage as set by California Labor Code (currently set at $8). ______

BY SIGNING BELOW, I AFFIRM THAT I HAVE THOROUGHLY READ THROUGH AND AGREE TO ABIDE BY THE AGENCY'S POLICY REGARDING TIMELINESS AND SUBMISSION OF DOCUMENTATION.

Printed Name ______________________ Signature ______________________ Date ______________

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217, Brea, CA 92821 Telephone No: (714) 256-0756 Fax No:(714) 256-0754

HEALTH HISTORY AND PHYSICAL EXAMINATION

Date of Employment: ________________________ Position: ____________________

Health History (To be completed by Employee)

Have you had or do you have any of the following conditions (check Yes or No).

Allergies: No ☐ Yes ☐ List:

____

	Yes	No		Yes	No
Back Pain	☐	☐	Hepatitis	☐	☐
Chest Pain	☐	☐	High Blood Pressure	☐	☐
Chronic cough	☐	☐	Low Blood Pressure	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Epilepsy	☐	☐	Shortness of Breath	☐	☐
Fainting or Dizziness	☐	☐	Tuberculosis	☐	☐
Hearing Disability	☐	☐	Varicose Veins	☐	☐
Headaches (frequent)	☐	☐	Venereal Disease	☐	☐
Heart trouble	☐	☐	Visual Problems	☐	☐

Other: ____

Physical Exam: (to be completed by Physician)

Height __________ Weight __________ Blood Pressure _________ Pulse __________

PPD Test: Indicate: Negative _____ Positive _____ Erythema = _____mm. Induration = _____mm.

A positive PPD must be followed by a 35.56 cm x 43.18 cm (14" x 17") chest X-ray unless contraindicated by the physician.

Chest X-ray Results: ____

Any Treatment recommended for Positive Chest X-ray ______________________________

Comments: ____

I certify that the applicant is physically and medically qualified to perform the duties assigned and has no health condition that would create a hazard to patients.

Physician's signature: ________________________________ Date: ____________________

Physician's Address: ____

Street City Zip

Physician's Telephone Number: ____

Applicant's Name (Printed): ______________________________ SS#: _________________

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VACCINATION DECLINATION FORM

***Please print clearly ***

Employee Name:

____

Last First MI

Discipline:____________________SS#_______ - _______ - _______

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to me. However, I decline this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature/Title: ____

Date:__________________

Agency Representative Signature/Title:______________________________

Date:__________________

Beneficial Home Health Services, Inc.

Hepatitis Vaccine Requirement

I ____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

_________ request that I receive the Hepatitis vaccine.

_________ refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

_________ provide written proof of immunity (attach)

_________ provide written proof of previous vaccination (attach)

_________ provide written proof of medical contraindication (attach)

Signature: ______________________________________ Date: ______________

Supervisor or witness: ____________________________ Date: ______________

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ADA REQUIREMENTS

Position: ____

The information below is intended to describe the general context/requirements for performance of this job. During the workday, this position requires the activities listed. *It is not to be considered an exhaustive statement of duties responsibilities, or requirements and does not limit the assignment of additional duties.* The frequency of each activity is identified by the following columns:

Physical activities required in this position	**Rarely Less than .5 hr/day**	**Occasionally .5 to .25 hr/day**	**Frequently 2.5-5.5 hr/day**	**Continually 5.5-8.0 hrs/day**	NA
Sitting					
Stationary standing					
Walking on a variety of surfaces (inside/outside)					
Ability to be mobile					
Crouching (bending at knees)					
Kneeling/Crawling					
Stooping (bending at waist)					
Twisting (knees/waist/neck)					
Turning/Pivoting					
Climbing					
Balancing					
Reaching Overhead					
Reaching Extension					
Grasping					
Pinching					
Position requires individual to:					
• **Push/Pull**					
- Less than 20 pounds					
- Typical Weight: 20 to 50 pounds					
- Maximum Weight: 75-100 pounds					
• **Lift/Carry**					
- Less than 20 pounds					
- Typical Weight 20-50 lbs					

Physical activities required in this position	**Rarely Less than .5 hr/day**	**Occasionally .5 to .25 hr/day**	**Frequently 2.5-5.5 hr/day**	**Continually 5.5-8.0 hrs/day**	NA
- Maximum Weight 75-100 pounds					
Other (specify):					
Sensory Activities					
Talking in person					
Talking on the telephone					
Hearing in person					
Hearing on telephone					
Vision for close work					
Other (specify):					
Environmental Considerations					
Driving a car in all weather conditions					
Providing services in variety of environment					
Potential for exposure to infections disease					
Ability to manage clinical equipment/machines					

I have read and understand the job description of ________________________________
as described on these pages.

Signed: ______________________________________ Date: _____ / _____ / _____

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

COORDINATION OF CARE

It is the policy of Beneficial Home Health Services, Inc. that the skilled nurse shall be responsible for notifying physician for every significant change in patient's condition.

The following conditions must be reported to the attending physician once they are identified:

1. Temperature of > 100F
2. Blood pressure SBP > 160 or <90, DBP > 100 or < 50, unless reporting parameters were established by attending physician.
3. Blood sugar <80 mg/dl or > 300 mg/dl unless specified by attending physician.
4. Signs and symptoms of hyper/hypoglycemia.
5. Presence of adventitious breath sounds, cyanosis, and increasing SOB or respiratory rate of < 14/min, or >24/min.
6. Fainting episodes.
7. Sudden changes in mental status/behavior, decreasing level of consciousness.
8. Falls, with or without injury.
9. Visual changes, slurred speech, weakness and numbness of extremities.
10. Chest pain not relieved by NTG or rest.
11. Wound not responding to prescribed treatment regimen in 4 weeks.
12. Bleeding from any orifice/impending signs and symptoms of shock, call 911.
13. Signs and symptoms of drug, food reaction such as itchiness, SOB, rash, palpitation, confusion.
14. Signs and symptoms of drug toxicity and sub-therapeutic levels.
15. Any abnormal laboratory results.
16. Pulse <60/min, or >120/min.
17. Unusual incidents and occurrences.

Any field staff is responsible for notifying the PMD/DPCS/Case Manager promptly (within 24 hours) of any significant change in patient's condition or treatment plan (MD orders, need for other services, etc.).

______________________	______________________	______________
Name	Signature	Date

Beneficial Home Health Services, Inc.
770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714)256-0754

FIELD PERSONNEL STANDARDS AND PROCEDURES

Beneficial Home Health Services, Inc. requires adherence to the following standards and procedures:

1. All personnel are expected to dress in a manner appropriate to the health care environment, or as directed by the client/patient's family. This includes personal hygiene, jewelry, hair and make-up.
2. Smoking in the presence of the client/patient is prohibited.
3. Licensed personnel must always wear the company's badge, and carry their current professional license and CPR card while on assignment.
4. All personnel are expected to arrive on time to all accepted assignment. However, in the case of emergency or any other situation that should cause absence or at least a five minute delay on the assignment, Beneficial Home Health Services must be notified immediately.
5. If you have any problems, incident, or accidents on the job, do not discuss it with the client/patient, call Beneficial immediately.
6. If you are relieved by someone else, do not leave until your relief person has arrived.
7. Any deviation from the scheduled duration of assignment must be authorized by Beneficial Home Health Service, Inc.
8. Paraprofessional personnel (i.e. aides) hereby acknowledge that they WILL NOT UNDER ANY CIRCUMSTANCE, DISPENSE OR ADMINISTER ANY MEDICATION.
9. Under no circumstance is the client/patient's personal property to be asked, accepted or taken home.
10. Any involvement with the client/patient's financial affairs (i.e. check writing) is strongly prohibited.
11. All personnel are expected to honor the confidentiality of any client/patient information which is obtained in the regular course of employment.
12. No services of any kind, that require the "touching" of any person or running errands for others, will be performed on non-Beneficial Home Health Services patients.
13. All services must be provided by qualified assigned Beneficial staff.
14. No form of compensation will be accepted/made to or by Beneficial Home Health staff for services to be provided by Beneficial Home Health staff.

INITIAL HERE: ___________

Beneficial Home Health Services, Inc.
770 S. Brea Blvd., Suite 217, Brea, CA 92821 Tel: (714)256-0756 Fax: (714)256-0754

Reporting of Child, Elder, Dependent Adult Abuse and Domestic Violence

California law requires the reporting of incidents of child, elder, dependent adult abuse and/or domestic violence that comes to your attention in your professional capacity. Please read the statements below and sign in the space provided to acknowledge that you will comply with the reporting requirements. If you have any questions, or need assistance with this requirement, please notify your Supervisor.

Chapter 1396, Status of 1987 mandates the reporting of any suspected Dependent Adult/Elder physical abuse. Any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who in his or her professional capacity or within the scope of his or her employment, either has observed an incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse either to the long-term coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a protective services agency or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report (SOC 341) thereof within two (2) working days.

Any person knowingly failing to report, when required, an instance of elder or dependent adult abuse is guilty of a misdemeanor punishable by imprisonment in the county jail for a maximum of six (6) months or fine $100 or both imprisonment and fine.

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non medical practitioner, or employee of a child in his or her professional capacity or within the scope of his or her employment who he or she know or reasonably suspects on an instance of child abuse, to report to the child protective agency immediately or as soon as practically possible by telephone and/or prepare and send a written report thereof within 36 hours of reviewing the information concerning the incident.

Section 11160 of the Penal Code requires health care workers to report known or suspected cases of a wound or injury resulting from domestic violence or spousal abuse. Such cases must be reported immediately by telephone (or as soon as practically possible) to the local law enforcement agency, followed by a written report to the local law enforcement agency within two (2) working days.

________________________ __________________

Signature Date

Job Title/Position: *Licensed Practical/Vocational Nurse*

Reports To: *Clinical Supervisor*

Supervised By: *Registered Nurse*

JOB DESCRIPTION SUMMARY

The Licensed Practical/Vocational Nurse is responsible for providing direct patient care under the supervision of a registered nurse. Responsibilities include following the plan of care, providing treatments, and working collaboratively with the members of the team to help meet positive patient care outcomes.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

1. Provides direct patient care as defined in State Nurse Practice Act.

2. Implements current nursing practice following a patient assessment and an approved plan of care initiated by the registered nurse.

3. Provide accurate and timely documentation of patient services to reflect the plan of care.

4. Assess and provide patient and family/caregiver education and information pertinent to diagnosis and self plan of care.

5. Participates in coordination of Home Health services, appropriately reporting the identified needs for Home Health interdisciplinary group members. Examples include Home Health aide, OT, PT, MSW, ST, Dietitian or Clinical Supervisor.

6. Uses equipment and supplies effectively and efficiently.

7. Provides appropriate pain/symptom management. Evaluates patient's response to treatments/medications.

8. Participates in personal, professional growth and development. Also participates in organization's quality management program.

9. Performs other duties as assigned by the registered nurse.

The above statements are intended to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job-related tasks other than those stated in this description.

Job Title/Position: *Licensed Practical/Vocational Nurse*

POSITION QUALIFICATIONS

1. Graduate of an accredited practical nurse or vocational nursing program.
2. Three years nursing experience. Community health/Home Health or medical/surgical experience is preferred.
3. Currently licensed as an LPN/LVN in the State.
4. Complies with accepted professional standards and practice.
5. Demonstrates good verbal and written communication, and organization skills.
6. Must be a licensed driver with an automobile that is insured in accordance with state and/or organization requirements and is in good working order.
7. Understands philosophy of Home Health concept. Also understands needs of the terminally ill.

Beneficial Home Health Service, Inc.

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PERSONNEL ORIENTATION CHECKLIST

Name : ______________________________ Date: _____/_____/_____

Personnel Orientation Checklist	Date Completed	Orientation by Whom	Personnel Initials
A. Completion of all Employment forms			
B. Orientation content for all personnel will include the following as applicable and approiate to the care and service provided:			
1. Overview of agency mission			
2. Organizational structure			
3. Goals, philosophy, and objectives			
4. Services provided by the agency			
5. Contract agreement, if applicable			
6. Medicare, Medicaid and state license regulatory board			
7. Overview of functions and coordination with other services			
8. Client rights and responsibilities			
9. Infection prevention control,OSHA Blood borne pathogen policies, TB and Hepatitis prevention and control, Hepatitis B declination			
10. Advance Directives/DNR-DNI/ Procedures regarding death and dying			
11. Emergency preparedness within agency and in the home			
12. Vulnerable adult and child screening and reporting			
13. Performance Improvement expectations and plan			
C. Agency personnel policies, including employee grievance procedures, safety magnt. programs and individual employee.Non Discrimination policy ,Sect. 504			
D. Hazardous materials/waste management			
E. Confidentiality of client information (signed and dated confidentiality statement)			
F. Ethical issues			
G. Documentation and reporting guidelines			
H. Plan of Care 485			
I. Oasis: Start of Care (SOC),Transfer,Resumption of Care (ROC), Re-certification,Discharge			
J. Guidelines for Completion of Documentation			
K. Documentation Timeline			

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— LICENSED PRACTICAL/VOCATIONAL NURSE

Name: ______________________________

Date of Employment: ____________________ Date Completed: ________________

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:	*		
				1. Assess patient response to treatment			
				2. Transfer of Patient	*		
				3. Attends Case Conference	*		
				4. Adheres to POC	*		
				5. Performs services as ordered	*		
				6. Reports and documents key information to physician, DC planner, Case Manager, pharmacist, supervisor	*		
				7. Communicates/coordinates as appropriate with other team members	*		
				8. Coordinates community resources	*		
				9. Documents according to POC			
				a. Medicare guidelines for documentation	*		
				b. Corrections to the clinical record	*		
				c. Accident/incident reports	*		
				d. Clinical notes, flow charts	*		
				10. Other			
				a. HME requisition and management			
				b. Supply requisition and management			
				B. Review of Systems: Demonstrates ability to obtain and document appropriate age specific history/ assessment for patients in the following categories:			

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				1. Pulmonary System			
				a. Pulmonary Assessment			
				b. Tracheostomy care			
				c. Oxygen administration			
				d. Pharyngeal suction			
				e. Use of oral/nasal inhalers			
				f. Oxymeter			
				g. CPAP			
				h. Oxygen mask, nasal cannula, concentrator, portable oxygen			
				i. Airway insertion			
				j. SVN/Nebulizer treatment			
				k. Home ventilator management			
				l. Foreign body airway obstruction			
				m. Breathing exercises/incentive spirometry			
				n. Other			
				2. Cardiovascular System			
				a. Cardiovascular assessment			
				b. Pulses (apical, radical, femoral, pedal)			
				c. Edema assessment and management			
				d. Supine and orthostatic blood pressure			
				e. NTG use, inhaler use			
				f. CPR			
				g. Energy conservation techniques			
				h. Other			
				3. Neurologic System			
				a. Neurologic assessment			

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				b. Aphasia care			
				c. Mental status exam			
				d. Seizure precautions			
				e. Spinal cord injuries care			
				f. Head injury care			
				g. Other			
				4. Gastrointestinal System			
				a. Gastrointestinal assessment			
				b. NG tube insertion/care			
				c. Jejunostomy tube care			
				d. Gastrostomy tube care			
				e. Enteral feedings			
				f. Suction machine(s)			
				g. Ostomy care			
				h. Dysphagia precautions			
				i. Impaction removal			
				j. Enema			
				k. Bowel training			
				l. Other			
				5. Genitourinary System			
				a. GU assessment			
				b. Urinary catheterization insertion and care (male and female)			
				c. Irrigation of catheters			
				d. Obtaining specimens			
				e. Removal of urinary catheter			
				f. Care of supra-pubic catheter			
				g. Care of urostomy			

Self Assessment – Do you have experience with this skill?		Are you competent performing the following:		Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
YES	NO	YES	NO				
				h. Bladder training			
				i. Nephrostomy tubes			
				j. Knowledge of types of catheters and indications for use (straight, indwelling, condom)			
				k. Ileostomy care			
				l. Incontinence care			
				m. GU post op care			
				n. Other			
				6. Integumentary/Wounds/Dressings			
				a. Assessment of skin/wound			
				b. Measurement of wounds			
				c. Wound irrigation			
				d. Wet to dry dressing(s)			
				e. Decubitis care:			
				• Assessment and staging			
				• Prevention			
				• Various treatments (hydrocollid, calcium, alginate, transparent films)			
				• Documentation/pictures			
				f. Ace wrap, case care, compresses			
				g. Hemovac			
				h. Sterile dressing change			
				i. Suture/staple removal			
				7. Musculoskeletal System			
				a. Assessment			
				b. Range of motion (ROM)			
				c. TED hose			
				d. Total knee care			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				e. Total hip care			
				f. Case assessment and care			
				g. Devices:			
				• Walker			
				• Wheelchair			
				• Transfer board			
				• Hoyer lift			
				h. Pain assessment			
				i. Transfers			
				j. Other			
				8. Metabolic			
				a. Assessment			
				b. Diabetic assessment and teaching			
				• Insulin types and teaching			
				• Use, care and teaching of glucose monitoring system			
				• Diet, exercise and sick day teaching			
				• Signs and symptoms of Hypo-Hyperglycemic reactions			
				• Foot and skin care			
				c. Coumadin therapy			
				d. Other			
				9. Behavioral Health			
				a. Assessment			
				b. Suicide precautions			
				c. Psychotropic drugs			
				d. Care of the demented patient			
				e. Other			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				10. Miscellaneous Skills			
				a. Vital signs			
				b. Intake and output			
				c. Caring for immuno-compromised patients			
				d. eye/ear irrigation			
				e. Post mortem care			
				f. Collection, labeling and delivering laboratory specimens (blood, urine, sputum, wound, stool)			
				C. Medication Administration: Demonstrates ability to administer, monitor and document medications for patients.			
				1. Medication Administration techniques			
				a. Oral			
				b. Intra muscular			
				c. Subcutaneous			
				d. Suppositories			
				e. Ear, eye, nose drops			
				f. Heparin administration			
				g. Insulin administration, site rotation			
				h. Assessment for side effects, adverse reactions, therapeutic response			
				D. Infection Control			
				1. Hand washing technique	*		
				2. Aseptic technique	*		
				3. Proper bag technique	*		
				4. Safe needle technique	*		
				5. Personal protective equipment	*		
				6. Exposure control plan	*		

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				7. TB exposure control plan	*		
				8. Reporting of infections for patient and staff	*		
				9. Standard precautions	*		
				E. Equipment			
				1. Displays knowledge of the following:			
				a. Electric bed			
				b. Special beds			
				c. Alternating pressure mattress			
				d. Infusion pumps			
				e. Ambulatory infusion devices			
				2. Home Glucose Monitoring:			
				a. Verbalizes purpose of test	*		
				b. Specimen collection	*		
				c. Instrument calibration	*		
				d. Quality control process	*		
				e. Test correctly performed and interpreted	*		
				3. Other			
				F. Safety			
				1. Restraints, indications and policy			
				2. Fire extinguishers			
				3. Emergency preparedness			
				4. Hazardous materials			
				5. Assessment of patient safety risks and home safety			
				G. Patient Education			
				1. Determine patient and family learning needs	*		
				2. Sets measurable objectives	*		

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				3. Develops/implements teaching plan	*		
				4. Evaluates effectiveness of teaching	*		
				5. Revises teaching plan based on patient needs	*		
				6. Documents response to teaching	*		
				7. Provides instruction in the following:			
				a. Emergency care	*		
				b. Diet and nutrition	*		

Comments:

____

____

Employee Signature	Date
Supervisor Signature	Date
Preceptor(s)	Date
Preceptor(s)	Date
Preceptor(s)	Date

PERFORMANCE EVALUATION

Job Title/Position: *Liscensed Practical/Vocational Nurse*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other Page 2

Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance

B. Organizational Responsibilities	Rating
1. Adheres to patient assignments as directed by immediate Clinical Supervisor.	1 2 3 4
2. Nursing care is covered by medical orders from the physician as appropriate.	1 2 3 4
3. Maintains an acceptable work record. ______ Days Tardy ______ Days Absent	1 2 3 4
4. Informs coordinator of availability weekly.	1 2 3 4
5. Reviews policy manual when patient care procedures and organization personnel procedures need clarification.	1 2 3 4
6. Accepts responsibility for behavior and activity.	1 2 3 4
7. Is respectful of individuals rights in interacting with patients, families/caregivers and coworkers.	1 2 3 4
8. Follows organization guidelines in practice of: (a) Infection Control (b) Fire/Safety (c) Patient Care Stds.	1 2 3 4
9. Displays appropriate management of equipment and supplies (acquisition to distribution).	1 2 3 4
10. Participates in organization quality activities to improve organizational performance.	1 2 3 4
11. Interacts collaboratively with all team members.	1 2 3 4

Targeted Goals For Next Review Cycle: ______________________________

____

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Comments:

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Reviewer: ______________________________ Date: __________
Name of Personnel: ______________________________ Date: __________

PERFORMANCE EVALUATION

Job Title/Position: *Liscensed Practical/Vocational Nurse*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 1**

Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance

A. Patient Care Responsibilities	Rating
1. Provides direct patient care as defined, in State Nurse Practice Act.	1 2 3 4
2. Implements plan of care initiated by the clinician.	1 2 3 4
3. Provides accurate and timely documentation consistent with the plan of care.	1 2 3 4
4. Assesses and provides patient and family/caregiver education and information pertinent to diagnosis and plan of care.	1 2 3 4
5. Participates in coordination of Home Health services, appropriately reporting the identified needs for other disciplines (HHA, OT, PT, MSW, ST, Dietician) to the clinician and/or Clinical Supervisor.	1 2 3 4
6. Uses equipment and supplies effectively and efficiently.	1 2 3 4
7. Participates in personal, professional growth and development.	1 2 3 4
8. Performs other duties as assigned by the RN.	1 2 3 4

Targeted Goals For Next Review Cycle: ______________________________

____

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Comments: ______________________________

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Reviewer: ______________________________ Date: __________

Name of Personnel: ______________________________ Date: __________