Nannys for Grannys

34 Sunset Lane Patchogue NY 11772
Phone: 631-730-8500
Fax: 631-569-4989

Mandatory Documents for Employment

***Please be sure to check off and send all of the documents requested below**

Expiration Date

- _____ (1,2,3) Skilled Professional Agreement _____
- _____ (1R,2R) Employment Application _____
- _____ (12R,13R) Reference Request Form _____
- _____ (15R,16R) I-9 List A_____ List B_____ List C_____
- _____ (19R) Fingerprint Consent Form _____
- _____ (21R) Drug Free Workplace _____
- _____ (22R) Pre Employment Physical Assessment

PPD_____Chest XRay_____Rubella_____Rubeola_____DrugScreen_____FluShot_____

- _____ (23R) PPD (23R) _____
- _____ (24R) Hepatitis B Vaccine Program _____
- _____ (28R) Declination Of Influenza Vaccination (28R) _____
- _____ (29R) Employee Vaccination Policy Acknowledgement of Receipt _____
- _____ (62R) Authorization For Release of confidential HIV Related Information _____
- _____ (63R) HIV Confidentiality Statement and Acknowledgement _____
- _____ Copy of License or Certificate #_____Expiration Date_____
- _____ Background Check Y/N_____Agency Reporting_____

Social Security Number_____Birth Date_____

Pay Rate_____Tax Status_____

Nannys for Grannys

34 Sunset Lane Patchogue NY 11772
Phone: 631-730-8500

SKILLED PROFFESIONAL AGREEMENT

This Agreement is made effective as of _____by and between Nannies for Grannies, Inc. of 34 Sunset Lane Patchogue NY 11772 and:

_____
NAME

_____
ADDRESS

_____
CITY, STATE, and ZIP CODE

In this Agreement, the party who is contracting to receive services shall be referred to as "NFG Inc." and the party who will be providing the services shall be referred to as "SP" "Skilled Professional."

Skilled Licensed Professional is a: (Initial one)

___ **Registered Nurse (RN)** providing private duty nursing services or skilled nursing visits in a home health care setting, paid on an hourly basis or at a flat rate to be determined between NFG. and RN.

___ **Licensed Practical Nurse (LPN)** providing private duty Nursing services or skilled nursing visits in a home health care setting, paid on an hourly basis or at a flat rate to be determined between NFG and LPN.

___ **Licensed Physical Therapist (PT)** providing private Physical Therapy visits in a home health care setting, paid on an hourly basis or at a flat rate to be determined between NFG and PT.

___ **Licensed Occupational Therapist (OT)** providing private Occupational Therapist service visits in a home health care setting, paid on an hourly basis or at a flat rate to be determined between NFG and OT.

___ **Licensed Respiratory Therapy (RT)** providing private Respiratory Therapy services visits in a home health care setting, paid on an hourly basis at a flat rate to be determined between NFG. and RT.

___ **Licensed Medical Social Worker (MSW)** providing private duty medical social worker service visits in a home health care setting, paid on an hourly basis or at a flat rate to be determined between NFG. and MSW.

___ **Licensed Nutritional Therapy Practitioner (NTP)** providing private Nutritional Therapy service visits in a home health care setting, paid on an hourly basis or at a flat rate to be determined between NFG. and NTP.

SP is willing to provide the applicable services, as indicated above, to NFG Inc., and NFG Inc. desires to obtain such services provided by SP.

Skilled Professional Responsibilities:

Skilled Professional's duties shall include, without limitation, the following:

1. Practices with professionalism, compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. Accepting assignments from NFG Inc. and fulfilling responsibilities to patient and NFG Inc. in accordance with patient physician orders, current standards of practice, and regulatory requirements.

3. Conform to all policies and procedures of NFG Inc. including upkeep of personnel record requirements. Personnel records include, but are not limited to, all applicable licensures, TB screening, Hep B, flu vaccination, and CPR certification.

4. Complying with the provisions of all state, local and federal laws, regulations, ordinances, requirements and codes which are applicable to the performance of services to be rendered.

5. Not discriminating against any person on the basis of race, color, national origin, age, sex, sexual orientation, religion, disability, or any other protected basis under federal, state, and local laws, in the performance of work for NFG Inc.

6. Adhering to privacy and confidentiality of patient records and communication as outlined in HIPAA regulations and agency policy.

7. The SP will maintain a current NYS license as a Registered Professional, NYS Certification as a SP as stated above, a valid DEA number, current malpractice insurance, current CPR as well as valid driver's license and current auto insurance (if performing home and/or outside agency visits)

8. The SP will supply his/her own tools and examination instruments pertaining to each individual contracted service.

TERMINATION AND AT-WILL EMPLOYMENT

SP status with NFG is at will. Thus, either or NFG Inc. may terminate SP's service with the Company at any time, for any reason or no reason, with or without cause, advance notice, or warning.

RETURN OF RECORDS

Upon termination of SP's duties with the NFG, SP immediately shall deliver all records, notes, data, memoranda, models, and equipment of any nature that are in SP's possession or under SP's control and that are NFG Inc.'s property or relate to NFG Inc.'s business or patients.

CONFIDENTIALITY

Employee shall protect the confidentiality of all records and other materials containing personal identifying information the Company's patients. Any disclosure of protected health information will only be done in accordance with HIPAA guidelines. Except as provided by law, no information in possession of SP about any individual shall be disclosed in any form, including identifying information, without the prior written consent of the person in interest, a minor's parent, or guardian.

SP shall not, either during the term of this Agreement or at any time subsequent to that date upon which his or her relationship with NFG, Inc. shall terminate, for any reason whatsoever, disclose to any person or entity, other than in the discharge of his or her contractual duties to NFG, Inc., any information concerning (a) the business operations or internal structure of NFG, Inc.; (b) the shareholders, officers, or employees of NFG, Inc.; (c) his or her work performed for NFG, Inc.; or (d) any method or procedure relating or pertaining to projects developed or implemented by NFG, Inc. or contemplated by NFG, Inc. to be developed or implemented. Further, upon termination of SP'Ss relationship with NFG, Inc. for any reason whatsoever, SP shall not take with him or her, without the prior written consent of the Board of Directors of NFG, Inc., any drawing, blueprint or other reproduction, any data, reports, programs, tapes, card decks, listings (including, but not limited to, shareholder lists), programming documentation, or any other written, graphic or recorded information, instrument or document relating or pertaining to NFG, Inc. As a violation by NFG of the provisions of this paragraph could cause irreparable injury to NFG Inc. and there is no adequate remedy at law for such violation, NFG, Inc. shall have the right, in addition to any other remedies available to it, at law or in equity, to enjoin NFG in a court of equity for violating such provisions without posting a bond.

Independent Contractor

The SP is solely esponsibile for his/her own state and federal taxes, FICA, Social Security, Medicare, workers' compensation, and unemployment insurance. As an independent contractor, the SP is not entitled to any fringe benefits, such as unemployment insurance, medical insurance, pension plans, vacations, sick or holiday pay or other such benefits that may be offered to regular employees by NFG. The SP will pay all automobile expenses related to home/agency visits unless otherwise stated or approved in writing

Payment for professional services will be rendered once all required documents and or necessary forms have been completed in its entirety and received by NFG

AMENDMENT

This Agreement may be modified or amended only if the amendment is made in writing and is signed by both parties.

SEVERABILITY

If any provision of the Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid, in effect and enforceable. If a court finds that any provision of the Agreement is invalid or unenforceable, but that by limiting such provision would become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

WAIVER OF CONTRACTUAL RIGHT

The failure of either party to enforce any provision of the Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of the Agreement.

Signed and Dated_____

NANNIES FOR GRANNIES

Employment Application

Full Name:				Date:	
	Last	*First*	*M.I.*		
Address:					
	Street Address		*Apartment/Unit #*		
	City		*State*	*ZIP Code*	
Phone: ( )		Cell Phone:			
Emergency Contact: # 1	Name:	Phone:	Emergency Contact: # 2	Name:	Phone:
Date Available:		Social Security No.:		Desired Salary:	$
Position Applied for:					
Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐	NO ☐
Have you ever been convicted of a felony?	YES ☐	NO ☐	If yes, explain:		
Do you drive and have access to an automobile?	YES ☐	NO ☐	If NO, How will you get to assignments?		
Please Check Availability	DAYS ☐	EVENINGS ☐	NIGHTS ☐	LIVE-IN ☐	

EDUCATION

High School:			Address:					
From:		To:		Did you graduate?	YES ☐	NO ☐	Degree:	
College:			Address:					
From:		To:		Did you graduate?	YES ☐	NO ☐	Degree:	
Other:			Address:					
From:		To:		Did you graduate?	YES ☐	NO ☐	Degree:	

EMPL0YMENT HISTORY AND REFERENCES

Company:			Phone:	( )	
Address:			Supervisor:		
Job Title:		Starting Salary:	$	Ending Salary:	$
Responsibilities:					
From:	To:	Reason for Leaving:			
May we contact your previous supervisor for a reference?	YES ☐	NO ☐			

Company:			Phone:	( )	
Address:			Supervisor:		
Job Title:		Starting Salary:	$	Ending Salary:	$

NANNIES FOR GRANNIES

Responsibilities:					
From:		To:		Reason for Leaving:	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐			
Company:				Phone:	( )
Address:				Supervisor:	
Job Title:		Starting Salary:	$	Ending Salary:	$
Responsibilities:					
From:		To:		Reason for Leaving:	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐			
Name				Phone:	( )
Address:				How Known?	
Name				How Known	
Address:				Supervisor:	

MILITARY SERVICE:

Branch:				From:	To:
Rank at Discharge:		Type of Discharge:			
If other than honorable, explain:					

I certify that my answers are true and complete to the best of my knowledge. I authorize A1A Home Health Services to conduct a complete background investigation including criminal check and prior employment. I give my consent to drug test screening as a condition of employment. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature:		Date:	

We are an equal opportunity employer.

Nannys For Grannys
Reference Request Form

Name of Applicant:_____

Position Applied For:_____

Name: _____ Company: _____ Title:_____

Phone Number: _____ Fax Number: _____

Address: _____

Release of information: I hearby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: _____ Date: _____

The person identifed above has applied for a positon at Nannys for Grannys, Inc. Would you kindly complete the reference information below and return the reference information. This information will be kept confidential. Thank you.

Position held at your organization: _____

References relationship to applicant: _____

Dates employed from: _____-_____ To: _____

Reason for Leaving: _____

Would you re-employ?_____ If No, then why? _____

Applicants Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Critisim			
Appearance			

Any Additional Comments: _____

References Signature: _____ Date: _____

Reference Validation: _____ Title: _____ Date:_____

12R

Nannys For Grannys
Reference Request Form

Name of Applicant:_____

Position Applied For:_____

Name: _____ Company: _____ Title:_____

Phone Number: _____ Fax Number: _____

Address: _____

Release of information: I hearby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: _____ Date: _____

The person identifed above has applied for a positon at Nannys for Grannys, Inc. Would you kindly complete the reference information below and return the reference information. This information will be kept confidential. Thank you.

Position held at your organization: _____

References relationship to applicant: _____

Dates employed from: _____-_____ To: _____

Reason for Leaving: _____

Would you re-employ?_____ If No, then why? _____

Applicants Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Critisim			
Appearance			

Any Additional Comments: _____

References Signature: _____ Date: _____

Reference Validation: _____ Title: _____ Date:_____

13R

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

16R

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

NYS Department of Health, Criminal History Record Check Unit

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name	First Name	Middle Initial	Maiden Name

Date of Birth (mm/dd/yyyy)	Alias/AKA	Mother's Maiden Name

Mailing Address (street)	City	State	ZIP Code

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for any non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.

NYS Division of Criminal Justice Services
Criminal History Bureau
Record Review Unit-5th Floor
4 Tower Place
Albany, NY 12203
(518) 485-7675

Federal Bureau of Investigation
Criminal Justice Information Services
(CJIS) Division
1000 Custer Hollow Road
Clarksburg, WV 26306

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   _____
8. My current mailing or home address is indicated in Section 1 of this form.
9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: _____ Date: ___/___/_____

Name and Signature of Parent or Legal Guardian: _____ Date: ___/___/_____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	Operating License Number (PFI):
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

This form is to be retained by the agency. Do not forward to the DOH CHRC Unit.

There are two types of drug tests:

Pre-employment testing

• Applicants for employment at **NANNIES FOR GRANNIES, INC.** are drug-tested after receiving a final offer of employment and prior to beginning work. Applicants are notified at the time of application that testing for drugs is a requirement for employment process. Offers of employment are contingent upon successfully passing a drug test.

Testing for Reasonable Suspicion:

• A drug screen may be ordered by the Director of Clinical Services, in consultation with the

Administrator, when a reasonable suspicion of working under influence exists. Refusal to submit to the testing may result in disciplinary action, up to and including termination.

• A positive drug screen means the verified presence of alcohol or other controlled substances. All positive test results are maintained in a separate, confidential, need-to-know access file.

• Every employee, as a condition of continued employment, is required to immediately notify the Administrator, if they are convicted under federal or state criminal statue whether the act causing the conviction occurred on or off work time.

• The company will report information concerning possession distribution or use of any illegal drug to law enforcement officials.

*** I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.**

_____ _____

Employee Signature *Date*

NANNIES FOR GRANNIES, INC. EMPLOYEE PHYSICAL EXAMINATION REPORT

☐Pre-Employment Physical Assessment ☐Annual Assessment ☐Return to work/LOA ☐Other:

Name:	Marital Status: ☐M ☐S ☐W ☐D	Sex:☐M ☐F
Address	SS #:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:

EYES:

NECK:

BREASTS:

LUNGS:

CARDIOVASCULAR:

MUSCULOSKELETAL:

ABDOMEN:

GENITOURINARY:

CENTRAL NERVOUS SYSTEM:

COMMENTS:

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	DATE	RESULTS	
RUBELLA TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
MEASLES TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY (+PPD)	Date:	Results:	

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
OTHER:			

☐This individual is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his/her behavior.

☐**This individual is able to work with the following limitations:**

☐This individual is not physically/mentally able to work. *(specify reason):*

Physician Signature: **Lic. No.** **Date:**

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22R

Nannys for Grannys

The following individual has a positive PPD and has had an initial negative chest x-ray for tuberculosis. This assessment form must be completed annually for continued employment with Nannys for Grannys.. This self assessment is in place of additional x-rays that it may be harmful to the employee's health.

Name: _____ Date: _____

Please complete:

Do you have any signs or symptoms of the following:

Cough lasting longer than 3 weeks	☐yes	☐ no
Fever lasting longer than 3 weeks	☐yes	☐ no
Night sweats	☐yes	☐ no
Unintentional weight loss	☐yes	☐ no
Malaise/fatigue	☐yes	☐ no

If I have answered yes to two or more of the above symptoms I will check with my physician regarding my condition. To the best of my knowledge as a health care professional, I certify that I do not have any symptoms or conditions which indicate I may have tuberculosis as of this time.

Signature: _____ Date: _____

23R

NANNIES FOR GRANNIES, INC.

HEPATITIS B VACCINE PROGRAM

☐ I do not wish to be given the Hepatitis B Vaccine at this time. I am aware that I may request to be provided the vaccine at a later date during my employment with the agency.

☐ I have already received the Hepatitis B Vaccine series.

Signature: _____ Date: _____

☐ I am requesting to receive the Hepatitis B Vaccine. (complete consent below)

HEPATITIS B VACCINATION CONSENT

I, _____, have been provided with information on the Hepatitis B vaccine and have been evaluated by an agency health professional.

I have had the opportunity to ask questions about the benefits and risks of Hepatitis B Vaccination.

I also understand that there is no guarantee that I will become immune and that there is a possibility that I will experience an adverse side effect from the vaccine.

I am **NOT allergic** to yeast or yeast products.

I am **NOT currently immunosuppressed**, neither by disease or medication.

For women: I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the Hepatitis B vaccine relating to the developing fetus is currently unknown.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

24R

Declination of Influenza Vaccination
For Health Care Personnel

Employee's Name:_____
Employee's ID#:_____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.

- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.

- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.

- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.

- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.

- I understand that I cannot get influenza from the influenza vaccine.

- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

- Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature:_____
Date:_____

Witness:_____
Date:_____

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Employee Influenza Vaccination Policy
Acknowledgement of Receipt

Please print your name and title and then sign and date the form to indicate that you have received a copy of Nannys For Grannys Policy for the Administration of Influenza Vaccine dated September 3, 2013. You are responsible for reading and adhering to the policy.

_____ _____

Print Name **Signature**

_____ _____

Job Title **Date**

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (800) 523-2437. This Agency is responsible for protecting your rights.

**Name of Person Whose HIV Related Information Will Be Released

_____

Name and address of person signing this form (if other than above).

_____

Relationship to person whose HIV information will be released.

_____

Name and address of person who will be given HIV related information.

_____

Reason for release of HIV related information.

_____

Time during which release is authorized From: To:

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

* _____

Date Signature Witness

New York State Form 2557
*Human Immunodeficiency Virus That Causes AIDS

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HIV CONFIDENTIALITY STATEMENT AND ACKNOWLEDGEMENT

" CONFIDENTIAL HIV RELATED INFORMATION MEANS ANY INFORMATION CONCERNNG WHETHER AN INDIVIDUAL HAS BEEN THE SUBJECT OF AN HIV RELATED TEST, OR HAS HIV INFECTION, HIV RELATED ILLNESSES OR AIDS, OR INFORMATION WHICH IDENTIFIES OR REASONABLY COULD IDENTIFY AN INDIVIDUAL AS HAVING ONE OR MORE OF SUCH CONDITIONS, INCLUDING INFORMATION PERTAINING TO SUCH INDIVIDUAL'S CONTACTS"

I HAVE BEEN GIVEN AND UNDERSTAND NANNYS FOR GRANNYS POLICY AND PROCEDURE REGARDING HIV CONFIDENTIALITY LAW AND RELEASE OF HIV INFORMATION

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

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