GRACELAND

Rehabilitation and Nursing Center

DATE COMPLETED ____________

EMPLOYMENT APPLICATION

THIS IS A DRUG FREE WORKPLACE. WE ARE AN EQUAL OPPORTUNITY EMPLOYER

Please print clearly in blue/black INK only. Please read carefully and complete ALL information.

PERSONAL INFORMATION

Last Name	First Name	Middle	
Street Address / Apt. #	City		State / Zip
Home Phone Number ( )	Cell Phone Number ( )	E-mail Address	

POSITION INFORMATION/REQUESTS

Position(s) Applying For:

Salary Request	Status Request
$ ____________	☐ Full-Time
	☐ Part-Time
Salary of Previous Position:	☐ Temporary
$ ____________	☐ Contractual

REFERRAL INFORMATION

Referral Source

- ☐ Advertisement
- ☐ Friend
- ☐ Employment Agency
- ☐ Walk In
- ☐ Relative
- ☐ Current Company Employee* (Please indicate employee's name) ____________
- ☐ Other ____________

QUESTIONS

Have you completed an application for employment here before? ---->	☐ Yes ☐ No If yes, when? ___/___/_____
Have you been employed by our company before? ---->	☐ Yes ☐ No If yes - From ___/___/___To ___/___/___
What date are you available for work? ---->	___/___/___
Are you 18 years of age or in possession of a valid work permit? ---->	☐ Yes ☐ No
Are you legally eligible for employment in the United States? ----> (As a condition of employment you must complete an I-9 form required by the Immigration and Naturalization Service.)	☐ Yes ☐ No
Are you currently employed? --->	☐ Yes ☐ No If yes – Where?____________
May we contact your current employer? --->	☐ Yes ☐ No If yes – Please provide contact information ____________

Education Level	Name/Location of School	Major/Degree	Graduation/Completion
High School:			☐ Yes ☐ No
College:			☐ Yes ☐ No
Graduate Work:			☐ Yes ☐ No
Trade/Other Training:			☐ Yes ☐ No

EMPLOYMENT HISTORY (Begin with most recent position)

	Employer's Name/Address	Position (s)	From(MM/DD/YY)	To: (MM/DD/YY)	Starting Rate/ Final Pay		Reason for Leaving
1.					$	$	
2.					$	$	
3.					$	$	

PROFESSIONAL LICENSES/CERTIFICATES (Can include other special training that applies to position)

	Type	License Number	Date Issued	Issued by Organization/State
1.				
2.				
3.				
4.				

PROFESSIONAL REFERENCES (use an additional paper if more space is necessary)

Name	Professional Relationship	Company Address	Telephone
	□ Supervisor □ Colleague □ Other		
	□ Supervisor □ Colleague □ Other		
	□ Supervisor □ Colleague □ Other		
	□ Supervisor □ Colleague □ Other		

BACKGROUND INFORMATION

A conviction record will not necessarily be a bar to employment.

Have you been convicted of a felony in the past 7 years, excluding misdemeanors and summary offenses, which have not been annulled, expunged, pardoned, statutorily eradicated, dismissed upon condition of probation, or sealed by a court? **A conviction includes a plea of no contest, a plea of guilty or any court determination of guilt.** **A conviction will not necessary disqualify you from employment. We will consider the nature, date, and circumstances of each offense as well as whether the offense is relevant to the duties for the position for which you are applying for.**	□ Yes □ No	If "Yes", please describe in full detail:
Have you ever been discharged, suspended, or asked to resign from any position?	□ Yes □ No	If "Yes", please describe in full detail:

GRACELAND

Rehabilitation and Nursing Center

APPLICANT'S CERTIFICATION – Please read carefully before signing.

I hereby certify that all answers on this application are true and correct to the best of my knowledge and belief. I understand that any misrepresentation will be considered just cause for rejection of this application or dismissal from employment. I understand and agree that, if employed, such employment may be terminated at any time, without prior notice, and that my employment will not be governed by any expressed or implied contract, but is at will.

We conduct our business with the highest possible degree of safety and efficiency. Because of this, we require all applicants after receiving a conditional offer of employment to undergo urinalysis screening for drug or alcohol use as part of a pre-placement physical examination, and/or drug testing. Successful completion of an employment physical exam, which includes completion of a medical history questionnaire and testing for drugs, is required for employment. I acknowledge that refusing to submit to such screening will cause my application for employment to be rejected. In addition, all employees of the company may be subject to random urinalysis screening for drug or alcohol use.

The company is an equal opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, age, gender, religion, national origin, marital status, veteran status, disability, or any other status protected by federal, state, or local law. We assure you that your opportunity for employment depends solely upon your qualifications.

It is the company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the Americans with Disabilities Act. A reasonable accommodation is a change in the way job duties are normally performed that will ensure an equal employment opportunity without imposing an undue hardship on the company. Please inform the company's HR Delegate if you need assistance completing any forms or to otherwise participate in the application process.

"If I test positive for drugs which are not part of a currently prescribed medical treatment program by a licensed physician, I will not be considered for employment."

I understand that if I am hired, my employment is for no definite time and may be terminated at any time without prior notice.

APPLICANT'S SIGNATURE ______________________________ **DATE** ______________

This company is an equal opportunity employer. All applicants will be considered without discrimination of race, religion, color, sex, age, national origin, marital status, veteran status, medical condition, disability or any other status protected by federal, state, and local law.

GRACELAND

Rehabilitation and Nursing Center

EQUAL OPPORTUNITY EMPLOYER

In order to provide equal employment opportunities to all individuals, employment decisions will be based on merit, qualifications, and abilities. It is at all times our intent to comply with Title VI and VII of the Civil Rights Act of 1964 and all state and local anti-discrimination laws. This policy applies to all employees and clients. It is, therefore, prohibited for any employee to discriminate against a fellow employee or client in the terms and conditions of employment, or in providing services and care to clients, on the basis of race, color, religion, national origin, sex, age, marital status, veterans status, personal appearance, sexual orientation, family responsibilities, genetic information, disability, matriculation, or political affiliation, or any other status protected by law.

Provide Equal Employment Opportunity – The Facility is an equal opportunity employer. The Facility does not discriminate based on race, color, religion, sex, handicap, disability, age, marital status, sexual orientation, national origin, veteran status, or any other characteristic(s) protected by federal, state, and local laws. The Facility will also make reasonable accommodations for qualified individuals with disabilities should a request for an accommodation be made. A key part of this policy is to provide equal employment opportunity regarding all terms and conditions of employment and in all aspects of a person's relationship with the Facility including recruitment, hiring, promotions, upgrading positions, conditions of employment, compensation, training, benefits, transfers, discipline, and termination of employment.

GRACELAND

Rehabilitation and Nursing Center

Consent to Criminal Background Check

Disclosure of Intent and Authorization to Obtain and Use Information from a Consumer Reporter Agency

The Company hereby discloses that it may, it is discretion, from time to time before or during the course of my employment request that a consumer reporting agency provide information for employment purposes bearing on my character, general reputation, mode of living and personal characteristics, such as a criminal background or lack of criminal background. I understand such information may be obtained by direct or indirect contact from or with former employers, schools, financial institutions, landlords and public agencies or other persons or entities that may have such knowledge. The communication received from the agency may contain information gathered from a nationwide inquiry. The communication may be used in whole or in part for employment purposes, including evaluating me for employment, promotion, reassignment or retention. The evaluation may result in adverse action such as refusal to hire, promote or assign, or a decision to demote, reassign or terminate me. I understand that before I am denied employment based on information obtained in the report, I will be provided a copy of the report and a description of my rights under the Fair Credit Reporting Act. I understand that if I disagree with the accuracy of any information in the report, I must notify the Company within five days of my receipt of the report. If I notify the Company within five days of the receipt of the report that I am challenging the information in the report, the Company will not make a final decision on my employment status until after I have had a reasonable opportunity to address the information in the report.

My signature on this document ACKNOWLEDGES that I have read and understand the above disclosure and AUTHORIZES the Company, as a condition of employment and continuation of employment:

- To request such information from a consumer reporting agency.
- To receive communications containing the requested information from the consumer reporting agency.
- To use the information contained in the communication for the purposes described above, understanding that the evaluation may result in adverse action affecting my employment or continuation of employment.

I also AUTHORIZE all persons, state and federal agencies to provide to the Company all information, including criminal records, that are requested concerning my background and release the Company to the fullest extent authorized by law from any and all claims, damages, losses, liabilities, and expenses that I may have against the Company arising from the retrieving and reporting of any such information. I also ACKNOWLEDGE that this Disclosure and Authorization in no way alters the "at will" status of employment with the Company.

Last Name	*First Name*	*Middle Name*
Maiden Name(s)	*Race*	*Sex*
Date of Birth	*Social Security #*	
Signature	*Today's Date*	

Pre-Employment REFERENCE VERIFICATION

APPLICANT NAME: ____

POSITION APPLIED FOR: ____

DATE OF APPLICATION : ________/________/________

AUTHORIZATION TO CONTACT REFERENCES: YES / NO ☐ Applicant initials

Employee is to complete the contact information listed below. Human Resource Director will attempt to contact reference two times, after an unsuccessful attempt, the employee will be contacted to provide another form of reference before their first day of employment.

PLEASE PRINT CLEARLY

1. EMPLOYER/BUSINESS NAME: ____

Address: ____

City, State, Zip: ____

PHONE: ______________________ EXT: ____________

CONTACT NAME: ____

POSITION HELD WITH COMPANY: ______________________ ☐ VERIFIED ☐ Inaccurate) (SEE NOTES)

DATES OF EMPLOYMENT: ____/______/____ TO ____/______/____ ☐ VERIFIED ☐ Inaccurate(SEE NOTES)

COMMENTS: ____

____

2. EMPLOYER /BUSINESS NAME: ____

Address: ____

City, State, Zip: ____

PHONE: ______________________ EXT: ____________

CONTACT NAME: ____

POSITION HELD WITH COMPANY: ______________________ ☐ VERIFIED ☐ Inaccurate) (SEE NOTES)

DATES OF EMPLOYMENT: ____/______/____ TO ____/______/____ ☐ VERIFIED ☐ Inaccurate(SEE NOTES)

COMMENTS: ____

____

I VERIFY THAT I HAVE CONFIRMED THESE REFERENCES PRIOR TO HIRING.

REFERENCE CHECK VERIFIED BY: ______________________ **TITLE:** ______________________

GRACELAND
Rehabilitation And Nursing Center

EMERGENCY CONTACT INFORMATION

EMPLOYEE NAME________________________________

PHONE NUMBERS________________________________

ADDRESS________________________________

____

YOUR PHYSICIAN________________________________

PHYSICIAN'S PHONE NUMBER________________________

HOSPITAL PREFERENCE________________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

1) NAME________________________

   PHONE NUMBER________________________

   RELATIONSHIP TO EMPLOYEE________________________

2) NAME________________________

   PHONE NUMBER________________________

   RELATIONSHIP TO EMPLOYEE________________________

EMERGENCY MEDICAL INFORMATION (ALLERGIES, MEDICATION) ETC.

____

____

____

____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	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

Form **W-4**
(Rev. December 2020)
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

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

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . . ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ ________

Multiply the number of other dependents by $500 . . . . ▶ $ ________

Add the amounts above and enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Graceland Rehabilitation & Nursing Center

EQUAL EMPLOYMENT OPPORTUNITY DATA FORM

Anti-Discrimination Notice: *It is an unlawful employment practice for an employer to fail or refuse to hire, promote or discharge any individual, or otherwise to discriminate against an individual with respect to that individual's terms and conditions of employment, based on such individual's race, color, religion, gender or national origin.*

IMPORTANT - To All Employees: To enable us to meet government reporting regulations, **Graceland Rehabilitation & Nursing Center** requests that you complete this personal data form. Information will be used solely for government reporting purposes and will be detached and kept separate from your personnel file. Any information that you choose to provide will not be considered by **Graceland Rehabilitation & Nursing Center** for employment purposes and will be treated as personal and confidential. Your voluntary cooperation will be appreciated.

Name: ____

Last First Initial

Date: ______________ Position: ______________________________

Gender: ☐ Male ☐ Female

☐ **Hispanic or Latino**: a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

☐ **White (Not Hispanic or Latino):** a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American (Not Hispanic or Latino):** a person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino):** a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino):** a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino):** a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Two or More Races (Not Hispanic or Latino):** All persons who identify with more then one of the above five races.

GRACELAND
Rehabilitation And Nursing Center

Cell Phone Policy

Effective 07/07/2015

PLEASE no cell phones are to be used in resident living areas. This includes resident's rooms, hallways, or nurses' stations (unless in an emergency situation). Cell phones maybe used in the break room or outside. They are not to be used to listen to music. Failure to comply will result in termination.

____

Printed Name:

____

Signature:

____

Date:

Rehabilitation and Nursing Center

ELECTRONIC COMMUNICATION, DATA SECURITY, AND CONFIDENTIALITY AGREEMENT

I understand and agree to the following conditions for electronic communications, data security, confidentiality, and network access:

1. All electronic communication sent, received, or stored on Graceland Rehabilitation and Nursing Center systems are the property of the Organization and must be treated in a highly confidential manner.
2. Graceland Rehabilitation and Nursing Center computers and networks are solely for use in conducting Organization business.
3. Any software programs not registered to Graceland Rehabilitation and Nursing Center will not be installed on any Organization computer or network without the express consent of Senior Management.
4. Software programs owned by Graceland Rehabilitation and Nursing Center will not be removed or transferred from Organization property for any reason.
5. I acknowledge that I have no expectation of privacy in connection with any communication or information I send, receive, or store using the Organization's e-mail, internet, or voice mail systems.
6. I also acknowledge and consent to Graceland Rehabilitation and Nursing Center monitoring of my e-mail and internet use. I understand that such monitoring can include intercepting, copying, printing, or reading all e-mail entering, leaving, or stored on the system as well as tracking of the websites visited on the internet.

Detailed information on electronic communication, data security and confidentiality may be found in the Employee Handbook or Manager's Guide.

Employee Printed Name: ______________________________

Employee Signature: ______________________________

Date: ______________

Compliance and Ethics In-Service
Certification and Acknowledgement

I certify as follows:

I have received Graceland Rehabilitation and Nursing Center's ("Graceland") Compliance and Ethics Manual (the "Manual");

I completed Compliance and Ethics Training;

I understand that Graceland takes compliance and ethics very seriously;

Neither Ownership nor Management desires for me to act in violation of law for any reason;

I will faithfully follow the code of conduct and directives set forth in the Manual;

I will report any suspected unlawful or inappropriate conduct to the Chief Compliance Officer or a member of the Compliance and Ethics Committee (the "Committee") or anonymously through the Compliance and Ethics Hotline (the "Hotline");

I understand that Graceland has a strict No Retaliation Policy whereby staff members who report known or suspected violations of the Compliance and Ethics Program or other illegal or unethical activity are protected from any intimidation, coercion, discrimination or any other form of retribution or adverse employment action for coming forward; and

Violation of any of these obligations, including the obligation to report suspected violations to a member of the Committee or through the Hotline or Online System, can result in disciplinary action up to and including termination and/or civil or criminal legal action against me and/or Graceland.

____________________________ ____________________________
Signature Date

____
Printed Name

STATEMENT OF RECEIPT

Drug Free Workplace and Drug Testing Policy

I have received a copy of the Company's Drug Free Workplace and Drug Testing Policy, devised 10/26/2009. I understand that the company prohibits being under the influence of any activities associated with illicit drugs, alcohol and abuse of controlled substances while at work.

I understand that the Company will be employing drug and alcohol testing of applicants and employees in its attempt to enforce its Drug Free Workplace Policy and ensure the safety of its employees, residents and guests.

I am aware that employees may be required to submit to testing for the presence of illicit and prohibited substances post-incident/injury/accident, or when the company has "reasonable suspicion" to believe an employee may have violated the Drug Free Workplace and Drug Testing Policy. Please refer to the policy for further information on this topic.

I am aware that any violation of this policy may result in disciplinary action up to and including discharge, for cause, and that a positive drug test related to a work injury may affect Worker's Compensation benefits.

I am aware that the Company considers refusal to submit to testing when requested as an admission of guilt and that such a refusal may result in disciplinary action up to and including discharge for cause.

I understood that I am expected to read this policy and if unsure of any part therein, I will bring my concerns forward to an appropriate member of management.

_______________________________ _______________________

Signature of Employee Dated

_______________________________ _______________________

Signature of Witness Dated

Employee Authorization for Release Of Health Information

Employee Authorization

I, ______________________ (*Employee*), hereby authorize the release, use, or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:
(*e.g., results of fitness-for-duty examination, drug test results for employment purposes, doctor's evaluation or notes supporting request for accommodation and/or FMLA leave, etc.*).

____

____

I hereby authorize ______________________ (*insert name of individual(s) and/or organization(s) providing information*) **to release the above-described information to** ______________________________ (*insert name of individual(s) and/or organization(s) receiving the information*).

I understand that this Authorization will permit the above-named parties to use or disclose the identified medical information for employment-related purposes beyond treatment, payment, or health care operations as provided by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:
____________________________ (*e.g., employer's human resource manager or appointed privacy official*).

The revocation will be effective on the date when it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this Authorization prior to the effective date of revocation. This Authorization shall remain in effect during my employment with
______________________________ (*Company Name*) and for a period of six months thereafter.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Employee's Signature

Employee's Printed Name: ______________________________________

Employee's Signature: ____________________________ Date: ____________

Employee's Personal Representative (if applicable)

Printed Name: ____

By signing as Employee's personal representative, I represent that I have legal authority to sign and act on the employee's behalf for purposes of executing this Authorization.

Signature of Employee's Representative: ______________________________

Employer Information

Company Name: ____

Recipient of Authorization (print name): ______________________________

Title: ______________________________ Date Received: ____/____/____

☐ Check here to indicate that Employee was given a copy of signed Authorization.

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ABUSE POLICY

Residents and patients of this facility are to be treated with dignity and respect at all times and under any circumstances. Mistreatment in the form of verbal, physical, mental, sexual, seclusion, misappropriation of property, and/or neglect of any nature will not be tolerated. Any employee guilty of abusing a resident or patient is subject to immediate discharge/termination. Local authorities will be notified immediately and criminal chargers may be filed against any employee guilty of abuse. Employees may be fined up to $5,000.00 and sentenced to up to three (3) years in prison.

____

Employee Signature

____

Witness Signature

____

Date

ACKNOWLEDGEMENT BY EMPLOYEE FOR FILE

The information contained in the Facility Handbook to employment is intended to outline some Facility policies and benefits. Material in this Facility Handbook may change and may be revised at any time without direct or immediate notice to you. Due to the nature of the Facility's operations and variations necessary to accommodate individual situations, the policies and procedures set fort in this Handbook may not apply in every situation.

This Facility Handbook to employment does not represent an expressed or implied employment contract for any duration between you and the Facility. This Facility Handbook is not contractually binding. You retain your right to terminate you employment at anytime and the Facility retains the same right.

Employees involuntarily terminated for violations of this Facility Handbook will not be eligible for unemployment compensation benefits.

I acknowledge that I have **read and received**, and understand that I am required to read and refer to, the Policies and Procedures Manual for Employees and adhere to the policies and procedures it contains.

Name (Please Print): ______________________________

Signature: ______________________________

Date: ______________________________

HR Delegate Signature: ______________________________

Sign and return to your HR Delegate. This document will be placed in the employee's personnel file.

MANAGER'S ACKNOWLEDGEMENT of Privacy Obligations under HIPAA

I understand that it is the intent of GRACELAND REHAB & NURSING CENTER (the Company) to safeguard and protect the privacy of its applicant's and employees' "protected health information" as defined by the Health Insurance Portability and Accountability act of 1996 ("HIPAA").

I understand that "protected health information" includes individually identifiable information, maintained or transmitted through any medium, relation to an individual's past, present, or future physical or mental health or healthcare. Health information is considered individually identifiable if it either identifies a person by name or creates a reasonable basis to believe the individual could be identified (through identifiers such as address, social security number, dates of service, telephone number, email address, or vehicle identification number).

In the course of my employment with the Company, I understand that I may come into contact with protected health information of applicants or employees. In consideration of my employment and/or continued employment with the Company, I hereby agree that I will not at any time (either during my employment with Company, or anytime thereafter) access, use, or disclose to any person or entity, any protected health information of the Company's applicants or employees, except as necessary and authorized in the course of my duties and responsibilities for the Company. I understand that this confidentiality obligation applies regardless of the manner in which I acquired the protected health information, whether it was communicated verbally, in writing, electronically, or in any other format, and regardless of whether it was communicated directly to me or intended for my access. I understand that this obligation survives the termination of my employment with the Company, regardless of the reason for such termination.

I understand that the unauthorized access, use, or disclosure of protected health information in violation of this policy may subject me to disciplinary action up to and including termination of my employment. I also understand that violating the privacy rights of individuals under HIPAA may also result in the imposition of civil and/or criminal penalties and other sanctions provided by federal and state laws.

By signing below, I acknowledge that I have read this policy and that I understand my obligations as an individual and member of the Company to protect the confidentiality of protected health information relating to any employee or applicant.

Employee's Printed Name: ______________________________

Signature: ______________________________ **Date:** ___/___/___

Manager's Printed Name: ______________________________

Signature: ______________________________ **Date:** ___/___/___

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