AMBULANCE PERSONNEL CHECKLIST

NAME:_________________________________________________________ Date:____________________

1. ___ Application

2. ___ W4

3. ___ I9 (with copy of required documentation)

4. ___ DL

5. ___ Certifications

6. ___ CPR Card

7. ___ Hep B Vaccine or Waiver

8. ___ TB Vaccine

9. ___ Confidentiality Policy

10. ___ Medical Provider Policy

11. ___ HIPAA

12. ___ Background Check

13. ___ Policy and Procedure Acknowledgement
**APPLICATION FOR EMPLOYMENT**

(Please Print Clearly)

<table>
<thead>
<tr>
<th>Personal Information</th>
<th>Date of Application</th>
<th>Date Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present Address</td>
<td>Street</td>
<td>City</td>
</tr>
<tr>
<td>Permanent Address (if Different than Present Address)</td>
<td>Street</td>
<td>City</td>
</tr>
</tbody>
</table>

If you cannot be reached at above phone number, where may we contact you? Name of Person | Phone |

---

**Employment Desired**

<table>
<thead>
<tr>
<th>Type of Work Desired</th>
<th>Shift</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Choice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Are You 18 Yrs. of Age or Older? ☐ Yes ☐ No

Are You Employed Now? ☐ Yes ☐ No

May We Contact Your Present Employer? ☐ Yes ☐ No

How Did You Learn Of This Opening? |

---

**Education**

Circle Highest Grade Completed

<table>
<thead>
<tr>
<th>Scholastic Honors Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Location (City, State)</th>
<th>Courses Taken</th>
<th>Completed</th>
<th>Type of Degree or Certificate Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grammar or Grade School</td>
<td></td>
<td>☐ No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td></td>
<td>☐ No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>College</td>
<td></td>
<td>☐ No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Vocational or Business</td>
<td></td>
<td>☐ No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Professional Education</td>
<td></td>
<td>☐ No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Laboratory or X-Ray Training</td>
<td></td>
<td>☐ No</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Extracurricular Activities While in School |

Member of Professional Organizations |

Honors Received, Volunteer or Community Service or Other Qualifications You Have Which You Feel Are Related to the Position for Which You Are Applying |

Were you in the U.S. Armed Forces? ☐ Yes ☐ No If yes, what branch? |

Dates of Duty: From / / Year To / / Year Rank at Discharge |

---

**Professional Licenses and/or Certifications**

<table>
<thead>
<tr>
<th>Type</th>
<th>Organization or State Issued</th>
<th>Date Issued</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Organization or State Issued</td>
<td>Date Issued</td>
<td>Number</td>
</tr>
<tr>
<td>Type</td>
<td>Organization or State Issued</td>
<td>Date Issued</td>
<td>Number</td>
</tr>
</tbody>
</table>
# Employment Record

(Complete this section first)

<table>
<thead>
<tr>
<th>Present and Former Employers</th>
<th>Dates Employed</th>
<th>Salary Range</th>
<th>Position &amp; Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>From</td>
<td>Starting</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>To</td>
<td>Ending</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Name                        | From           | Starting     |                  |
| Address                     | To             | Ending       |                  |
| City/State/Zip              |                |              |                  |
| Supervisor                  |                |              |                  |
| Phone                       |                |              |                  |

| Name                        | From           | Starting     |                  |
| Address                     | To             | Ending       |                  |
| City/State/Zip              |                |              |                  |
| Supervisor                  |                |              |                  |
| Phone                       |                |              |                  |

| Name                        | From           | Starting     |                  |
| Address                     | To             | Ending       |                  |
| City/State/Zip              |                |              |                  |
| Supervisor                  |                |              |                  |
| Phone                       |                |              |                  |

If your former employment references, education, or military service are under a name other than indicated on front of application, please indicate below.

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been convicted of a crime? □ Yes □ No If Yes, for what, when and where?

Conviction of a criminal offense will not necessarily preclude your employment.

Use this space to give us further information which will assist us in placing you, including at least two personal references not related to you, whom you have known at least one year.

<table>
<thead>
<tr>
<th>Reference 1</th>
<th>Address 1</th>
<th>Relationship 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 2</td>
<td>Address 2</td>
<td>Relationship 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Do Not Answer Questions In This Area - To Be Completed After Employed

Date of Birth   Marital Status   Sex   Nationality   Number and Ages of Children

Notify In Case of Emergency:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street   City   State   Zip Code   Telephone

What Language(s) (Other than English) Do You Speak?
This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, Vietnam era veteran status, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this institution the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical examination, and such future physical examinations as may be required by this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

I understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form.

If employed, I will be required to complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility for employment.

<table>
<thead>
<tr>
<th>Day</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td>A.M.</td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>P.M.</td>
<td>P.M.</td>
</tr>
<tr>
<td>Monday</td>
<td>A.M.</td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>P.M.</td>
<td>P.M.</td>
</tr>
<tr>
<td>Tuesday</td>
<td>A.M.</td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>P.M.</td>
<td>P.M.</td>
</tr>
<tr>
<td>Wednesday</td>
<td>A.M.</td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>P.M.</td>
<td>P.M.</td>
</tr>
<tr>
<td>Thursday</td>
<td>A.M.</td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>P.M.</td>
<td>P.M.</td>
</tr>
<tr>
<td>Friday</td>
<td>A.M.</td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>P.M.</td>
<td>P.M.</td>
</tr>
<tr>
<td>Saturday</td>
<td>A.M.</td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>P.M.</td>
<td>P.M.</td>
</tr>
</tbody>
</table>

Please indicate days and hours you are available for work (be specific).

Availability Record

Primary position desired

Will you accept another position? □ Yes □ No

If so, what?

Are you available to work: Weekends? □ Yes □ No

Holidays? □ Yes □ No

Rotating Shifts? □ Yes □ No

Do you limit your annual earnings due to Social Security or other reasons? □ Yes □ No

If yes, please state what is the maximum amount you wish to earn

If your availability changes, it is your responsibility to fill in an “Availability Card” indicating the changes. Such changes will be effective, then, for any future employment.

I understand that emergency conditions may require me to temporarily work shifts other than the one for which I am applying and agree to such scheduling change as directed by my department head or administrator of this institution.

Applicant’s Signature __________________ Date _____________

Applicant’s Signature __________________ Date _____________
## Interviewers Comments

<table>
<thead>
<tr>
<th>Interviewer</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Reference and Prior Employment Check

<table>
<thead>
<tr>
<th>Individual Contacted</th>
<th>Name of Firm</th>
<th>Results of Check</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## For Personnel Office Use

Hired __________________ For what department __________________ Position __________________

Salary __________________ per Year  Month  Hour  Starting Date __________________
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-earner/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 dependents (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.

Nontaxable income. If you have a large amount of nontaxable 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 aliens. If you are a nonresident alien, see Notice 1020, 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 much you are having withheld compared to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $160,000 (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

  • You are single and have only one job; or

B Enter "1" if

  • You are married, have only one job, and your spouse does not work; or

  • Your wages from a single job or your spouse’s wages (or the total of both) are $1,500 or less.

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

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

E Enter “1” if you will file as head of household on your tax return (see conditions under Head of household above)

F Enter “1” if you have at least $1,900 of child or dependent care expenses (for which you plan to claim a credit) (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 $55,000 and $84,000 ($95,000 and $119,000 if married), enter “1” for each eligible child

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.

---

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.

1 Your first name and middle initial

2 Your social security number

3 Single Married Married, but withheld at higher Single rate.

Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box

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)

6 Additional amount, if any, you want withheld from each paycheck

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.

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

(If your employer requires a signature.)

Date

---

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cal. No. 10220Q
Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>E-mail Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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): ____________________________

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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 examine a combination of one document from List B and one document from List C as listed on the "List of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.

<table>
<thead>
<tr>
<th>List A</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity and Employment Authorization</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td>Document Title:</td>
</tr>
<tr>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
</tr>
<tr>
<td>Document Number:</td>
<td>Document Number:</td>
<td>Document Number:</td>
<td>Document Number:</td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
</tr>
</tbody>
</table>

**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.]

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td>First Name (Given Name)</td>
<td>Employer's Business or Organization Name</td>
</tr>
<tr>
<td>Employer's Business or Organization Address (Street Number and Name)</td>
<td>City or Town</td>
<td>State</td>
</tr>
</tbody>
</table>

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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: | Date (mm/dd/yyyy): | Print Name of Employer or Authorized Representative: |
# LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

<table>
<thead>
<tr>
<th>LIST A</th>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>LIST B</th>
<th>Documents that Establish Identity</th>
<th>AND</th>
<th>LIST C</th>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>U.S. Passport or U.S. Passport Card</td>
<td>1.</td>
<td>Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td>1.</td>
<td>A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>2.</td>
<td>ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td>2.</td>
<td>Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3.</td>
<td>School ID card with a photograph</td>
<td>3.</td>
<td>Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4.</td>
<td>Voter's registration card</td>
<td>4.</td>
<td>Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</td>
<td>5.</td>
<td>U.S. Military card or draft record</td>
<td>5.</td>
<td>Native American tribal document</td>
<td></td>
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<tr>
<td>6.</td>
<td>Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-84 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI</td>
<td>6.</td>
<td>Military dependent's ID card</td>
<td>6.</td>
<td>U.S. Citizen ID Card (Form I-197)</td>
<td></td>
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<td></td>
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<td>7.</td>
<td>U.S. Coast Guard Merchant Mariner Card</td>
<td>7.</td>
<td>Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
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<td>9.</td>
<td>Driver's license issued by a Canadian government authority</td>
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<td>For persons under age 18 who are unable to present a document listed above:</td>
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<td>10.</td>
<td>School record or report card</td>
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<td>11.</td>
<td>Clinic, doctor, or hospital record</td>
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<tr>
<td></td>
<td></td>
<td>12.</td>
<td>Day-care or nursery school record</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.
AFFIRMATION OF LEGAL WORK STATUS
Pursuant to Colorado Revised Statute 8-2-122

Employee Name: ________________________
                         Last           First           Middle           Date of Birth

Social Security Number: _______ - _______ - _______   Date of Hire: ________________

In accordance with Colorado Revised Statute 8-2-122, I have:

_____ examined the legal work status of the above named employee.


_____ not altered or falsified the employee’s identification documents.

_____ not knowingly hired an unauthorized alien.

Employer Name / Designated Representative: ________________________________________

__________________________________   __________________
Signature                           Date

Official Title

CRS 8-2-122 (2) On and after January 1, 2007, within twenty days after hiring a new employee, each employer in Colorado shall affirm that the employer has examined the legal work status of such newly-hired employee and has retained file copies of the documents required by 8 U.S.C. sec. 1324a; that the employer has not altered or falsified the employee’s identification documents; and that the employer has not knowingly hired an unauthorized alien. The employer shall keep a written or electronic copy of the affirmation, and of the documents required by 8 U.S.C. sec. 1324a, for the term of employment of each employee.

This affirmation and the documents required by 8 U.S.C. sec. 1324 (copies or electronic copies) will be retained for the duration of the above named individual’s employment.

This affirmation is provided as a courtesy by the Colorado Division of Labor.
HEPATITIS B VACCINE

VACCINE #1 GIVEN ON ____________________________ BY ______________________
NOTE ANY REACTIONS ______________________________________________________

VACCINE #2 GIVEN ON ____________________________ BY ______________________
NOTE ANY REACTIONS ______________________________________________________

VACCINE #3 GIVEN ON ____________________________ BY ______________________
NOTE ANY REACTIONS ______________________________________________________

UPON COMPLETION OF SERIES, THIS DOCUMENT IS TO BE PLACED IN EMPLOYEE PERSONNEL FILE.
5. Users of unlawful injectable drugs. Sharing needles is an extremely high-risk activity for transmitting hepatitis B.

6. Recipients of certain blood products. Persons such as hemophiliacs who receive special products to help their blood clot are at high risk of infection.

7. Household and sexual contacts of HBV carriers. When HBV carriers are identified, household and sexual contacts should be offered vaccine.

8. Adoptees from countries with high rates of HBV infection. Families with orphans or unaccompanied minors from such countries should have the child checked for HBV carriage, and, if positive, family members should be vaccinated.

9. Other contacts of HBV carriers. Vaccine use should be considered in classroom and other day settings where deinstitutionalized developmentally disabled HBV carriers may expose contacts to their blood or body secretions. Teachers and aides have been shown to be at significant risk in these settings. Other persons who have casual contact with carriers at schools and office are at little risk of catching HBV infection and vaccine is not recommended for them.

10. Special populations from areas with high rates of hepatitis B. These groups include Alaskan natives, native Pacific islanders, immigrants and refugees from eastern Asia and sub-Saharan Africa, and their U.S. born children.

11. Inmates of long-term correctional facilities. The risk of inmates catching HBV infection may be due to use of unlawful injectable drugs and male homosexual practices.

12. Heterosexuals who come in for treatment of other newly acquired sexually transmitted diseases who have histories of sexual activity with multiple sexual partners in the past 6 months.

13. Persons who plan to travel to areas outside the United States that have high rates of hepatitis B infection, stay in these areas for more than 6 months, and have close contact with the local population; and, persons traveling for shorter durations who may have contact with blood from or sexual contact with local persons in areas where HBV infection is common. Persons traveling abroad who will perform medical procedures in areas where HBV infection is common are at very high risk.

**ADDITIONAL VACCINEES:**

Hepatitis B vaccine is also recommended as part of the therapy used to prevent hepatitis B infection after exposure to HBV. Postexposure use of hepatitis B vaccine is recommended for the following persons: (1) infants born to mothers who have a positive blood test for hepatitis B surface antigen (HBsAg); (2) persons having accidents involving HBsAg-positive blood where there is entry through the skin or mucous membrane; (3) infants less than 12 months old whose mother or primary caregiver has HBV infection; and, (4) persons having sexual contact with someone who has a positive blood test for HBsAg. The hepatitis B vaccine series should be started at the same time as other therapy, primarily, treatment with hepatitis B immune globulin (HBIG).

**POSSIBLE SIDE EFFECTS FROM THE VACCINE:**

The most common side effect is soreness at the site of injection. Illnesses, such as neurologic reactions, have been reported after vaccine is given, but hepatitis B vaccine is not believed to be the cause of these illnesses. As with any drug or vaccine, there is a rare possibility that allergic or more serious reactions or even death could occur. No deaths, however, have been reported in persons who have received this vaccine. Giving hepatitis B vaccine to persons who are already immune or to carriers will not increase the risk of side effects.

**PREGNANCY:**

No information is available about the safety of the vaccine for unborn babies; however, because the vaccine contains only particles that do not cause hepatitis B infection, there should be no risk. In contrast, if a pregnant woman gets a hepatitis B infection, this may cause severe disease in the mother and chronic infection in the newborn baby. Therefore, pregnant women who are otherwise eligible can be given hepatitis B vaccine.

**QUESTIONS:**

If you have any questions about hepatitis B or hepatitis B vaccine, please ask us now or call your doctor or health department before you sign this form.

**REACTIONS:**

If the person who received the vaccine gets sick and visits a doctor, hospital, or clinic during the 4 weeks after receiving the vaccine, please report it to:

---

**PLEASE KEEP THIS PART OF THE INFORMATION SHEET FOR YOUR RECORDS**

I have read or have had explained to me the information on this form about hepatitis B and hepatitis B vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the hepatitis B vaccine and request that it be given to me or to the person named below for whom I am authorized to make this request.

HEPATITIS B
2/1990

---

**INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Age</th>
<th>Gender</th>
<th>Address</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**FOR CLINIC USE**

<table>
<thead>
<tr>
<th>Date Vaccinated</th>
<th>Manufacturer and Lot No.</th>
</tr>
</thead>
</table>

**Site of injection**

---

Signature of Person to receive vaccine or person authorized to make the request.
HEPATITIS B VACCINE DECLINATION

WALSH HEALTHCARE CENTER
Employer

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccine at this time. I understand that by declining 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

________________________________________
Date
MANTOUX TEST WORKSHEET

1. Have you had tuberculosis or are you a known tuberculin-positive reactor?

2. Have you had an allergic reaction, or a local skin reaction to a skin test?

3. If yes, what kind of a reaction, to what kind of a test?

4. Do you have any allergies?

5. Are you on corticosteroids or other immunosuppressives?

6. Have you had a virus vaccine in the past 4-6 weeks?

7. Are you pregnant?

8. You need to remain at the WHC at least 20 minutes after this injection is given to you.

9. You need to have an RN read you Mantoux Test in 48 to 72 hours.

__________________________________________________________________________________________

Signature/Date

__________________________________________________________________________________________

Name

_intradermally on_________ by ___________________________ Signature/Title

MANUFACTURER AND LOT NO. Date/Time/Rt or Lt arm Read after_________ Read before_________

EXPIRES_________

Results are ____________________________

Negative/Positive with description

Read by ____________________________

Signature/Title Date/Time

__________________________________________________________________________________________

2nd Mantoux received 1-2 weeks following initial skin test(negative)

intradermally on_________ by ___________________________ Signature/Title

MANUFACTURER AND LOT NO. Date/Time/Rt or Lt arm Read after_________ Read before_________

EXPIRES_________

Results are ____________________________

Negative/Positive with description

Read by ____________________________

Signature/Title Date/Time

wpjamsww7/97
CONFIDENTIALITY POLICY

There are rules that govern the resident's personal and health information, as well as, employees' information.

Health information is generally classified into two categories:

1. Non-confidential information is that information which is generally common knowledge, and there is no specific request by the patient to restrict disclosure. Generally, non-confidential information may include:
   a. Name of the patient.
   b. Verification of hospitalization or output services.
   c. Dates of service.

2. Confidential information is made available during the course of a confidential relationship between the patient and healthcare professionals. Confidential information includes, but is not limited to, all clinical data and a patient's address on discharge. This information may be disclosed only upon written authorization where such disclosure is required by federal or state law, or court order.

Protected Health Information (PHI) includes: (name, address, age, telephone number, e-mail address, medications, any information regarding the resident's medical condition, identity of the resident's treating health care providers, and any oral or written communication received from outside entities concerning a resident's medical condition.

Minimum Necessary information can be used or disclosed for routine disclosures. (Only give departments the information they need to care for the resident).

Violation of this facility's policy, as well as a breach of the HIPAA regulations, to intentionally seek out PHI that you don't normally have access to may lead to termination.
STATEMENT OF CONFIDENTIALITY FOR EMPLOYEES

I understand that as an employee of the Walsh Healthcare Center I will be exposed to information about the Healthcare Center and the Residents. In order to do my job it is necessary to become acquainted with resident's health problems and personal confidences. However, I am NOT to discuss these matters outside of the Healthcare Center, in front of other residents, with unauthorized employees or any situation where I may be overheard.

I further understand that any breach of the above mentioned confidentiality will result in immediate disciplinary action and/or termination from employment with the Healthcare Center. As the HIPAA motto goes:

What you see here
What you hear here
When you leave here
Let it stay here.

_________________________________________  _________________________
Employee's Signature                        Date

_________________________________________  _________________________
Witness (Healthcare Employee)                Date
DESIGNATED MEDICAL PROVIDER POLICY

The Walsh Healthcare Center has selected the following physicians as Designated Medical Providers for it’s Workmen’s Compensation Insurance Program: Southeast Colorado Hospital Physicians Clinic in Springfield, Stanton County Clinic, Dr. Bill Troup in Johnson, Kansas or Walsh Medical Clinic. Should you sustain minor injuries while on the job, you have the right to choose either of the above physicians for your care. Should you need specialty care beyond their scope of practice, they will refer you to the appropriate physician.

If you receive a back injury, you are required to go to Centura Centers for Occupational Medicine in Pueblo, Colorado. You will be reimbursed $0.30 per mile, round trip for mileage. To receive the mileage reimbursement, you must list the date, address of origin, mileage to and from the destination address, then contact Walsh Healthcare Center Administration. The phone number to Centura Centers is 719-562-6300. Walsh Healthcare Center Administration will call to make your initial appointment. Jan Munoz, receptionist at Centura, will schedule the appointment with either Dr. Bailey or Dr. Olsen.

In signing this form I acknowledge that I have been informed and understand who the Designated Medical Providers are for the Walsh Healthcare Center’s Workmen’s Compensation Insurance Program.

__________________________________________
Employee’s Signature

__________________________________________
Date
Walsh HealthCare Center

SUMMARY OF PRIVACY POLICIES FOR STAFF

I. Understanding the Resident’s Health Information

Each time a resident is admitted to Walsh HealthCare Center, a record of the resident’s visit is created. This record typically contains the resident’s name and other information that may identify them, their symptoms, examination and test results, diagnoses, treatment, and plan for future care. This record, sometimes referred to as the resident’s “medical record” or “medical chart,” may be written on paper and electronically stored in a computer. This record serves as:

1. A tool for physicians, nurses, and other health professionals to plan and coordinate treatment;
2. Proof to health insurance plans paying for the resident’s care that medical services were provided;
3. A source of data for medical researchers and public health agencies that oversee the delivery of health care; and
4. A means for us to assess and assure the quality of care provided.

II. Our Privacy Policies

We are committed to preserving the confidentiality of each resident’s health information created and maintained by us. Our privacy policies apply to all of the resident’s health information. Health information that does not identify the resident and, with respect to which there is no reasonable basis to believe that the information can be used to identify the resident, is not confidential health information subject to our privacy policies.

This Summary describes the ways in which we may use or disclose a resident’s health information. We are required by law to maintain the privacy of the resident’s confidential health information and to provide the resident with a “Notice of Privacy Practices” that describes our duties and privacy practices regarding the resident’s health information. A copy of our Notice of Privacy Practices is attached. We will not use or disclose the resident’s health information without the resident’s prior written authorization, except as described in this Summary. We are required by law to abide by the terms of our Notice of Privacy Practices currently in effect. We reserve the right to revise our Notice of Privacy Practices and to make the revisions apply to the resident’s health information that we created or received prior to the effective date of the revision. We will notify the resident of any revisions to our Notice of Privacy Practices by posting the revised notice in the common area and on our website.

If you have any questions about this Summary of Privacy Policies or the attached Notice of Privacy Practices, please contact Michelle England (719)-324-5262 ext. 122

III. How We Will Use and Disclose Health Information
a. Uses and Disclosures Not Requiring the Resident's Prior Written Authorization or Oral Agreement

i. Treatment. We will use the resident's health information to provide health care treatment. For example, nurses, therapists, and other members of our staff will record health information, such as results of examinations and other observations, in the resident's medical record. Our staff will then use the medical record to determine the best course of treatment. We will also disclose the resident’s medical record to healthcare professionals not on our staff, such as specialist the resident’s attending physician, hospitals, and diagnostic laboratories, to assist them as they provide health care to the resident.

ii. Appointment Reminders / Information About Treatment Alternatives. We may contact the resident to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to them.

iii. Payment. We will use the resident's health information to obtain payment for our services. For example, we may send a bill to the resident or the resident’s health insurance plan. The information on or accompanying the bill may include information that identifies the resident, his/her diagnoses, and medical procedures performed by us. We also may tell the resident’s health insurance plan about the treatment the resident is going to receive in order to obtain prior approval for the services or to determine whether the health insurance plan will pay for the treatment.

iv. Health Care Operations. We will use the resident's health information for regular health care operations. For example, department supervisors and members of the Quality Assurance Committee may use information in the resident’s medical record to assess the quality of care provided to the resident and to monitor the performance of our staff. We also may combine the resident’s health information with information from other health care providers to assess our performance and make improvements in the care provided to our residents.

v. Business Associates. We will use and disclose the resident’s health information to certain “business associates” that perform or assist us with the performance of administrative tasks, such as data analysis, quality assurance, and billing. Business associates also include certain persons that provide services to us, such as our attorneys, accountants, accreditation organizations, and computer consultants. Whenever we disclose the resident’s health information to our business associates, we will first obtain satisfactory written assurances that our business associates will appropriately safeguard the resident’s health information.

vi. Fundraising. We may use, or disclose to a business associate or to a foundation related to us, the following information about the resident for the purpose of raising funds for our benefit: (A) the resident’s demographic information (such as name, address, and phone number); and (B) dates when we provided health care to that resident. If the resident is contacted in our fundraising effort, the resident will have the opportunity to opt out of receiving any further fundraising communications from us.
b. Uses and Disclosures Requiring Only The Resident's Oral Agreement

Under certain circumstances, we may use or disclose the resident's health information if we inform the resident in advance of the use or disclosure and the resident has the opportunity to orally agree to, or prohibit or restrict, the proposed use or disclosure. Under such circumstances, we will rely on the resident's oral agreement rather than the resident's written authorization. Such circumstances include:

i. Facility Directory. We may use or disclose the resident's health information to maintain a "directory" of residents receiving care at, and currently on, the premises of, our facility. Such health information will be limited to the resident's name, date of birth, location, and a statement of the resident's condition in general terms that does not communicate specific medical information about the resident. The directory information may be given to people who ask for the resident by name, such as family and friends who come to visit the resident.

ii. People Involved in Care. We may disclose the resident's health information to people who are involved in the resident's care or who help pay for the resident's care, such as family members, other relatives, close personal friends, or any other person identified by the resident. We also may disclose the resident's health information to a person or organization assisting in disaster relief efforts for the purpose of notifying the resident's family or friends about the resident's location and general condition.

Sometimes, we may reasonably infer from the circumstances that the resident agrees to the use or disclosure of his/her health information to people involved in his/her care. For instance, if the resident's spouse or child is present when treatment is being discussed, and the resident does not object to his/her spouse's or child's involvement, we will reasonably infer that the resident agrees to the disclosure of his/her health information to his/her spouse or child.

c. Uses and Disclosures Requiring the Resident's Prior Written Authorization

Except as stated in this Summary of Privacy Policies and in the Notice of Privacy Practices, we may not use or disclose the resident's health information unless we obtain the resident's prior written authorization. The resident has the right to revoke his/her written authorization at any time as long as his/her revocation is provided to us in writing. If the resident revokes his/her written authorization, we will no longer use or disclose the resident's health information for the purposes identified in the authorization.

We are not required to retrieve any disclosures made pursuant to the resident's authorization prior to its revocation. Examples of uses or disclosures that may require the resident's prior written authorization include:

1 A request to provide the resident's health information to a long-term care insurance company for the company's marketing and advertising purposes;
2 A request to provide the resident's health information to an attorney for use in civil litigation; and
3 A request to include information about the resident in a brochure about our facility.

A copy of the authorization form, entitled "Authorization for Use/Disclosure of Health Information," is attached to this Summary for your review.
d. Uses and Disclosures Permitted or Required by Law

There are certain uses and disclosures of a resident’s health information that are permitted or required by law. Under the following circumstances, we do not need the resident’s prior written authorization to use or disclose their health information:

i. **Public Health Activities.** We may use or disclose the resident’s health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling diseases, injuries, and disabilities. For instance, Colorado and federal law require nursing homes and assisted living facilities to report certain events to governmental agencies, such as: (A) certain communicable diseases; (B) births and deaths; (C) suspected or actual abuse, neglect, or domestic violence involving a child or an adult; and (D) problems with medical equipment. We may also disclose the resident’s health information to people who may have been exposed to a communicable disease carried by the resident, or who may otherwise be at risk of contracting or spreading a disease or condition carried by the resident.

ii. **Health Oversight Activities.** We may use or disclose the resident’s health information to a health oversight agency that is authorized by law to conduct health oversight activities. Such oversight activities may include audits, investigations, inspections, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.

iii. **Judicial and Administrative Proceedings.** We may use or disclose the resident’s health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose the resident’s health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to: (A) notify the resident of the request for disclosure or (ii) obtain an order protecting the resident’s health information.

iv. **Workers’ Compensation.** We may use or disclose the resident’s health information to workers’ compensation programs when the resident’s health condition arises out of a work-related illness or injury.

v. **Law Enforcement.** We may use or disclose the resident’s health information in response to a valid request received from a law enforcement official: (A) if we are required by law to do so; (B) pursuant to a court order, court-ordered warrant, subpoena, or summons; (C) for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; (D) regarding a victim of a crime; (E) to report a death that we believe may be caused by criminal conduct; (F) to report criminal conduct at our facility; and (G) in emergency situations, to report a crime.

vi. **Coroners, Medical Examiners, and Funeral Directors.** We may use or disclose the resident’s health information to: (A) coroners or medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; and (B) to funeral directors, consistent with
applicable law, as necessary to carry out their duties.

vii. Organ, Eye, and Tissue Donation Purposes. We may use or disclose the resident’s health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of facilitating donation and transplantation, consistent with applicable laws and the resident’s status as an organ donor.

viii. Research. We may use or disclose the resident’s health information without the resident’s prior written authorization: (A) for certain research studies approved by an Institutional Review Board or a Privacy Board pursuant to federal law; and (B) to certain researchers preparing to conduct a research project in order to assist them in identifying residents with specific health care issues who may qualify to participate in the proposed research project, with the limitation that such researchers identifying qualified participants will conduct their health information review onsite at facility.

ix. To Avert Serious Threats to Health and Safety. Consistent with applicable law and standards of ethical conduct, we may use or disclose the resident’s health information: (A) if necessary to prevent or lessen a serious and imminent threat to the health or safety of any person or the public; (B) if necessary for law enforcement authorities to identify or apprehend a person admitting participation in a violent crime; (C) when it appears that someone has escaped from a correctional institution or from lawful custody.

x. Specialized Government Functions. We may use or disclose the resident’s health information: (A) to appropriate domestic military command authorities if the resident is a member of the Armed Forces of the United States of America; (B) to appropriate foreign military command authorities if the resident is a member of a foreign military; (C) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act; and (D) to authorized federal officials for the provision of protective services to the President of the United States of America, other federal officials, and foreign heads of state.

xi. Inmates and Persons in Custody. If the resident is an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose the resident’s health information to the correctional institution or to the law enforcement official as may be necessary: (A) for the correctional institution to provide the resident with health care; (B) to protect the health or safety of the resident or another person; and (C) for the safety and security of the correctional institution.

xii. Other Uses or Disclosures Required by Law. We may use or disclose the resident’s health information as required by federal, state, or local law.

I. The Resident’s Rights Regarding Health Information Created and Maintained at Our Facility

   e. Right to Request Restrictions on Certain Uses and Disclosures of Health
Information

The resident has the right to request restrictions on our uses and disclosures of his/her health information to carry out treatment, payment, or health care operations, which are explained above in Section III(a) of this Summary. We, however, are not required to agree to the resident’s requested restriction. We will not agree to a requested restriction if it would interfere with normal treatment, payment, or health care operations.

f. Right to Receive Confidential Communications of Health Information

The resident has the right to make requests to receive communications about his/her health information from us by alternative means or at alternative locations. For instance, the resident has the right to request exclusion from the facility directory. Or, the resident has the right to restrict communication about his/her health information to certain family members, explained above in Section III(b) of this Summary. Or, the resident may request that we send any bills for payment to an address other than his/her home. We must accommodate such requests if they are reasonable. We may condition our accommodation on: (A) the resident’s agreement as to how payment, if any is due, will be handled; and (B) specification of an alternative address or other method of contact. We will not, however, require the resident to explain why he/she is requesting communication by an alternative means or at an alternative location.

g. Right to Inspect and Copy Health Information

The resident has the right to inspect and copy his/her health information. This includes medical and billing records, but does not include: (A) psychotherapy notes; (B) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; (C) any of his/her health information subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent that his/her access would be prohibited by law; and (D) any of his/her health information exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2). If the resident requests any of these four categories of information, or if you are not sure whether the resident’s request falls within one of these four categories, please contact the facility’s Privacy Contact Person.

To inspect and copy health information, the resident must submit his/her request in writing to Michell England, P.O. Box 206 Walsh, Co. 81090. If the resident requests a copy of his/her health information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with the request in accordance with federal, state, and local laws. If we grant or deny the resident’s request to inspect and copy his/her health information, we will do so in writing within [COLO. REV. STAT. § 25-1-802 STATES ACCESS MUST BE GIVEN “AT REASONABLE TIMES AND UPON REASONABLE NOTICE,” AND CDPHE REGULATIONS STATE THAT THIS PERIOD OF TIME IS 24 BUSINESS HOURS. NOTE THAT, UNDER SOME CIRCUMSTANCES SUCH AS EMERGENCIES OR OTHER URGENT SITUATIONS, ACCESS SHOULD BE GIVEN IMMEDIATELY]. If the resident’s health information is stored off-site, we may require additional time to obtain it for inspection and copying.

We may deny the resident’s request to inspect and copy his/her health information in
certain limited circumstances. If we deny the resident’s request, we will notify him/her in writing of the denial and our reasoning. If the resident is denied access to his/her health information, he/she may request that the denial be reviewed. If the resident is entitled to a review of the denial, a reviewing official selected by our community health center will review the resident’s request and the denial. The reviewing official will not be the person who denied the resident’s request. We will abide by the reviewing official’s decision if the resident is entitled to a review.

h. Right to Request an Amendment to Health Information

The resident has the right to request that we amend his/her health information maintained by us. We may deny the resident’s requested amendment if we determine that the health information at issue: (A) was not created by Walsh HealthCare Center, unless the resident provides a reasonable basis for us to believe that the originator of his/her health information is no longer available to act on his/her requested amendment; (B) is not part of the group of records maintained by or for us; (C) is not available for the resident’s inspection for the reasons described in Section IV(e) of this Summary; or (D) is accurate and complete.

Any requested amendment must be made in writing and describe the reasons supporting the requested amendment. We will endeavor to act on the resident’s requested amendment no later than 60 days after receipt of such request. We may extend this time limit to 90 days if we are unable to process the requested amendment within 60 days, but in so doing we will provide the resident with a written statement of the reasons for the delay and the date by which we anticipate acting on the such request.

If we grant the resident’s requested amendment, in whole or in part, we will: (A) make the appropriate amendment to the resident’s health information or record that is the subject of the request by, at a minimum, identifying the records that are affected by the amendment and appending or otherwise providing a link to the location of the amendment; (B) inform the resident that the amendment is accepted; and (C) make reasonable efforts to inform persons identified by the resident who require knowledge of the amendment; and (D) make reasonable efforts to inform persons known to us, including our business associates, that have the resident’s health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to the resident’s detriment.

If we deny the resident’s requested amendment, in whole or in part, we will provide the resident with a timely, written denial describing: (A) the basis for the denial; (B) the resident’s right to submit a written statement disagreeing with the denial and how the resident may file such a statement; (C) how the resident may complain to our community health center or the Secretary of the Department of Health and Human Services.

If the resident submits a statement of disagreement, the resident must describe the basis of his/her disagreement. We may reasonably limit the length of the resident’s statement of disagreement. We may also prepare a written rebuttal to the resident’s statement of disagreement, a copy of which we will provide to the resident. If the resident does not submit a statement of disagreement, he/she nonetheless may request that we provide his/her request for amendment and the denial with any future disclosures of his/her
health information that is the subject of the amendment.

i. Right to Receive an Accounting of Disclosures of Health Information

The resident has the right to receive an accounting of disclosures of his/her health information made by Walsh HealthCare Center during the last six years, or such lesser time as you designate, before the date on which he/she requests the accounting. The accounting will not describe disclosures: (A) made for purposes of treatment, payment, and health care operations; (B) made to the resident; (C) made pursuant to the resident's prior written authorization as described in Section III(c) of this Summary; (D) made for our community health center's directory or to people involved in the resident's care as described in Section III(b) of this Summary; (E) for national security or intelligence purposes, or to correctional institutions or law enforcement officials as described in Section III(d) of this Summary; and (F) that occurred prior to April 14, 2003. The resident's right to receive an accounting of disclosures of his/her health information may be suspended by a public health agency or law enforcement official.

The accounting will include, if possible for each reportable disclosure: (A) the date of the disclosure; (B) the name of the person who received the resident's protected health information and, if known, the address of such person; (C) a brief description of the information disclosed; and (D) a brief statement of the purpose of the disclosure. If, during the period covered by the accounting, we made multiple disclosures of the resident's health information to the same person or entity for a single purpose, the accounting may provide detailed information about the first disclosure, the date of the last disclosure, and statement regarding the frequency, periodicity, or number of disclosures made during the accounting period.

We will act on the resident's request for an accounting no later than 60 days after receipt of such a request. We may extend this time limit to 90 days if we are unable to process the requested accounting within 60 days, but in so doing we will provide the resident with a written statement of the reasons for the delay and the date by which we anticipate acting on the such request. We will impose a reasonable, cost-based fee for accounting requests to the extent permitted by law.

V. Complaints

If the resident believes his/her privacy rights have been violated, he/she may file a complaint with our facility or with the Secretary of the Department of Health and Human Services. To file a complaint with our facility, the resident must contact Michelle England, P.O. Box 206 Walsh, Co. 81090, (719)-324-5252 ext. 122. All complaints must be submitted in writing. We will not retaliate against the resident for filing a complaint.
ACKNOWLEDGMENT OF RECEIPT OF “SUMMARY OF PRIVACY POLICIES FOR STAFF,” “NOTICE OF PRIVACY PRACTICES,” “AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION,” AND PRIVACY POLICIES

I, _______________________, acknowledge receiving and reading a complete copy of the “Summary of Privacy Policies for Staff,” “Notice of Privacy Practices,” “Authorization for Use/Disclosure of Health Information,” and Privacy Policies of Walsh Hospital District on this _____ day of _____________, 20___. I further acknowledge that, as of today's date, I have no questions regarding the information contained in these documents.

________________________________________  ______________________________________
Signature                                                                 Signature of Witness

________________________________________  ______________________________________
Printed Name of Employee                Printed Name of Witness

________________________________________
Address of Employee
# Walsh Healthcare Center

## TODAY'S DATE:

### SECTION I: TO BE COMPLETED BY THE APPLICANT IN BLACK INK ONLY.

ALL INFORMATION IS REQUIRED TO BE COMPLETED. ***PLEASE WRITE LEGIBLY***

**PRINT**

<table>
<thead>
<tr>
<th>Full Name (First, Middle, Last):</th>
<th>Date Name was Used</th>
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Driver’s Lic. No., State of Issue, & Name as it appears on the license:

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<tr>
<th>Date of Birth:</th>
<th>Social Security No.:</th>
<th>Sex: M</th>
<th>F</th>
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SEVEN YEARS OF ADDRESS INFORMATION IS REQUIRED.

LIST CURRENT ADDRESS FIRST. INCLUDE STREET, CITY, STATE AND ZIPCODE. ATTACH AN ADDITIONAL SHEET IF NECESSARY.

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### NOTIFICATION AND RELEASE AUTHORIZATION FOLLOWS:

THE PURPOSE OF THIS SECTION IS TO NOTIFY YOU THAT A CONSUMER REPORT(S) WILL BE RUN ON YOU IN THE COURSE OF CONSIDERATION FOR EMPLOYMENT WITH WALSH HEALTHCARE CENTER.

I. In connection with my application for employment, I understand that an investigative consumer report may be requested that will include information as to my character, work habits, performance, including oral assessments of my job performance, experiences, and abilities, along with reasons for termination of past employment. I understand that as directed by company policy and consistent with the job description, you may be requesting information from public and private sources about my: workers’ compensation injuries, driving record, criminal record, education, credit, and previous employment.

II. Medical and workers’ compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws.

According to the Fair Credit Reporting Act (FCRA), I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency. If so, I will be notified and be given the name of the agency or the source of information.

III. In connection with this request, I hereby authorize, without reservation, all corporations, former employers, credit agencies, educational institutions, law enforcement agencies, city, state, county and federal courts, military services, information service bureau, employer or insurance company and persons to release and furnish information they may have about me as described in Section I to the person or company with which this form has been filed, or their agent, PreSearch Background Services. This releases the aforesaid parties from any liability and responsibility for collecting the above information.

Applicant Signature (REQUIRED)  Date Signed (REQUIRED)

### SECTION II: TO BE COMPLETED BY THE EMPLOYER.

<table>
<thead>
<tr>
<th>Type of Applicant (OPTIONAL)</th>
<th>Company Authorized Signature (REQUIRED)</th>
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SELECT TYPES OF BACKGROUND CHECKS REQUESTED. If background selection type is not made, a criminal search will be conducted searching the name(s) used in the countie(s) lived as provided by the applicant on this form. All Felony, misdemeanor, & traffic-related records will be provided to you following the F.C.R.A.

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<tr>
<th>Pre-Emp 7 year search □</th>
<th>Applicant Verification Report (SSN Trace) □</th>
<th>Criminal County Search, list City and State □</th>
<th>Other □ Please list,</th>
</tr>
</thead>
</table>

### SECTION III: BACKGROUND INVESTIGATION RESULTS. To be Completed by PreSearch Background Services.

This report is provided with the understanding that the tenets of the Fair Credit Reporting Act as well as other applicable Federal, State and Local statutes apply. Every effort has been made to assure the accuracy and completeness of the data. PreSearch Background Services cannot act as guarantor of the information.

STATE OR COUNTY CRIMINAL:

CLEAR □  ( ) RECORDS, REPORT FOLLOWS  DATE COMPLETED:

STATE OR COUNTY CRIMINAL:

CLEAR □  ( ) RECORDS, REPORT FOLLOWS  DATE COMPLETED:

OTHER:

CLEAR □  ( ) RECORDS, REPORT FOLLOWS □  DATE COMPLETED:

(SSN TRACE REPORT):

NO DISCREPANCY □  NAME AND/OR ADD DISC (*) □  REPORT FOLLOWS □