



ABSOLUTE HEALTHCARE SYSTEMS, INC
2860 S. RIVER ROAD SUITE 355
DES PLAINES, IL 60018
Phone: (847) 635-0700 | Fax: (847) 635-0707
yourabsolutecare.com

APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, sex, age, natural origin, or handicap. All information provided here in will be kept confidential. A pre-employment health examination is required by all applicants offered a job at ABSOLUTE HEALTHCARE SYSTEMS, INC.

PERSONAL

Last Name : First Name : MI :

Other Name Used (i.e. Maiden Name Used in the Last Place of Employment):

Street Address Apt #

City : State : ZIP :

Home Phone : Cell Phone :

Social Security Number : Date of Birth :

Emergency Contact Person :

Phone :

Have you applied for employment with ABSOLUTE HEALTHCARE SYSTEMS, INC.? ☐ YES ☐ NO

How many hours/days in a week you are available for work?

minimum : maximum :

Are you willing to work in the weekend? ☐ YES ☐ NO

When are you available to start working?

Do you have a reliable transportation? ☐ YES ☐ NO

Are you legally eligible for employment in the United States? ☐ YES ☐ NO

How did you learn our organization?

Position applying for:

Visiting/Registered Nurse/Licensed Practical Nurse
Visiting Physical Therapist/Assistant Occupational Therapist
Visiting Occupational Therapist/Assistant Occupational Therapist
Visiting Speech/Language Pathologist
Visiting Medical Social Worker
Home Health Aide



EDUCATION

	School Name	School Location	Course of Study	Years Completed	Degree/Diploma Earned
Masters/ Doctorate					
College					
College					
High School					

Professional references that we may contact for employment verification preferably the last three recent employers:

1. Name of Supervisor :

Telephone. No :

Company Name & Address:

Your Position/title in the company :

Brief description
of your job

Dates of employment : from through :

Starting pay : Ending pay :

Reason for leaving :

2. Name of Supervisor :

Telephone. No :

Company Name & Address:

Your Position/title in the company :

Brief description
of your job

Dates of employment : from through :

Starting pay : Ending pay :

Reason for leaving :

3. Name of Supervisor :

Telephone. No :

Company Name & Address:

Your Position/title in the company :

Brief description
of your job

Dates of employment : from through :

Starting pay : Ending pay :

Reason for leaving :



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GENERAL

Have you been convicted of a crime in the past 10 years, excluding misdemeanors and summary offenses, which have not been annulled, expunged or sealed by a court? ☐ YES ☐ NO

Conviction will not necessarily disqualify an applicant from employment. If yes, please describe

Are you capable of performing the duties and responsibilities set forth in the job description of the position you applied for? ☐ YES ☐ NO

List of licenses

Illinois Professional License Number (LPN, RN):

Expiration date :

Illinois drivers license number:

Expiration date :

Credentials/specialized skills and qualifications

SIGNATURE

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that if employed, falsified statements on this application *SHALL BE GROUND FOR DISMISSAL*.

I authorize complete investigation of all statement contained herein and hereby give my full permission for ABSOLUTE HEALTHCARE SYSTEMS, INC to contact and fully discuss my background and history with all persons and entities listed above to give ABSOLUTE HEALTHCARE SYSTEMS, INC any and all information concerning my previous employment any information they may have, release all former employers and others listed above from all liability for any damage that may result from furnishing same to ABSOLUTE HEALTHCARE SYSTEMS, INC.

I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not application are being accepted at that time.

Applicant Signature Over Printed Name

Date



ORIENTATION CHECKLIST

Initial and date

I have been oriented to the policies and procedures of the agency

I have read the HIPAA policies and procedures and obtained orientation

I received a copy of my job description

I understand my job description thoroughly

I have received and read the employee manual

I have read and signed a current employment contract

I understand the employment contract thoroughly

I have received a copy of the infection control policy

I have been trained in the equipment issued to me

I understand how to operate the equipment issued to me

I received an ID badge

My signature below signifies that the above is true and correct.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems Inc. Representative
Signature Over Printed Name, Designation

Date



SUBJECT: SKILLED NURSE (SN) JOB DESCRIPTION

JOB TITLE: Skilled Nurse

RESPONSIBLE TO: Director of Nursing

SUPERVISES DIRECTLY: Licensed Practical Nurses and Home Health Aides

QUALIFICATIONS:

- A graduate of an accredited nursing program
- Have a current Illinois license as a Registered Nurse:
- Have at least one (1) year clinical nursing experience, preferably in rehabilitation or medical-surgical nursing (home health experience preferred).
- Have current CPR certification.
- Possesses interpersonal, communication and organizational skills necessary to complete job responsibilities.
- Has an insured automobile and a valid driver's license, or access to adequate transportation.
- Has the ability to make home visits and provide skilled nursing assessments and skilled care in the home.
- Must not pose as a "direct threat" to the health or safety of the individual or others in the workplace or in the job performance.

DESCRIPTION

The Skilled Nurse has clinical nursing knowledge, physical assessment, teaching and procedural skills. He/she has the ability to be directly responsible for assessing, planning, providing and documenting nursing care for a designated group of patients in accordance with the physician's plan of care and agency's policies and procedures. The provision of quality care is accomplished by implementing, supervising and coordinating services provided and utilizing division and community resources to meet patient's needs. The Skilled Nurse provides supervision to LPN'S, Home Health Aides and completes documentation of effectively and timely.

DUTIES AND RESPONSIBILITIES

1. Completes referrals and takes physician's verbal orders as necessary in a timely manner. Channels referrals appropriately to Director of Nursing for assignment.
2. Makes home visits, performs physical assessments, evaluates patient's needs and consults with physician if necessary to develop plan of care and documents appropriate and in a timely manner.
3. Assesses need for additional health or ancillary services and refers patients for service(s) when appropriate, on a timely basis.
4. Assesses family and home environment and makes recommendations, which will Enhance patient care and promote safety.



5. Involves patients and/or family in developing and revising an individualized care plan including necessary teachings with realistic goals, update plan of care as goals are met or change in intervention as required and documents changes appropriately within five (5) days.
6. Coordinates the multidisciplinary care team and plans for patient care and documents appropriately.
7. Interprets the admission, discharge and other policies of the company to patient, Physician, family, other health care providers, and community as needed.
8. Provides clear, written and verbal Home Health Aide and LPN assignments, updates instructions for the aides and LPN'S in a timely manner and documents verbal instructions appropriately.
9. Provides skilled nursing care and assessments to patients in the home environments, according to the plan of care and promptly revises the plan, as necessary, in consultation with the physician and other team members. Establishes and modifies goals as appropriate.
10. Informs physician within four (4) hours of changes in patient's condition in accordance with generic screens or physician's orders and documents communication with physicians appropriately.
11. Initiate appropriate preventive, rehabilitative, comfort, pain management nursing Procedures and provides instructions to patient/caregivers, and staff in a timely manner. Follows company policies and utilizes company forms in documenting.
12. Explains to the patient and family the diagnosis and the nature of the treatment consistent with the physician's orders and plan of treatment.
13. Performs LPN supervisory visits to evaluate competency, at least once every month or more frequently, if necessary. Provides skilled services and appropriate instructions to LPN and documents accordingly.
14. Conducts Home Health Aide supervisory visits at least every 2 weeks either when the home health aide is present to observe and assist or when the home health
15. Aide is absent to assess relationships and determine whether goals are being met.
16. Performs specialized care in accordance with the competencies and demonstrates initiative in learning new skills and developing competency.
17. Maintains current assigned patient's clinical records including medications profiles, plan of care, case conferences, progress notes, and other required documentation. Conducts patient care conferences (PT, QT, SLP) every three weeks from the start of care and report unusual occurrence changes to the attention of the physician. The patient and family are consulted and informed about all the changes in the care plan.
18. Completes clear, concise and accurate clinical notes which documents skilled services and other required documentation appropriately and submit on a timely basis. Utilizes only universally approved abbreviations.
19. Communicates necessary information to the Director of Nursing.
20. Demonstrates professionalism by maintaining high standards of clinical care and staying current on clinical and medical issues.
21. Attends and participates in multidisciplinary patient case conferences, in service
22. Programs, quality improvement activities and staff meetings as assigned and documents appropriately.



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23. Conducts and documents formal and informal case conferences to demonstrate effective coordination and continuity of patient care, as well as, schedule cases to be brought to the clinical records review committee.
24. Works with patient, family and health care team members effectively to coordinate services and to promote quality care and positive patient care outcomes.
25. Cooperates and is reliable with providing on call coverage and making PRN, weekend and holiday visits to the patients.
26. Establishes and maintains working relationships and open lines of communication with personnel from physician's offices, area hospitals, clinics, etc. To assure flow on information, referrals for service and continuity of care.
27. Completes nutritional assessments and provides patient' caregiver instructions on diet 'nutrition and seeks consultation as necessary.
28. Uses appropriate infection control procedures and safety measures.
29. Administer CPR, provides emergency care when necessary and maintains current CPR certifications.
30. Assists in orienting' preempting new staff when necessary.
31. Provides and documents services in accordance with State, Federal, Medicare, Medicaid, regulations as applicable.
32. Provides and documents services in accordance with third party payer requirements and obtains prior authorization as required. Submits 485, recertification information timely, accurately and legibly. Notifies data processing of payer source changes in a timely manner.
33. Performs job duties and uses resources appropriately.
34. Coordinate with Administrator' DON program to improve deficient services and the development and implementation of plan of correction.
35. Adhere to the policies and procedures of the Agency.
36. Perform other duties as assigned by the Director of Nursing.

ACCEPTED BY:

EMPLOYEE NAME AND SIGNATURE

DATE

APPROVED BY:

LAGRIMAS E. SORRONDA, Administrator

SUPERVISOR NAME AND SIGNATURE

DATE



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EXPERIENCE AND SKILLS INVENTORY: SKILLED NURSE

WORK PLACE EXPERIENCE

- ☐ Nursing Home
☐ Hospital

- ☐ Home Care
☐ Rehabilitation Center

CLINICAL EXPERIENCE

- ☐ Medical
☐ Surgical
☐ Hospice
☐ ICU/CCU

- ☐ Rehabilitation
☐ Children
☐ Geriatrics

- ☐ Oncology
☐ Post Partum
☐ Neurology

SKILLS INVENTORY

- 0- No Experience
1- Need Review/Limited Supervision
2- Can Perform Independently

	0	1	2
Perform Venipuncture	0	1	2
PICC Line Insertion	0	1	2
Care of Triple Lume	0	1	2
Care of Groshong Catheter	0	1	2
IV Antibiotic Infusion	0	1	2
Use of Feeding Pump	0	1	2
Use of IV Pump	0	1	2
Care of G-Tubes	0	1	2
TPN	0	1	2
Ventilators	0	1	2
Tracheostomy Care	0	1	2
Foley Catheter Insertion	0	1	2
Ostomy Care	0	1	2
Use Glucometer	0	1	2
Decubitus Care	0	1	2
Use of Hoyer Lift	0	1	2
Use of Oxygen	0	1	2
Nebulizer Treatment	0	1	2

EMPLOYEE NAME: _____ DATE: _____

EVALUATOR'S NAME AND SIGNATURE: LAGRIMAS E. SORRONDA DATE: _____



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EMPLOYMENT AGREEMENT

This employment agreement (agreement) is made effective as of _____ and between **ABSOLUTE HEALTHCARE SYSTEMS INC**, (the employer), of 2860 S. River Rd., suite 355 Des Plaines, IL 60018 and ("the employee").

- A. Employer is engaged in the business of home health care
- B. Employer desires to have the services of employee/contractor
- C. Employee/contractor is willing to be employed by employer

Therefore, the parties agrees as follows:

1. **Employment.** Employee shall provide to employer the services described on the attached **exhibit A**, which is made a part of this agreement by this reference.
2. **Best effort of employee.** Employee agrees to perform faithfully, industriously, and to the best of employees ability, experience, and talents, all of the duties that may be required by the expressed and implicit terms of this agreement to the reasonable satisfaction of employer. Such duties shall be provided in the state of Illinois where the agency is licensed in the counties of Cook, Lake, DuPage, Boone, Winnebago, McHenry, Will, and Kane, and at such other places as the needs , business, or opportunities of the employer may require from time to time.
3. **Compensation of employee.** As compensation for services provided by employee under this agreement, employee will pay employee_____/visit/hr. This amount shall be paid every 15th and 31st of the month in accordance with the usual payroll procedures. Upon termination of this agreement, payments under this paragraph shall cease; provided however, that the employee shall be entitled to payments for periods or partial periods that occurred prior to the date of termination and for the employee has not yet been paid. **See exhibit B**, Full time/Part time contract agreement.
4. **Reimbursement for expenses in accordance with employer policy.** The employer will reimburse the employee for the mileage as "out of pocket" expenses in accordance with employer policies in effect from time to time.
5. **Termination due to discontinuance of business.** If the employer discontinues operating its business at 2860 S. River Rd, suite 355 Des Plaines, IL 60018, then this agreement shall terminate upon notice of termination as provided in this agreement.
6. **Recommendations for improving operations.** Employee shall provide employer all information regarding employers business of which employee has knowledge. Employee



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shall make all suggestions and recommendations that will be of mutual benefit to employer and employee.

7. **Confidentiality.** Employee recognizes that employer has and will have information regarding the following:

- a) Products
- b) Prices
- c) Future plans
- d) Business affairs
- e) Processes
- f) Trade secrets
- g) Customers list
- h) Protected health information
- i) Other vital information (collectively, information) which are valuable, special and unique assets of employer

Employee agrees that the employee will not at any time or in any manner, either directly or indirectly, divulge, disclose, or communicate in any manner any information to any third party without prior written consent of the employer. Employee will protect the information and treat it as strictly confidential. A violation by employee of this paragraph shall be a material violation of this agreement and will justify legal and/or equitable relief.

8. **Unauthorized disclosure of information.** If it appears that employee has disclosed or has threatened to disclose) information in violation of this agreement, employer shall be entitled to an injunction to restrain employee from disclosing, in whole or in part such "information" or from providing any services to any party to whom such information has been disclosed or may be disclosed employer shall not be prohibited by this provision from pursuing other remedies, including a claim for losses and damages. **See exhibit C**, addendum to contract.

9. **Non compete agreement.** Non compete is a condition for acceptance in seeking employment at Absolute Healthcare Systems, Inc. Recognizing that the various items of information are special and unique assets of the company, employee willfully agrees without inflicting any force or coercion, and covenants that for a period of two (2) years following the termination of this agreement, whether such termination is voluntary or involuntary, employee will not directly or indirectly engage in any business competitive with employer. This covenant shall apply to the geographical service area which includes but shall not be limited to the following counties:

Cook	Boone
Lake	Winnebago
DuPage	Will
McHenry	Kane



Employee will not directly or indirectly engage in any competitive business includes, but is not limited to:

- a) Engaging in a business as owner, partner, or agent
- b) Becoming an employee of any third party that is engaged in such business
- c) Becoming interested directly or indirectly in any such business
- d) Soliciting any customer or employees of employer for the benefit of a third party that is engaged in such business

See exhibit D Non Competition Covenant and Written Consent

- 10. **Compliance with employers rules.** Employee agrees to submit all of the rules and regulation of employer.
- 11. **Return of records.** Upon termination of this agreement, employee shall deliver all property (including keys, records, notes, data, memorandum, models, and equipment) that is in the employees possession or under the employees control which is employers property or related to employers business.
- 12. **Notices.** All notices required or permitted under this agreement shall be in writing and shall be deemed delivered when delivered in peson or deposited in the United States mail, postage paid, and addressed as follows:

Employer:

ABSOLUTE HEALTHCARE SYSTEMS INC.
2860 S. RIVER RD., SUITE 355
DES PLAINES IL 60018

Employee/Contractor:

Such addresses maybe changed from time to time by either party by providing written notice in the manner set forth above.

- 13. **Entire agreement.** This agreement contains the entire agreement of the parties and there are no other promises or condititions in any other agreement whether oral or written. This agreement supersede any prior written or oral agreements between the parties.
- 14. **Amendment.** This agreement may be modified or amended if the amendment is made in writing and is signed by both parties.



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15. **Severability.** If any provisions of this agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions of this agreement shall continue to be valid and enforceable. If a court finds that any provision of this agreement is invalid or unenforceable, but that by limiting such provision it would become valid or enforceable, then such provision shall be deemed to be written, construed and enforced as so limited.
16. **Waiver of contractual right.** The failure of either party to enforce any provision of this agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this agreement.
17. **Applicable law.**

This agreement shall be governed by the Laws of the State of Illinois.

Employee/Contractor:

Applicant Signature Over Printed Name

Date

Employer:

ABSOLUTE HEALTHCARE SYSTEMS, INC. Representative
Signature Over Printed Name, Designation

Date



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EXHIBIT A

DESCRIPTION OF SERVICES

Name: _____

Employee agrees during the term of this agreement that patients are accepted for care by ABSOLUTE HEALTHCARE SYSTEMS, INC. And no other party. Employee is hereby engaged to work for the service in the capacity of **Home Health Nurse (RN)/(LPN)** .

Employee agrees to provide primary home health care on behalf of Absolute Healthcare Systems, Inc. This includes the following:

1. Following all the directives from the Administrative staff and licensed health care providers of Absolute Healthcare Systems, Inc.
2. Help to develop and mutually agree as to a patient care and treatment plan with Absolute Healthcare Systems, Inc. and ordering physicians and once said plan is developed follow through with care, submit all progress notes timely, schedule visits, and periodic patient evaluations and conferences as called for by the services operating procedures.
3. Acknowledge receipt and understanding of Absolute Healthcare Systems, Inc policies and procedures.
4. Submit in writing requests for payments using Absolute Healthcare Systems Inc forms and procedures. All forms are to be completed in full and executed by all appropriate parties before there is an obligation on the part of the agency to make payment there unto.
5. Employee agrees to provide and possess his/her malpractice insurance applicable licensure and auto insurance. Employee, once each year will provide to the agency a signed physician health statement to certify that the employee is free from communicable disease and in good health, able to do all duties required by the agency.
6. Employee agrees to attend such in service and patient care conferences as mandated by the State of Illinois or by the agency policy. Employee understands that failure to attend such conferences maybe grounds for termination of this contract.
7. Employee acknowledges that should he/she decides to resign from the agency or have to leave a case(patient/patients) to which they are assigned, employee must give advance notice of at least 15 days to allow time for a replacement to assume the case load/patient.



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8. Employee acknowledges that all records kept in the course of this contract to which employee may be assigned are the sole property of Absolute Healthcare Systems, Inc, all records should immediately be delivered to the agency at the address stated above. Office hours are from 9:00 AM to 5:30PM, Monday thru Friday.
9. Employee further acknowledges and understands that from time to time employee may be required to provide nursing services to persons with communicable disease or patients that may become violent. Employee, in his/her professional capacity understands and assumes the risk of any and such contact and hereby releases and holds harmless Absolute Healthcare Systems, Inc from any damages, illness, or injuries that might result from such contact with patients. Employee agrees that neither the employee or his/her heirs, exucutors, administrators will at any time assert any claim whatsoever against the agency based upon the employee being exposed to or contracting any disease or injury as a result of employment in the agency.
10. This agreement, regulations of the Illinois Department of Public Health and the policies and procedures of Absolute Healthcare Systems, Inc constitutes the whole agreement between the parties. Modifications or changes to this contract between the parties must be in writing.
11. Employee expressly grants to the agency the right to investigate fully any and all statements contained in the employee history as supplied to the service and releases the service from any and all liability as a result of any such investigation into the employee's history as provided to the agency.
12. Payment for the services will be based on the category of insurance of the patient, specialty of this servicing professional, experience and on time completion of notes and quality assurance requirements. Field visits will be limited to 40 hous per week at a rate of \$_____/visit as agreed upon by both parties. Any overtime will be paid at a regular rate. Failure to submit notes timely (every Tuesday) are subjected to a reduction of visit rate at \$1 each working day. Incomplete visit notes/OASIS will be returned unpaid, employee will be compensated at a rate of \$8.75/visit note or OASIS which may be resubmitted once completed and will subsequently be paid at a regular rate.
13. Frequent breaches of the regulation may result in transfer of the professional's caseload to other staff members.

Agreed:

Applicant Signature Over Printed Name

Date

Witness:

Absolute Healthcare Systems, Inc. Representative
Signature Over Printed Name, Designation

Date



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EXHIBIT B

PART TIME/FULL TIME AGREEMENT

(SEASONAL EMPLOYEES)

RN, LPN, PT, PTA, OT, OTA, ST, MSW

I, _____ hereby agree to work for **ABSOLUTE HEALTHCARE SYSTEMS, INC.** with a compensation of \$_____ per visit and to abide with all policies and procedures formulated by ABSOLUTE HEALTHCARE SYSTEMS, INC. Medicare standards, and other accrediting agency and performs additional duties and responsibilities as follows but not limited to:

1. That the patient shall be admitted by the agency only, and arrangements to provide services shall be done by the agency.
2. It is my responsibility to:
 - A. Coordinate with the formulation of Plan of Care for all patients.
 - B. Follow Plan of Care.
 - C. Implement Plan of Care,
 - D. Assess and re-assess patient's needs for services, progress, and deterioration of patient's condition.
 - E. Coordinate with all team members assigned to the patient.
3. Report to ABSOLUTE HEALTHCARE SYSTEMS, INC.. office any changes in patient's condition and need to decrease or increase service.
4. RN to communicate with the attending physician at the start of care, and update patient's condition to MD at least every four (4) weeks, and report to attending MD for any changes in patient's condition.
5. All doctor's order must be called in to his/her immediate supervisor and ABSOLUTE HEALTHCARE SYSTEMS Inc. office.
6. Comply with submission of documents policy.
7. Comply with ABSOLUTE HEALTHCARE SYSTEMS, INC. policy and procedure on Beeper/Pager/Cell phone.
8. Attend conferences scheduled by you and your immediate supervisor.
9. All visits shall be scheduled and approved by the Director of Professional Services and/or its designee, per physician's order. No field staff member shall schedule his/her own visit without prior approval from his/her supervisor.
10. Field staff member shall not quote any charges to patients or give information to patients regarding reimbursement by any provider or insurance.
11. I understand that as a part-time employee, my workload assignment is not guaranteed, assignment of workload will depend on the number of patients admitted to ABSOLUTE HEALTHCARE SYSTEMS, INC. and my availability at the time of the patient's admission.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc. Representative
Signature Over Printed Name, Designation

Date



EXHIBIT C

ADDENDUM TO CONTRACT

The following addendum becomes part of the current contractual agreement between Absolute Healthcare Systems, In and Employee.

Absolute Healthcare Systems, Inc. shall make available all records and information relevant to the patient for the purpose of the services being provided. The employee must maintain records and reports which are incorporated in the medical record no less than weekly, including progress notes, and proper reports to physiciain.

The employee and Abslute Healthcare Systems, Inc. are responsible for safeguarding the security and privacy of any information that the two parties exchange. Both parties will meet the HIPAA security standards for information that describes the health of individual patients. Specifically employee will:

- Not use or disclose PHI other than is required by his contract
 - Use appropriate safeguards to protect the PHI
 - Report any uses or disclosures not permitted
 - Ensure that all business associate are compliant with HIPAA regulations
 - Make all information available for inspection by the patient or regulatory agencies
 - Allow the patient to request an amendment
 - Provide an accounting of any non covered disclosures
 - Make all internal practices available to regulatory agencies -
- Return or destroy all PHI upon termination of contract

Agreed upon and made part of the existing contract effective

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems Inc. Representative
Signature Over Printed Name, Designation

Date



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EXHIBIT D

NON COMPETITION COVENANT

Agreement made between _____ as employee and
Absolute Healthcare Systems, Inc., employer.

The parties to this agreement, in consideration of the mutual covenant and stipulations set forth agree as follows:

Due to the importance of the patient and its referral source to the company and the catastrophic effect on the financial interest of the company, the Employee is hereby covenants and agrees that he/she will not at any time during the period of this employment and a period of (2) years after termination of Employee's employment for any reason "the restricted period," directly or indirectly, without Absolute Healthcare Systems, Inc. prior written consent, solicits in correspondence with, initiate contact with any patient, treated or visited by the employee while under employment of Absolute Healthcare Systems, Inc. or any referral source of Absolute Healthcare Systems, Inc. in any, without limitations to any home health agencies, directly and indirectly advise and or request any patient of Absolute Healthcare Systems, Inc. to withdraw, curtail or cancel such patients business with Absolute Healthcare Systems Inc. A penalty of \$10,000.00 for each patient transferred to another home health agency will be enforced.

This instrument contains the entire agreement between the parties, and no statements, promises or inducements made by either party or agent of either party that are not contained in this contract shall be valid or binding; this contract may not be enlarged, modified or altered except in writing signed by both parties and endorsed in this agreement.

This agreement shall inure to the benefit of and be binding on the heirs, executors, assignees, and successors of the respective parties.

In witness whereof, we have hereunto signed this agreement on _____.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc. Representative
Signature Over Printed Name, Designation

Date



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ADDENDUM TO NON COMPETITIVE COVENANT

A WRITTEN CONSENT

This is an acknowledgment that this written consent is given to Employee, by Absolute Healthcare Systems, Inc. The above employee is hereby given consent to seek employment only within a restricted period of the non competitive covenant. These employments will not interfere with his/her work productivity and expectations of Absolute Healthcare Systems, Inc.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc.
Signature Over Printed Name, Designation

Date



STAFF RESPONSIBILITY

A. PATIENT CARE

1. Communicate patient condition/changes, questions, and concerns to ABSOLUTE HEALTHCARE SYSTEMS, INC. nursing services in a timely manner.
2. Do not violate patient confidentiality. Strict laws exist for protection of client's rights to confidentiality.
3. Do not violate the patient/employee relationship
 - a. Remember that staff members work for ABSOLUTE HEALTHCARE SYSTEMS, INC. and not for the patient.
 - b. Do not share your personal life with the client, especially problems and concerns.
 - c. Do not get involved with patient's family conflicts.
 - d. Do not assume responsibility for client's lifestyle but instead remember his/her choices.
 - e. Do not request or accept money from any client or client's family members.
 - f. Do not accept personal gifts from clients or client's family members.
 - g. Do not give personal gifts to any clients or client's family members.
 - h. Do not take clients home.
 - i. Do not take your family, children, or friends to client's homes while working or any other time.
 - j. Do not make personal phone calls from client's home, unless absolutely necessary or in an event of an emergency, and unless you have a client's permission.
 - k. Do not discuss salary with clients, client's family, or other staff members.
 - l. Unlicensed staff members: do not contact the client's physician without approval from ABSOLUTE HEALTHCARE SYSTEMS, INC. RN or Supervisor. If the client's family member requests that you contact the physician, inform them that you are not permitted to do so, but that you can contact the RN so that the RN can give assistance as necessary.
 - m. Under no circumstances is unlicensed staff members allowed to receive physician's orders.
 - n. Do not personally transport clients in an automotive vehicle.
 - o. Report suspected vulnerable client abuse and/or neglect according to the vulnerable Adult Act and the ABSOLUTE HEALTHCARE SYSTEMS, INC. policies and procedures.

Examples of Adult Abuse and Neglect:

 - i. Physical Abuse: Physical acts by a caregiver that causes pain, suffering, injury, or hurts a client; physical acts by a caregiver that chastises, belittles, embarrasses humiliates, or degrades a client; use of unapproved or excessive physical or chemical restraint techniques toward a client by a caregiver.



ABSOLUTE HEALTHCARE SYSTEMS, INC

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- ii. Verbal Abuse: Any derogatory, threatening, decisive, and or demanding language, whether oral or with gestures, directed toward a client by a caregiver; any profane language directed toward a client by a caregiver.
 - iii. Neglect: Failure or refusal to attend necessary care and treatment of a client by a caregiver to which they are entitled.
 - iv. Sexual Abuse: Any sexual activity between a caregiver and a client even if such actions are consented by the client or that of a person in the caregiver's position, should have reasonably known that the client would perceive as sexual activity; a caregiver using his/her position for sexual gratification or exploitation of clients
- p. Report any client sexual harassment to ABSOLUTE HEALTHCARE SYSTEMS, INC. nursing services.
- 4. Give verbal and written reports of client incidents/accidents to ABSOLUTE HEALTHCARE SYSTEMS, INC
 - a. Do the following for the client accident/incident:
 - i. Dial 911 for assistance in an emergency situation.
 - ii. Report the incident/accident to ABSOLUTE HEALTHCARE SYSTEMS INC. office
 - iii. Contact the client's physician as necessary.
 - iv. Document the client incident/accident without stating in the client's clinical record that any error has been made.
 - v. Record only an objective, factual account of the actual client accident/incident.
- 5. Follow infection control guidelines.

B. JOB PERFORMANCE

- 1. Report to ABSOLUTE HEALTHCARE SYSTEMS, INC. Supervisor who supervise, evaluate, and monitor your job performance.
- 2. Participate in annual job performance reviews done by ABSOLUTE HEALTHCARE SYSTEMS, INC.
- 3. Adhere to the following ABSOLUTE HEALTHCARE SYSTEMS, INC. standards in appearance and conduct:
 - a. Wear casual clothes: such as skirts, slacks, and shirts.
 - b. Maintain a neat appearance.
 - c. Wear ABSOLUTE HEALTHCARE SYSTEMS, INC. smock gown.
 - d. Keep fingernails clean and short.
 - e. Function within the limits set by ABSOLUTE HEALTHCARE SYSTEMS, INC. policies and procedures.
 - f. Do not use slang or foul language.
 - g. Be considerate and courteous in contacts with clients and other persons.
 - h. Treat clients with respect and recognize their need for privacy.



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- i. Ensure confidentiality with respect to client's conditions, histories, and behaviors
- j. Maintain a calm and reassuring attitude in crisis situations.
- k. Be tactful in manners and attitudes dealing with clients and other persons.
- l. Complete all assignments satisfactorily.
4. Do not abuse chemical, substance, e.g. alcohol, or drugs.
5. Do not witness signatures on any papers, e.g. sale of house or last will and testament.
6. Do not violate staff member's confidentiality.
7. Do not sign someone else's signature to time slips where the client is to sign.

C. DOCUMENTATION

1. Document client home health care information on skilled nursing visit report/home health aide visit report sheets according to ABSOLUTE HEALTHCARE SYSTEMS INC standards
2. Document:
 - a. Use black ballpoint ink.
 - b. Write legibly.
 - c. Use correct spelling and grammar.
 - d. Use objective statements.
 - e. Include only significant information about the client.
 - f. Do not use medical abbreviations on subjective data.
 - g. Deadlines, submission of documents:
 - i. Assessment due within five days of start of care.
 - ii. Care plan due within five days of start of care, updated monthly/or as problems resolve/or new problems identified.
 - iii. Skilled nursing visit report/home health aide visits report due weekly.
 - iv. Decubitus/wound reports due weekly.
 - v. Licensed practical nurse supervisory visits due every two weeks.
 - vi. Home health aide supervisory visits due every two weeks.
 - vii. Medication profile updated monthly and/or new orders received/discharge previous medication orders.
 - viii. Conference report with physical therapist, speech therapist, occupational therapist, or social worker due every three weeks.
 - ix. Discharge summary will be submitted at the end of service.

D. PERSONNEL

1. Keep professional license updated. Give copy of updated professional license to ABSOLUTE HEALTHCARE SYSTEMS, INC



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2. Attend continuing education classes as scheduled by ABSOLUTE HEALTHCARE SYSTEMS, INC. to keep professional knowledge and skills current.
3. Advise ABSOLUTE HEALTHCARE SYSTEMS, INC.'s office of any change in home address, telephone number, or availability to work.
4. Give ABSOLUTE HEALTHCARE SYSTEMS, INC.'s office a signed physician release statement for continued employment when treated for any communicable disease, back injury, mental illness, chemical dependency, or pregnancy.
5. Contact ABSOLUTE HEALTHCARE SYSTEMS, INC.'s office within twenty-four hours if injured while on duty. Failure to notify ABSOLUTE HEALTHCARE SYSTEMS , INC. office may disqualify you from receiving workers compensation benefit.
6. Document incidents/accidents immediately.

I have read and understood the responsibilities as ABSOLUTE HEALTHCARE SYSTEMS, INC. employee.

Applicant signature Over Printed Name

Date

Absolute Healthcare Systems ,Inc. Representative
Signature Over Printed Name, Designation

Date



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EMPLOYMENT REFERENCE RELEASE

I acknowledge that I have been informed that it is Absolute Healthcare Systems, Inc.'s general policy to disclose in response to a prospective employer's request only the following information about current or former employees:

1. The dates of employment
2. Descriptions of the job performed
3. Salary or wage rates

By signing this release, I am voluntarily requesting that Absolute Healthcare Systems, Inc. depart from this general policy in responding to reference requests from any prospective employer that may be considering me for employment. I authorize Absolute Healthcare Systems, Inc. to disclose to such prospective employers any employment related information that Absolute Healthcare Systems, Inc. in its sole discretion and judgment, may determine is appropriate to disclose, including any personal comments, evaluations, or assessments that Absolute Healthcare Systems, Inc. may have about my performance or behavior as an employee.

In exchange for Absolute Healthcare Systems, Inc. agreement to depart from its general policy and to disclose additional employment related information pursuant to my request, I agree to release and discharge Absolute Healthcare Systems Inc. , its successors, employees, officers, and directors for all claims, liabilities, and causes for action , known or unknown, fixed or contingent, that arise from from or that are in any manner connected to Absolute Healthcare Systems, Inc., disclosure of employment related information to prospective employers. This release includes, but is not limited to, claims of defamation , libel, and slander, negligence, or interference with contract or profession.

I acknowledge that I have carefully read and fully understand the provision s of this release. I further acknowledge that I was given the opportunity to consult with an attorney or any other individual of my choosing before signing this release and that I have decided to sign this release voluntarily and without coercion or duress by any person.

This release sets forth the entire agreement between Absolute Helthcare Systems , Inc. and me, I acknowledge that I have not relied upon any representation or statement , written or oral, not set forth in this documentation.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc. Representative
Signature Over Printed Name

Date



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AUTOMOBILE RELEASE OF LIABILITY

Employee Automobile:

It is my understanding and at my discretion to use my personal automobile as part of my duties in the care of clients assigned to me.

I acknowledge that I have the primary responsibility for my car insurance. I agree to hold Absolute Healthcare Systems, Inc. harmless in the event that there is an accident which there is a damage to my car or injuries to its occupants.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc. Representative
Signature Over Printed Name, Designation

Date



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AUTHORIZATION FOR BACKGROUND CHECK

I,

AUTHORIZE Absolute Healthcare Systems, Inc., to perform a criminal background check with the Illinois State Police in my behalf for employment purposes.

This also authorizes Illinois State Police to release any record pertaining to me.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc., Representative
Signature Over Printed Name, Designation

Date



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VERIFICATION OF PROFESSIONAL LICENSE

Name: _____

Address: _____

Illinois Professional License Number (LPN, RN): _____

Expiration date: _____

Social Security Number: _____

Illinois drivers license number: _____

Expiration date: _____

This is to certify that this is my true and correct Illinois License Number and information and that I am the named person stated on the license presented.

Applicant Signature Over Printed Name

Date

This is to certify that I have seen a valid and current copy of the license described above and have properly identified the licensee.

Absolute Healthcare Systems, Inc., Representative
Signature Over Printed Name, Designation

Date



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OSHA CERTIFICATION

This is to certify that _____, has completed inservices regarding the OSHA standard on air and blood borne pathogens, and occupational hazards.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems Inc, Representative
Signature Over Printed Name, Designation

Date

**Form I-9, Employment
Eligibility Verification**

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 documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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 #) _____
☐ An alien authorized to work (Alien # or Admission #) _____
until (expiration date, if applicable - month/day/year)

Employee's Signature

Date (month/day/year)

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.*

Preparer's/Translator's Signature

Print Name

Address (Street Name and Number, City, State, Zip Code)

Date (month/day/year)

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name ASAD MALIK	Title PRESIDENT
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) Absolute Healthcare Systems, Inc., 2860 S. River Rd., Des Plaines, IL 60018		Date (month/day/year)

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
-----------------------------	--

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
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 (month/day/year)

Form W-4 (2012)

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 2012 expires February 18, 2013. 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 \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

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

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

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at www.irs.gov/w4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	_____
B	Enter "1" if: { • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	_____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	_____
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 \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child	G	_____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ?	H	_____

For accuracy, complete all worksheets that apply.

{

• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.

• If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.

If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4 Department of the Treasury Internal Revenue Service 1 Your first name and middle initial Home address (number and street or rural route) City or town, state, and ZIP code 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 2012, 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 ? 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	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. Last name 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. 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 _____ 6 _____ 7 _____ 7 _____ 9 Office code (optional) 10 Employer identification number (EIN)	OMB No. 1545-0074 2012 2 Your social security number 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. 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 _____ 6 _____ 7 _____ 7 _____ 9 Office code (optional) 10 Employer identification number (EIN)
--	---	--

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

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

Date ?



ABSOLUTE HEALTHCARE SYSTEMS, INC
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HEPATITIS B VACCINATION APPROVAL

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 chose to be vaccinated at no cost by absolute Healthcare Systems Inc.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc, Representative
Signature Over Printed Name, Designation

Date

HEPATITIS B VACCINATION DECLINATION FORM

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 at no cost, 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 cost.

Applicant Signature Over Printed Name

Date

Absolute Healthcare Systems, Inc., Representative
Signature Over Printed Name, Designation

Date



EMPLOYEE HEALTH RECORD

Calendar Year:

Name of Employee: _____

Position (Applied For) _____

Address: _____

Date of Birth: _____

Please indicate by check mark if you have any of the following:

- | | |
|--|---|
| ☐ Severe headache | ☐ Nervous breakdown |
| ☐ Hearing difficulties | ☐ Vision impairment |
| ☐ Faintng/dizzy spells | ☐ Speech impairment |
| ☐ Frequent colds | ☐ Allergies, including asthma |
| ☐ Chronic coughing | ☐ TB or any communicable disease |
| ☐ Heart problems | ☐ Chest pain/pressure |
| ☐ High blood pressure | ☐ Hepatitis (A/B/C) |
| ☐ Back problems | ☐ Low blood pressure |
| ☐ Digestive system (part) ulcer | ☐ Arthritis/skeletal problems |
| ☐ Menstrual difficulties | ☐ Bowel/elimination problems |
| ☐ Diabetes | ☐ Venereal problems |
| ☐ Skin allergies/disease | ☐ Kidney problems/disease |
| ☐ Alcoholism/drug addiction | |

If you checked any of the above items, please give a brief description:

Medical History for the Past 5 Years:

1. Are you under a care of the physician? ☐ Yes ☐ No
2. Are you taking any medication? ☐ Yes ☐ No
3. Have you had any surgical operation? ☐ Yes ☐ No
4. Have you been hospitalized? ☐ Yes ☐ No
5. Have you had a serious accident that required hospitalization/surgical intervention?
☐ Yes ☐ No
6. Have you had a positive PPD reading? ☐ Yes ☐ No

If you answered YES to any of the above question, please give a brief description:



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If required in your position, would you be willing to undergo screening test for drugs and alcohol as a condition of employment?

☐ Yes

☐ No, please explain :

I, _____ of legal age hereby give permission to release the results of any test and/or information regarding my health status to Absolute Healthcare Systems, Inc.

I understand that I must undergo an annual PPD/X-ray to retain active employment with Absolute Healthcare Systems, Inc.

Signed _____ in the City of Des Plaines, Illinois.

Employee (Applicant) Signature Over Printed Name

Date

Position/Title

Employee/Applicant Name

Date of Birth

The following items must be completed by a physician or a health examiner

Required by Absolute Healthcare Systems, Inc.	Date of testing	Findings
A. Pre-employment Physical Examination		☐ Fit to work ☐ Unfit to work
B. PPD/Mantoux testing (if positive, chest x-ray is required)		# of mm induration _____ Read by: _____ Date: _____
C. (if mandated by State or contract) Rubella vaccine		
D. (if mandated by State or contract) Diphtheria-Tetanus booster		

PHYSICAL EXAMINATION	NORMAL	ABNORMAL	H&P FINDINGS	COMMENTS
Skin				
Eyes				
Respiratory				
Cardiovascular				
Gastrointestinal				
Urinary				
Nervous				
Musculoskeletal				

I certify that the above person is free from symptoms indicating the presence of infectious diseases and does not have any condition which would interfere with the performance of his/her duties as a _____.

Signed this _____ day of _____, 201____, city of _____, State of Illinois.

Signature of Physician or Health Examiner

Printed Name

Address/ Telephone Number

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APPLICATION CHECKLIST

Name:

Application Date:

Position Applied For:

Part I Application

- ☐ Application Form
- ☐ Orientation Checklist
- ☐ ATTACHMENT: JOB DESCRIPTION
- ☐ Employment Agreement
- ☐ Exhibits A (Description of Services), B (Part Time/Full Time Agreement), C (Addendum to Contract) and D (Non-Compete Covenant)
- ☐ Addendum to non-compete covenant
- ☐ Staff Responsibility
- ☐ Employment Reference Release
- ☐ Automobile Release of Liability
- ☐ Background Check Authorization
- ☐ Verification of Professional License
- ☐ Signed OSHA Affidavit
- ☐ ATTACHMENT: I-9 Form
- ☐ ATTACHMENT: W-4 Form

Part 2 Credentials

- ☐ Copy of Social Security Card
- ☐ Copy of Work Permit if applicable. Date of Expiration:
- ☐ Copy of Drivers License, Date of Expiration:
- ☐ Copy of Automobile Insurance, Date of Expiration:
- ☐ Copy of Professional License, Date of Expiration:
- ☐ Copy of License Verification, Date Verified :
- ☐ Copy of CPR Card, Date of Expiration :
- ☐ Illinois State Police Criminal Background Check Report :

Part 3 Performance Evaluation

- ☐ Skills Inventory
- ☐ Initial Performance Appraisal (RN/LPN); Date Performed
- ☐ Performance Evaluation (3 months);Date of Evaluation :
- ☐ Annual Performance Evaluation; Date of Evaluation:

Part 4 Health Record

- ☐ Physical Examination prior to initial patient contact; Date of Examination:
- ☐ Annual chest X-ray if mantoux is positive; Date of Chest X-ray:
- ☐ Consent for Hepatitis Vaccination/Declination Form; Date signed :
- ☐ Annual Physical Examination; Date of Examination :