

**JGC Healthcare Services**

**EMPLOYMENT APPLICATION**

\_\_\_\_\_ I give the employer the right to investigate all police, driving, and personal records and references, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

\_\_\_\_\_ The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state or federal law.

\_\_\_\_\_ Any controversy of any kind arising between the parties under this agreement or otherwise (or any agent, officer, director or affiliate of any party), including but not limited to common law, statutory, tort or contract claims, will be submitted to mediation, and failing settlement in mediation, to binding arbitration. Unless otherwise agreed, a mediation and arbitration designated by staff professionals will govern any mediation and arbitration. The parties will select the mediator or arbitrator from the designated company.

Panel of mediators and will notify the designated company, in writing, to initiate the selection process. The arbitration will be subject to and governed by the provisions of the Federal Arbitration Act. 9 U.S.C. Section 1-et seq. The parties hereto stipulate that this agreement involves matters affecting interstate commerce.

\_\_\_\_\_ this application is effective for 60 days. At the conclusion of this time, if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

<b>AGENCY MANAGEMENT NOTES :</b>

JGC Healthcare Services  
10306 Eaton Place, Ste 300-A2  
Fairfax, VA 22030

Date \_\_\_\_\_

✓ **EMPLOYEE REFERENCE CHECK**

JGC Healthcare Services has my authorization to check my references.

PRINT EMPLOYEE NAME: \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_

Company Contacted: \_\_\_\_\_

Mr. / Mrs.: \_\_\_\_\_ is seeking employment with our company. It is our policy to ask for references prior to employment. Please complete this form for our records ***and sign below***. We would greatly appreciate your assistance.

PLEASE VERIFY EMPLOYMENT DATES:

From: \_\_\_\_\_ To: \_\_\_\_\_

ELIGIBLE FOR REHIRE?

YES

NO

COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INFORMATION WAS RECEIVED BY:  Phone

Mail

Fax

Name of company \_\_\_\_\_

\* (IF FAXED) Company Contact Signature \_\_\_\_\_

\_\_\_\_\_  
Signature of Agency Representative & Title

\_\_\_\_\_  
Date

JGC Healthcare Services  
10306 Eaton Place, Ste 300-A2  
Fairfax, VA 22030

Employee Name: \_\_\_\_\_  
*Print Name*

**EMPLOYMENT AGREEMENT**

1. The employee will carry out the duties and responsibilities listed in the job description/ list of assigned tasks and signed by employee and employer.
2. Following are the hours the employee will work:  

Monday	_____	Friday	_____
Tuesday	_____	Saturday	_____
Wednesday	_____	Sunday	_____
Thursday	_____		
3. The employee will have the following time off:  
\_\_\_\_\_
4. The employer will pay the employee \$ \_\_\_\_\_. \_\_\_\_ per hour.
5. When leaving, the employee will give the approximate time of return and, if possible, leave a phone number where he/she can be reached. Also, when the employee is late in returning, he/she will call to let the employer know.
6. The employee is responsible for paying for long-distance telephone calls made/received by the employee.
7. The employee will not be paid for scheduled hours not worked unless the time not worked is covered by a benefit as provided by the employer.
8. Both parties to this agreement will respect each other's individuality and treat each other accordingly. Both will attempt to be flexible and work at solving problems as they arise.
9. At least 2 weeks' notice will be given by the employee regarding termination of this agreement.

Other agreements/ benefits:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Employer Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*



JGC Healthcare Services  
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Employee Name: \_\_\_\_\_  
*Print Name*

## CELLULAR PHONE USE

JGC Healthcare Services does not permit employees on company time to talk on their cellular phones while driving a vehicle. This is very dangerous and should be avoided at any time. It is mandatory that I must pull over and stop my vehicle each time I conduct agency business by cellular phone.

The agency is not responsible for any moving violations, accidents or other incident that may occur while I am using my cellular phone and driving.

**I have read and understand the above information of the agency regulation regarding cellular phone use, and I will comply.**

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Agency Representative*

\_\_\_\_\_  
*Date*

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**Fairfax, VA 22030**

**CLIENT BILL OF RIGHTS**

**PATIENT RIGHTS AND RESPONSIBILITIES**

**STATEMENT OF PURPOSE:** It is anticipated that observance of these rights and responsibilities will contribute to more effective care and greater satisfaction for the patient as well as the staff. The rights will be respected by all personnel and integrated into all Home Care programs. A copy of these rights will be given to patients and their families or designated representative. The client or his/her designated representative has the right to exercise these rights. In the case of a client adjudged incompetent, the rights of the client are exercised by the person appointed by law to act on the client's behalf. In the case of a client who has not been adjudged incompetent. Any legal representative may exercise the client's rights to the extent permitted by law.

**THE PATIENT HAS THE RIGHT:**

1. To be fully informed and knowledgeable of all rights and responsibilities before providing pre-planned care and to understand that these rights can be exercised at any time.
2. To appropriate and professional care relating to physician orders.
3. To choose a health care provider
4. To request services from the Home Care Agency of their choice and to request full information from their agency before care is given concerning services provided, alternatives available, licensure and accreditation requirements, organization ownership and control.
5. To be informed in advance about care to be furnished and of any changes in the care to be furnished before the change is made
6. To be informed of the disciplines that will furnish care and the frequency of visits proposed to be furnished
7. To information necessary to give informed consent prior to the start of any procedure or treatment and any changes to be made.
8. To participate in the development and periodic revision of the plan of care/service.
9. Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information..
10. To information necessary to refuse treatment within the confines of the law and to be informed of the consequences..
11. To treatment with utmost dignity and respect by all agency representatives, regardless of the patient's chosen lifestyle, cultural mores, political, religious, ethical beliefs, having or not having executed an advance directive and source of payment without regard to race, creed, color, sex, age or handicap.
12. To have his/her property and person treated with respect, consideration and recognition of client/patient dignity and individually..
13. To receive and access services consistently and in a timely manner from the agency to his/her request for service.
14. To be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed and to be informed of the agency's limitations.
15. To reasonable continuity of care..
- 16.. To an individualized plan of care and teaching plan developed by the entire health team including the patient and/or family.
17. To be informed of client patient rights under state law to formulate advanced care directives..
18. To be informed of anticipated outcomes of service/care and of any barriers in outcome achievement.
19. To be informed of client/patient rights regarding the collection and reporting of OASIS information
20. To expect confidentiality of the access to medical records according to State Statutes
21. To be informed within a reasonable time of anticipated termination of service of plans for transfer to another health care facility/provider
22. To be informed verbally and in writing ad before care s initiated of the organization's billing policies and payment procedures and the extent to which:
  - (a) Payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the organization
  - (b) Charges for services that will not be covered by Medicare
  - (c) Charges that the individual may have to pay
23. Be able to identify visiting staff members through proper identification.
24. To be informed orally and in writing of any changes in payment information as soon as possible, but no later than 30 days from the date that the organization becomes aware of the change

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25. To honest , accurate, forthright information, regarding the home care industry in general and his/her chosen agency in particular, including cost per visit, employee qualifications, names and titles of personnel, etc.
26. To access necessary professional services 24 hours a day, 7 days a week
27. To be referred to another agency if he/she is dissatisfied with the agency or the agency cannot meet the patient's needs
28. To receive disclosure information regarding any beneficial relationship the organization has that may result in profit for the referring organization.
29. To education, instruction and a list of requirements for continuity of care when the services of the agency are terminated.
30. To be free of abuse of any kind.
31. To privacy to maintain his/her personal dignity and respect.
32. To know that the agency has liability insurance sufficient for the needs of the agency.
33. To be advised that the agency complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law.
34. To receive advance directives information prior to or at the time of the first home visit, as long as the information is furnished before care is provided and to know that the Hotline number 1-800-442-2888 may be used to lodge complaints regarding the implementation of the Advance Directive requirement.
35. To voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect of property or recommend changes in policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal.
36. To be advised of the toll-free home health agency hot-line for the State of Virginia and the purpose of the hotline to receive complaints or questions about the organization. The State of Virginia Home Health Hotline Number is 1-800-955-1819. The number is operated 8AM to 5PM daily to receive complaints or questions about local Home Health Agencies. You may also register complaints in writing to:  
 Virginia Department of Health Professions  
 Perimeter Center  
 9960 Mayland Drive, Suite 300  
 Henrico, VA 23233-1463
37. To be informed of the toll-free abuse hot-line 1-888-832-3858 used to report abuse, neglect or exploitation.
38. To be informed of the toll-free child abuse hot-line 1-800-552-7096.

**THE PATIENT HAS THE RESPONSIBILITY:**

1. To provide, to the best of his/her knowledge, accurate and complete information about:
  - a. Past and present medical histories.
  - b. Unexpected changes in his/her condition.
  - c. Whether he/she understands a course of action selected.
2. To follow the treatment recommended by the particular handling of the case.
3. For his/her actions if he/she refused treatment or does not follow the physician's orders.
4. For accruing that the financial obligations of his/her health care are fulfilled as promptly as possible.
5. To respect the rights of all staff providing service.
6. To notify the agency promptly in advance of an appointment or visit you must cancel.
7. To become independent in care to the extent possible, utilizing self, family and other sources.
8. To pay for care or services not covered by 3<sup>rd</sup> party payers.
9. For complying with the rules and regulations established by the agency and any changes subsequent to the rules

\_\_\_\_\_  
 Signature of Patient                      Date of Signature                      Nurse/Therapist Signature                      Date of Signature

<b>PATIENT NAME(Last, First)</b>	<b>MEDICAL RECORD No</b>
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**CONFIDENTIALITY OF INFORMATION AGREEMENT**

EMPLOYEE NAME: \_\_\_\_\_  
PRINT NAME

**Confidentiality of Information**

- All information designated confidential that is obtained or generated because of any or all the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered, maintained or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

**WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION**

- To protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need-to-know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breach of the confidentiality agreement may be cause for immediate termination.

**I understand that I am responsible for following this Confidentiality Policy Agreement & the Guidelines, Both Written and Verbal.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*

**CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION**

It is both the Agency's and the employee's responsibility to ensure that every patient's health information is protected at all times. By signing below, you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health Information will be provided to you upon hire.

I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Employee Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PROTECTION OF HEALTH INFORMATION**

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.
- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patient being discharged.

I always pledge to make every effort to keep patient's Protected Health Information protected.

Employee Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FIELD EMPLOYEE STANDARDS AND PROCEDURES**

**JGC Healthcare Services**  
**10306 Eaton Place, Ste 300-A2**  
**Fairfax, VA 22030**

**Welcome! This Agency requires adherence to the following Standards and Procedures:**

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/client/family. This includes personal hygiene, jewelry, hair and makeup.
2. Please do not smoke in the presence of a patient/client or client's home.
3. Always wear your ID Badge. Licensed personnel must always carry their current nursing license and CPR card while on assignment.
4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. **PLEASE DO NOT CALL YOUR PATIENT DIRECTLY.** You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have any problem, incident, or accident on the job, do not discuss it with the patient/client, but call the Agency immediately.
6. If the patient/client asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**
8. **UNDER NO CIRCUMSTANCES** are you to ask for or accept any money from your patient/client or take-home property that belongs to the patient client.
9. There shall not be any involvement with the patient/client's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient/ client information which is obtained in the regular course of your employment.
11. No personal telephone calls should be made or received by you while on assignment. Except in emergencies. Obtain client permission.
12. Please do not discuss your pay or any other personal affairs with the patient/client/family/coworkers.
13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient/client contact us.

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14. It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule. If the patient/client is unable to sign your note, a family member or responsible party may sign.
15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.
16. Never leave your patient/client unattended.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Employee Policies & Procedures AGREEMENT**

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect, and Exploitation and agree to comply with and be bound by the Policy.

I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meeting and in-service training.

Home health aides are required to have 12 hours of in-service training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care of provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of the client/employee confidentiality is subject to civil and criminal penalties. If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely person drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**CRIMINAL HISTORY SEARCH  
CONSENT FORM**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

I, \_\_\_\_\_, have no pending charges within or outside the Commonwealth of Virginia and have had no prior convictions of an offense described in the **Health and Safety Code** which would bar or potentially bar employment as listed below.

CRIMINAL HOMICIDE

KIDNAPPING & FALSE IMPRISONMENT

INDECENCY WITH A CHILD

AGREEMENT TO ABDUCT FROM CUSTODY

SOLICITATION OF A CHILD

SALE OR PURCHASE OF A CHILD

ARSON

ROBBERY

AGGRAVATED ROBBERY

ASSAULTIVE OFFENSES

BURGLARY & CRIMINAL TRESPASS

THEFT

WEAPONS

FRAUD

PUBLIC LEWDNESS

INDECENT EXPOSURE

PUBLIC INDECENCY

A FELONY VIOLATION OF A STATUTE  
INTENDED TO CONTROL THE POSSESSION  
OR DISTRIBUTION OF A SUBSTANCE  
(VIRGINIA CONTROLLED SUBSTANCE ACT)

**I UNDERSTAND THAT FORTRESS GLOBAL SOLUTIONS IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT. I, THE UNDERSIGNED, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.**

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE

\_\_\_\_\_  
SIGNATURE OF SUPERVISOR

JGC Healthcare Services  
10306 Eaton Place, Ste 300-A2  
Fairfax, VA 22030

Name of Employee: \_\_\_\_\_  
*Print Name*

## DISCLAIMER AND WAIVER OF LIABILITY

I acknowledge and will adhere to the rules and regulations as set forth by the Department of Health Services and Medicare and Medicaid. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination. I therefore hold JGC Healthcare Services, its shareholders, directors and officers, harmless from any falsified documents.

I have read and understand the above information. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative

\_\_\_\_\_  
Date

## EMPLOYEE DRESS CODE

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Print Name*

**JGC Healthcare Services strives to present a professional and safe health care image to patient's families, the community, and other Health Care professionals. JGC Healthcare Services, staff members adhere to the following standards in their dress appearance.**

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1. All staff will wear an approved **JGC Healthcare Services** name badge when providing patient care.
2. Clothing shall be clean, neat, and well maintained.
  - a. *Allowed Clothing:* Loose comfortable clothing, scrubs, walking shorts that are at least mid thigh in length, hemmed blue jeans, plain T-shirt, and Casual Street wear. Appropriate undergarments should be worn.
  - b. *Not Allowed:* mini skirts, short shorts, tank tops, halter-tops, midriffs, cut offs, frayed blue jeans, or T-shirts with any sayings on them.
3. Shoes should be conservative and comfortable. We encourage closed toed shoes for personal safety and infection control while providing patient care. No flip-flops or thong sandals.
4. When attending school with a patient, the employee will be provided with a copy of the school's dress code and must adhere to it.
5. Nurses should keep a clean lab coat available to wear over their clothes when accompanying patients to any medical appointment. (These may be unexpected).

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Fairfax, VA 22030**

Employee Name: \_\_\_\_\_

**Dress Code (continued)**

6. JGC Healthcare Services employees will try to meet the requests of parents or primary caregivers within reason.
7. Employees are expected to keep their hair dry, neat, and clean. Long hair must be styled so it does not come in contact with the patient. Mustaches and beards must be clean and trimmed.
8. Perfume should be conservative. Strong odors can be offensive to patients.
9. Jewelry represents a safety hazard, so it must be worn with discretion, i.e. wedding rings, rings without large mountings, small earrings, or studs. Visible piercing, except for earrings, should be removed when providing patient care. Both professionalism and safety should be considered when wearing jewelry.
10. Fingernails are to be kept clean, trimmed and moderately short for patient safety.

**\* If an employee is sent home to change clothes due to inappropriate attire, the employee will be sent home on his/her own time and may result in disciplinary action.**

**\* Interpretation of compliance to this dress code policy is subject to the discretion of the Administrator, DON, or acting supervisor.**

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

JGC Healthcare Services  
10306 Eaton Place, Ste 300-A2  
Fairfax, VA 22030

Employee Name: \_\_\_\_\_  
*Print Name*

**FOLLOWING INFECTION CONTROL AGREEMENT**

JGC Healthcare Services wants to improve patient outcomes by identifying and reducing the risk of infection in patients and agency staff.

The agency will document infections that are acquired while the patient is receiving services from the agency. The documentation will include at a minimum the date that the infection was detected, patients name or number, primary diagnosis, signs/symptoms, type of infection, pathogens identified and treatment.

The infection control program will include surveillance, identification, prevention, control, and reporting. Targeted surveillance of infections will focus on specific patient populations or procedures.

Infection Control Standards are established in compliance with the recommendations of the National Center for Disease Control in Atlanta, Georgia. All staff is educated on these standards, and they are practiced consistently. Any incidents of infection related to care and service are reported.

**I recognize and am fully aware of the fact that any patient may be contagious at any time and that this may not always be a known fact while care is being provided. I will follow all Infection Control and Universal Precautions Procedures of the agency.  
I also state that currently I am in excellent health and have no impairments that may alter my job performance.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Agency Representative*

\_\_\_\_\_  
*Date*

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Employee Name: \_\_\_\_\_  
*Print Name*

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**I also state that currently I am in excellent health and have no impairments that may alter my job performance.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Agency Representative*

\_\_\_\_\_  
*Date*

## **EMPLOYEE ORIENTATION**

Employee Name: \_\_\_\_\_ Position: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Date of Orientation: \_\_\_\_\_

## **GENERAL ORIENTATION WITH HUMAN RESOURCES**

- HIPPA Privacy Regulations- Review handbooks and examination
- Discuss policies and procedures included in employee handbook, with focus on new and added updated policies and review policy and procedure examination
- Review employee benefits as applicable to various employee statuses
- Review complaint and grievances procedures
- Review sexual harassment policy
- Review Body Mechanics video and materials

## **GENERAL ORIENTATION WITH NURSING**

- **Instructive Memos from DON to clinical staff**
- **Sample Nurse's Notes**
- **Nursing Peer Review Process**
- **OSHA Infection Control**
- **Nursing Skills Checklist**
- **Detecting Patient Abuse: Child Abuse and Abuse of the Elderly**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Nursing Supervisor Signature**

\_\_\_\_\_  
**Administrator Signature**

JGC Healthcare Services  
10306 Eaton Place, Ste 300-A2  
Fairfax, VA 22030

NAME OF EMPLOYEE: \_\_\_\_\_  
*Print Name*

**POLICIES & PROCEDURES  
ORIENTATION ACKNOWLEDGEMENT**

I acknowledge that I have been oriented to agencies Policies and Procedures Manual and agree to follow all guidelines, both written and verbal. I understand that, if the guidelines, policies and procedures are not followed, I may be immediately terminated. I also had the opportunity to ask questions regarding the Policies and Procedures Manual, and I know where it's located for future reference.

\_\_\_\_\_  
**Employee's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agency Representative Signature**

\_\_\_\_\_  
**Date**

**REPORTING: ABUSE / NEGLECT / EXPLOITATION**

EMPLOYEE NAME: \_\_\_\_\_  
PRINT NAME

**REPORTING:**

- ABUSE
- NEGLECT
- EXPLOITATION

**All agency staff are required to report suspected abuse/neglect/exploitation and develop a plan to minimize the risk of such. The home health employee is responsible for reporting & documenting:**

- A child's susceptibility to abuse including self-abuse and neglect
- Elderly individuals as well as children are susceptible to abuse as well
- Physical components, such as impairments and the ability of patient/caregiver to provide adequate care
- Mental impairments, such as mental retardation, Alzheimer's disease, disorientation, confusion, etc.
- Emotional status, such as passive personality, depression, etc.
- Physical environment, such as safety in or outside the home

The employee is responsible for reporting all incidents to DON and/or Supervisor. A written report may be forwarded for Social Services with the request for referral. The Supervisor will review the situation and investigate to determine if this is a reportable incident. If so, it will be reported to the appropriate agency or Adult/Child Protection Agency by the DON/Administrator or an appropriate designee.

**\* I have read and understand the information above. As a home health employee, it is my responsibility to report & document any suspected abuse, neglect, or exploitation.**

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Employee Name: \_\_\_\_\_  
*Print Name*

## HEALTH & SAFETY AGREEMENT

I do understand the physical requirements of my job and understand proper lifting and moving techniques which I am expected to use in moving and lifting objects and/or patients.

I have been informed and do fully understand that any injury claimed by me while on the job must be reported immediately to my supervisor and documented on an Accident/Incident Report form. I understand that unless an incident report is completed immediately and signed by me, the agency may not consider a voluntary payment of any medical bills or any other benefits as a result of my injury. I further understand that if the accident/injury is proven to be a result of my failing to follow policy/procedure, the agency may not be expected to cover medical payments.

I do fully understand that I am not encouraged to lift or transfer any object or patient by myself unless I know that I can safely lift or transfer alone. If I believe there is no one readily available to assist me in lifting or moving patients or equipment while on duty, I am to wait until I can obtain assistance before moving or lifting.

**I have had the opportunity to review and have all questions answered regarding *Health & Safety*.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Agency Representative*

\_\_\_\_\_  
*Date*

JGC Healthcare Services  
10306 Eaton Place, Ste 300-A2  
Fairfax, VA 22030

Employee Name: \_\_\_\_\_  
*Print Name*

## SEXUAL HARASSMENT

JGC Healthcare Services does not tolerate **Sexual Harassment**, as it is a form of gender-based discrimination.

### Definition:

Under Title VII of the Civil Rights Act of 1964, any type of discrimination based on an individual's gender (male or female) is illegal. Sexual harassment is a form of gender discrimination. According to the Equal Employment Opportunity Commission, sexual harassment is "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to the conduct enters into employment decisions and/or the conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment."

The Agency will not tolerate any form of sexual harassment from any of its employees. The Agency encourages that any behavior which could be construed as sexual harassment be reported immediately to the supervisor and/ or Administrator. There is no need to fear retaliation. Both females and males can be sexually harassed when exposed to unwelcome sexual advances or to a pattern of verbal abuse, threatening, crude, impolite, or unprofessional conduct.

- Quid pro quo sexual harassment is also against company policy.
- The Agency encourages and urges an employee to come forward and discuss any sexual harassment that may have occurred with an Administrator.
- Every complaint will be taken seriously and investigated immediately. Investigations will be documented.
- Any employee involved a sexual harassment complaint will have a full opportunity to give a full account of their recollection of the incident or incidents.
- The incident(s) will be investigated thoroughly, and appropriate action will be taken.

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*Employee Signature*

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*Date*

## UNIVERSAL PRECAUTIONS

Name: \_\_\_\_\_  
PRINT NAME

Date: \_\_\_\_\_

✓ **LESSON 1 - BLOOD BORNE INFECTION**

- Definition of exposure
- Spread of HIV infection in the general population
- Symptoms and effects of HIV infection
- Spread of Hepatitis B, including number of infections, hospitalization, and deaths caused by HBV each year
- Symptoms and effects of HBV infection and HBV vaccination
- The hepatitis B virus and HIV virus can be transmitted in the workplace.
- It is estimated that there are 1 and ½ million HIV carriers in the U.S.
- There may be as many as one million carriers of HBV.

✓ **LESSON 2 - TRANSMISSION OF BLOOD BORNE INFECTION**

- Sources of blood borne infections in the workplace
- Four primary ways of getting blood borne infections outside the workplace
- Three primary ways of getting blood borne infections at work
- Risky jobs, tasks, and work practices

✓ **LESSON 3 - EXPOSURE CONTROL**

- The HBV vaccine for all workers who come into contact with blood or other potentially infectious body fluids on the job
- The definition of Universal Precautions
- The steps that should be taken after an exposure incident in order to prevent infection
- My rights in case of exposure and / or infection
- I have the right to have HBV vaccinations provided to me free of charge, if I am at risk for infection. If I refuse it at this time, I have the right to be vaccinated free of charge at any time in the future provided I am still at risk for infection.

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PRINT NAME: \_\_\_\_\_

## Training Documentation on Universal Precautions (continued)

### ✓ **LESSON 4 – USING PERSONAL PROTECTIVE EQUIPMENT**

Types of personal protective equipment (PPE) required for different tasks or situations

Key requirements for selecting, providing, using, and disposing of or cleaning PPE

Limitations of personal protective equipment

### ✓ **LESSON 5 – WORK PRACTICE CONTROLS**

Disposing of used needles or other sharps

Working with lab materials

Decontaminating work areas, instruments, and equipment

Identifying and handling regulated waste

Hand washing and other personal hygiene and health practices

**\* I have received training covering all of the above topics and been informed of my rights accordingly.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*