CARSON HEALTH CARE SERVICES

Employee's Name:____

EMPLOYEE'S CHECKLIST

The employee must have the following items in his/her file to be completed. Please check when items are inserted into file:

	In File	Not In File
1. Completed Application If Not, Missing:		
2. Orientation Checklist		
3. Glucometer Competency Assessment		
4. Employee Handbook (Release Form w/ Signature)		
5. Clinical Skilled Assessment		
6. OSHA Training		
7. Confidentiality Agreements a. Employer b. Client		
8. Job Description (Signed)		
9. Medical Data: a. Health Exam / Record (current)		
10. Tuberculosis Surveillance Record		
11. Waiver Hepatitis B Vaccination		
12. Clinical Competency Evaluations		
13. Employment Eligibility Verification (INS)		
14. W-4 Information *(the agency is issuing 1099 at the end of year, the worker is responsible to pay taxes as required)		
15. Employment Agreement (Payroll Schedule, Pay Rate, Reception) a. Areas of Coverage (If Applicable)		
16. Hire Date (Column 1) & Termination Date (Column 2)		
17. Identification (2) from List A. Book a. Driver's License (Current) b. State ID (Current) c. Social Security Card (Copy)		
18. Current License Applicable a. Clinical Licensures (Copy) b. CPR Card (Current) c. Auto Insurance (Copy)		
19. Applicable Performance Evaluations as indicated (timely)		
20. Record at current In-service		
21. Others		

EMPLOYEE HEALTH RECORD

Note: This section must be completed by employee and signed prior to employment.

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS		
POSITION	DATE OF BIRTH	SOCIAL SECURITY NO.:

Please indicate with an (X) if you have any of the following:

	Severe Headache		High Blood Pressure
	Vision Impairment		Low Blood Pressure
	Hearing Difficulties		Back Problems
	Speech Impairment		Arthritis/ Bone Problem
	Fainting/Dizzy Spells		Stomach Ulcer
	Allergy/wheezing/asthma		Bowel Problems/Hernia
	Frequent Colds		Menstrual Difficulties
	TB/Any Communicable Disease		Venereal Disease
	Chronic Coughing		Diabetes
	Chest Pain/Pressure		Kidney Problems/Disease
	Varicose Veins		Skin Allergies/Disease
	Hepatitis		Alcoholism/Drug Addiction
	Heart Problems		Nervous Breakdown

A. Are you under the care of a physician? ☐ Yes ☐ No

B. Are you taking any medication? ☐ Yes ☐ No

C. Have you had operation/ been hospitalized? ☐ Yes ☐ No

D. Have you had any serious accident? ☐ Yes ☐ No

E. Have you had a positive reading on a Tine or PPD? ☐ Yes ☐ No

If you answered YES to any of the above, please explain:

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If required in your position, would you be willing to have screening test for drug/alcohol done on your blood/urine as a condition of employment: ☐ Yes ☐ No

I hereby give my permission to release the results of any test and/ or information regarding my health status to CARSON HEALTH CARE SERVICES . I understand that I must have a biennial PPD to retain active employment with CARSON HEALTH CARE SERVICES

Signature of Employee:________________________________ **Date:** __________________