express nursing
Home Health Care Services

Express Nursing Inc, 4700 E. University Blvd, Odessa, Tx 79762, (432) 580-9393

Employment Application

Applicant Information

Last Name: _____First Name: _____MI: _____ SS#: _____-_____-_____

Street Address:_____City:_____State:_____Zip Code: _____

Phone Number: _____-_____-_____ Email Address: _____@_____

Date Available: _____/_____/_____ Position Applying For: _____

Are you a US citizen: ___Yes___No If No, are you authorized to work in the US? ___Yes ___No

Have you ever worked for this company? ___Yes ___No If Yes, When? ___/___/___thru___/___/___

Have you ever been convicted of a felony? ___Yes ___No

If yes, explain: _____

Education

High School: _____

From: _____/_____/_____ thru _____/_____/_____ Did you graduate? ___Yes ___No

College: _____

From: _____/_____/_____ thru _____/_____/_____ Did you graduate? ___Yes ___No

Degree: _____

Other: _____

From: _____/_____/_____ thru _____/_____/_____ Did you graduate? ___Yes ___No

Degree: _____

References

Please list three professional references:

1. Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____City:_____State: _____

2. Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____City:_____State: _____

3. Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____City:_____State: _____

Previous Employer

Company: ______________________ Phone: ______-______-______

Address: ______________________ Supervisor: ______________________

Job Title: ______________________ Starting Salary: $__________ Ending Salary: $__________

Responsibilities: ______________________

Employment Dates: _____/_____/_____ thru _____/_____/_____

Reason for leaving: ______________________

May we contact this employer for a reference? ___Yes ___No

Company: ______________________ Phone: ______-______-______

Address: ______________________ Supervisor: ______________________

Job Title: ______________________ Starting Salary: $__________ Ending Salary: $__________

Responsibilities: ______________________

Employment Dates: _____/_____/_____ thru _____/_____/_____

Reason for leaving: ______________________

May we contact this employer for a reference? ___Yes ___No

Company: ______________________ Phone: ______-______-______

Address: ______________________ Supervisor: ______________________

Job Title: ______________________ Starting Salary: $__________ Ending Salary: $__________

Responsibilities: ______________________

Employment Dates: _____/_____/_____ thru _____/_____/_____

Reason for leaving: ______________________

May we contact this employer for a reference? ___Yes ___No

Military Service

Branch: ______________________ Dates of service: _____/_____/_____ thru _____/_____/_____

Rank at discharge: ______________________

If Other than Honorable, explain: ______________________

____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information listed in this application may result in my release from employment with Express Nursing Inc.

Signature: ______________________ Date: ______________________

Printed Name: ______________________

Express Nursing Inc

Consent for Criminal History Check

I, _____, consent to allow Express Nursing Inc to complete a criminal history check on myself. I understand the information obtained may be used to determine employment status.

Please enter the following information as it appears on your Driver's License/State ID:

Name:

_____

Date of Birth:

_____-_____-_____

Signature: _____ Date: _____

Witness: _____ Date: _____

Express Nursing Inc

Consent for Reference Check

I, _____, consent to allow Express Nursing Inc to complete a thorough personal reference and past employment check on myself. I understand the information obtained may be used to determine employment status.

Signature: _____ Date: _____

Witness: _____ Date: _____

Express Nursing Inc

Reference Check Form

Name of Applicant: _____ Telephone: _____

Person Contacted: _____ Telephone: _____

Title: _____ Company Name: _____

Company Address: _____ City: _____ State: _____

Employment Reference:

Dates of Employment: _____/_____/_____ thru _____/_____/_____

Job title: _____ Job duties: _____

Is applicant eligible for rehire? ___Yes ___No

Explain: _____

_____

_____

Please check the appropriate box(es) that best describe applicant:

___Dependable ___Good attendance ___Takes responsibility ___Good attitude

___Team player ___Good work ethic ___Organized ___Works w/o supervision

___Able to meet deadlines ___Trustworthy ___Sincere about job duties

Comments: _____

_____

_____

Personal Reference:

Dates Known: _____/_____/_____ thru _____/_____/_____ ___Present

Is the applicant reliable? ___Yes ___No

Comments: _____

Does the applicant get along with others? ___Yes ___No

Comments: _____

Does the applicant have an overall good attitude? ___Yes ____No

Comments: _____

Additional Comments: _____

_____

Reference Checked by: _____ Date: _____

Reference Given by: _____ Date: _____

Express Nursing Inc

Reference Check Form

Name of Applicant: _____ Telephone: _____

Person Contacted: _____ Telephone: _____

Title: _____ Company Name: _____

Company Address: _____ City: _____ State: _____

Employment Reference:

Dates of Employment: _____/_____/_____ thru _____/_____/_____

Job title: _____ Job duties: _____

Is applicant eligible for rehire? ___Yes ___No

Explain: _____

_____

_____

Please check the appropriate box(es) that best describe applicant:

___Dependable ___Good attendance ___Takes responsibility ___Good attitude

___Team player ___Good work ethic ___Organized ___Works w/o supervision

___Able to meet deadlines ___Trustworthy ___Sincere about job duties

Comments: _____

_____

_____

Personal Reference:

Dates Known: _____/_____/_____ thru _____/_____/_____ ___Present

Is the applicant reliable? ___Yes ___No

Comments: _____

Does the applicant get along with others? ___Yes ___No

Comments: _____

Does the applicant have an overall good attitude? ___Yes ____No

Comments: _____

Additional Comments: _____

_____

Reference Checked by: _____ Date: _____

Reference Given by: _____ Date: _____

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Employment Category Verification

___ **Initial Employment** ___ **Change in status**

Employee Name: _____ **Date of Hire:** _____

Employment Category Classification:

***If this is a change in status, please indicate date of change.**

	Full Time Salary Employee	/ /
	Part Time Salary Employee	/ /
	Full Time Hourly Employee	/ /
	Part Time Hourly Employee	/ /
	PRN Employee	/ /
	PRN w/Full Time Benefits Employee (PRNFTB)	/ /

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

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201 EMPLOYMENT CATEGORIES

As defined in Section II of the Employee Handbook:

Full Time Salary Employee is an employee who is defined by the Federal Labor Standards Act (FLSA) as being exempt from this law's minimum wage and overtime requirements. A Full Time Salary employee is paid a pre-determined amount and is entitled to vacation and sick time benefits as well as participation in the health insurance program.

Part Time Salary Employee is an employee who is defined by the Federal Labor Standards Act (*FLSA*) as being exempt from this law's minimum wage and overtime requirements. A Part Time Salary employee is paid a pre-determined amount and is NOT entitled to vacation/sick time benefits or participation in the health insurance program.

Full Time Hourly Employee is an employee who is paid for their time on an hourly basis. They are eligible for overtime pay if they work more than 40 hours per week. Hourly employees jobs are covered by the wage and hours regulations of the Fair Labor Standards Acts (FLSA). A FTHE is entitled to vacation and sick time benefits as well as participation in the health insurance program.

Part Time Hourly Employee is an employee who is paid for their time on an hourly basis. They are eligible for overtime pay if they work more than 40 hours per week. Hourly employees jobs are covered by the wage and hours regulations of the Fair Labor Standards Acts (FLSA). A PTHE is *not* entitled to vacation and sick time benefits as well as participation in the health insurance program.

PRN Employee is an employee that is paid on and "as needed" basis determined by fluctuating patient census and/or business demands.

PRN w/Full Time Benefits Employee (PRNFTB) is an employee that is paid on an "as needed" basis determined by fluctuating patient census and/or business demands *and* is entitled to vacation time benefits, set according to the limitations defined in section 3 of this handbook, as well as participation in the health insurance program.

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WAGE DEDUCTION AUTHORIZATION AGREEMENT

I understand and agree that my employer, Express Nursing Inc., may deduct money from my pay from for reasons that fall into the following categories:

1. my share of the premiums for the Company's group medical/dental plan;
2. installment payments on loans or wage advances given to me by the Company, and if there is a balance remaining when I leave the Company, the balance of such loans or advances;
3. if I receive an overpayment of wages for any reason, repayment to the Company of such overpayments (the deduction for such a repayment will equal the entire amount of the overpayment, unless the Company and I agree in writing to a series of smaller deductions in specified amounts);
4. the cost to the Company of personal long-distance calls I may make, or messages I may send, using Company phones (land lines or cell phones) or Company accounts, of personal faxes sent by me using Company equipment or Company accounts, or of non-work related access to the Internet or other computer networks by me using Company equipment or Company accounts;
5. the cost of repairing or replacing any Company supplies, materials, equipment, money, or other property that I may damage (other than normal wear and tear), lose, fail to return, or take without appropriate authorization from the Company during my employment (except in the case of misappropriation of money by me, I understand that no such deduction will take my pay below minimum wage, or, if I am a salaried exempt employee, reduce my salary below its predetermined amount)*;
6. administrative fees in connection with court-ordered garnishments or legally-required wage attachments of my pay, limited in extent to the amount or amounts allowed under applicable laws;
7. if I take paid vacation or sick leave in advance of the date I would normally be entitled to it and I separate from the Company before accruing time to cover such advance leave, the value of such leave taken in advance that is not so covered;
8. the value of any time off for absences to which paid leave is not applied (except in the case of those who are paid a fixed salary for fluctuating workweeks, non-exempt salaried employees will have all such unpaid leave deducted from their salary, while exempt salaried employees will experience salary reductions only in units of a full day or week at a time, depending upon the exact nature of the absence, unless partial-day deductions are specifically allowed under federal law); and
9. if my employer pays any insurance premiums or retirement system contributions ("payments") on my behalf that I would normally make under the applicable Company benefit plan, the amount of such payments made by the Company, such payments being an advance of future wages payable to me.

I agree that the Company may deduct money from my pay under the above circumstances, or if any of the above situations occur. I further understand that the Company has stated its intention to abide by all applicable federal and Texas wage and hour laws and that if I believe that any such law has not been followed, I have the right to file a wage claim with appropriate Texas and federal agencies.

_____	_____	_____
Signature of Employee	Employee's Name – Printed	Date

Release of Financial Responsibility

Employee Name: _____

Date: _____

I, _____, authorize Express Nursing Inc to release any paychecks as so verbally authorized to any of the persons listed below. I understand only the persons listed below have authorization to collect any payroll checks issued, regardless of any verbal authorization given by me. I understand that a form of identification may be requested at time of release.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

_____ _____

Employee Signature Date

_____ _____

Authorization Acknowledgement Date

Employee:

Date	Authorized Individual	Acknowledgement

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Orientation Statement

This is to verify that I have read, understand and will comply with all applicable agency policies and procedures during the orientation process of this agency

Employee Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____

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Acknowledgment -Receipt of Employee Handbook

I, _____, have received a copy of the Express Nursing Employee Handbook. I understand and agree to abide by Express Nursing policies and procedures.

Employee Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____

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HIPAA-Health Insurance Portability & Accountability Act Policy

Express Nursing respects and safeguards all protected health information (PHI) of the patients it serves. All patients or their legal representatives will receive a copy of Express Nursing Notice of Privacy Practices no later than the date of the first service delivery. Express Nursing will make a good faith effort to obtain the patient's written acknowledgement of receipt of this notice to protect their privacy. Also, Express Nursing implemented safeguards to provide a secure environment while transferring, communicating, and storing PHI.

PHI is broadly defined as individually identifiable health information maintained or transmitted by a covered entity in any form or medium. Individually identifiable health information is health or demographic information created or received by a health care provider that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care of an individual; or the past, present, or future payment for the provision of health care to an individual. Individually identifiable health information readily identities an individual or even information to which there is a reasonable basis to believe the information can be used to identify the individual.

Patient health records will be stored in a locked cabinet in a designated area at the office of Express Nursing. Charts will be checked out as needed by the attending nurse, aide, or other care team member. Charts shouldn't be left open or unattended to be read by unauthorized personnel.

Patient PHI can only be communicated with patient, or individuals authorized by the patient. However, with certain precautions, security and privacy can be maintained. Verify the following to ensure you are sharing account/stay information with patient/authorized representative: Patient DOB, Last four digits of social security number, name of attending physician.

Secure PHI in a clasped envelope, briefcase, or a clipboard with a closing top when transferring health information to and from the patient's home. Also, during the home visit, take precautions so as not to expose the patient record to unauthorized individuals.

The intentional and deliberate violation of these privacy standards may result in termination of employment. Report any violations of the HIPAA Policy to the designated privacy officer. No action will be taken against an employee who reports a violation of the privacy standards.

I understand the definition of "Protected Health Information" and I must protect this right of the patients I serve.

Employee Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____

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Safe Working Practice Agreement

As a condition of employment, I, _____, do agree to comply with the following safe working practices.

1. *I agree to follow established agency safety procedures concerning hand washing, universal precautions, and infection control procedures.*
2. *I agree to report any work-related accident or injury to myself or t a patient to my supervisor as soon as it occurs, but no later than the end of my shift or visit.*
3. *I agree to use appropriate lifting devices to assist patients safely as needed.*
4. *I agree to use necessary personal protective equipment for lifting safety and for infection control procedures.*
5. *I agree to maintain a current driver's license and auto insurance. I will notify my supervisor if my driver's license expires or my insurance lapses.*
6. *I am able to physically and mentally perform my required job duties. If any time my mental or physical condition changes, I will notify my supervisor a soon as possible.*

By signing below, I acknowledge that I understand and agree to comply with the safe working practices mentioned above. I will report any unsafe working practices, accidents, incidents, and/or injuries I have knowledge of immediately to my supervisor.

Employee Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____

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Statement of Employability

All agency employees shall be required to sign the statement below disclosing all crimes with the exception of minor traffic violations upon hire. A criminal history will be requested only on unlicensed personnel that will be in direct contact of patient in their place of residence. Licensed personnel as described above may not be employed by Express Nursing if the person has been convicted of an offense listed below.

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20, Penal Code (kidnapping and false imprisonment);
- An offense under Section 21.11, Penal code (indecency with a child:;
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.07, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);

Licensed personnel as described above may not be employed by Express Nursing if the person has:

- *A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed under Subdivision s (1)-(13);*
- *A conviction of an offense under Chapter 31, Penal code (theft), that is punishable by a felony in a position that involved direct contact with a patient of the facility before the fifth anniversary date of the conviction. (This requirement only applies to those employees first employed by the facility or agency on or after September 1, 2001.)*

By Checking yes or no, I am disclosing my involvement in any crime, other than minor traffic violations. ___ Yes ___ No (If yes, the applicant is required to disclose the information concerning the violation to Express Nursing Management before hire.)

I understand that all information obtained by Express Nursing regarding my criminal history will remain confidential. I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Employee Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____

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Direct Care Staff Policy Statement

In accordance with TAC 97.245 (b) (10), all personnel who are direct care staff and who have direct contact with clients (employed by or under contract with agency) have read, understand, and will comply with all applicable agency policies, including but not limited to:

In addition to an initial search (upon an employee's hire) of the Nurse Aide Registry and the Employee Misconduct Registry, Express Nursing must search both registries annual for unlicensed employees and volunteers whose duties include face-to-face client contact. The registries must be checked using the DADS website at http://www.dads.state.tx.us/providers/employability/esearch/cfm.

Express Nursing must also document the searches and keep a copy of both the initial search and annual search in the employee's personnel record.

In accordance with 40 TAC Chapter 93, Employee Misconduct Registry, Express Nursing must provide written information about the EMR to unlicensed volunteer or employee within five working days of the date of the person's first face-to-face contact with client.

By signing below, I agree to the above Direct Care Staff Policy Statement and understand the information it contains:

Employee Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____

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Paperwork Deadlines

Policy: All SN/HHA/PT/OT/ST notes (including missed visits), and mileage sheets are due within 24 hours after a completed visit, regardless of employment status (ex: Salary, PRN, Contract). This is an effort to improve adherence to Medicare regulations and compliance with Express Nursing policy, as well as improve timeframes for billing. If for some reason you are not able to complete notes within the timeframe, please notify me or Payroll. At this time, we will look at possible schedule changes or other necessary arrangements. Noncompliance with policy will result in reprimands.

RN's: all OASIS documents R/C, ROC's, SOC's, D/C's are due within 48 hours of the RN visit. ROC's must have Xfer OASIS as well.

All Clinical documentation (SN/HHA/PT/OT/ST notes/assessments) must be submitted for payroll according to the deadlines listed below. The documentation/SN notes must be COMPLETED in order to be paid. Any INCOMPLETE documentation will be paid in the subsequent pay periods in which the documentation becomes COMPLETE.

Due:

For pay period reflecting the Payroll Day of the 1st of each month (day 10 of previous month thru day 24 of previous month), paperwork is due the 25th day of every month by 10am.

For pay period reflecting the Payroll Day of the 15th of each month (day 25 of previous month thru day 9 of current month), paperwork is due the 10th day of every month by 10am.

If the 10th or 25th day falls on a Saturday or Sunday, documentation/SN notes must be turned in no later that 10am the following business day.

Thank You

Myra Salazar, RN, DON.

Acknowledgment:

Printed Name	Signature	Date

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Home Health Care Services

Nurse Supply Check Out

Nurse Supplies:

_____ Glucometer

_____ BP Cuff

_____ Pulse Ox

_____ Stethoscope

_____ Thermometer: Oral____ Temporal_____ Tympanic_____

Employee Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____

Express Nursing Inc
521 N. Grant
Odessa, Texas 79761

Device Usage Policy

Policy: Express Nursing provides specific electronic devices as needed to ensure that the staff is able to perform work duties timely and affectively. These devices include, but are not limited to: personal computer, device, tablet, ipad, air card. Due to the sensitivity and required maintenance of the device, additional security provisions are required.

The individual using the device is responsible for the security of that device, regardless of whether the device is located or used in the office, at the individual's place of residence, or in any other location such as a hotel, conference room, car or airport. The device is for the sole purpose of business and employee and should not be used by other family members or co-workers and must be with the assigned employee at all times. Employees may not install additional software on device.

Express Nursing reserves the right to monitor individual user devices at random and/or for cause of damage or negligence. Intentional misuse and/or inappropriate use may result in disciplinary action up to and including dismissal.

Failure to comply with information security policies or associated polices, standards, guidelines and procedures may result in disciplinary actions up to and including termination of employment for employees or termination of contracts for volunteers, contractors consultants, and other entities. Legal actions also may be taken for violations of applicable regulations and laws.

I have read and understand Device Policy.

Print Name: _____

Signature: _____ **Date:** _____

Express Nursing Inc
521 N. Grant
Odessa, Texas 79761

Device Check Out

The device indicated below is provided to you by Express Nursing. This device is to be used for Express Nursing business only. In the instance that you decide to leave the company, you will be asked to return your device in working condition to your immediate supervisor. Failure to return the device may result in withholding of earnings in compliance with the Wage Deduction Authorization Agreement. Please sign below acknowledging that you have received the device indicated below.

Quantity	*Device*	*Serial No.*	*Value*

I have read and understand.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

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HEPATITIS B VACCINE ACCEPTANCE / DECLINATION FORM

ACCEPTANCE:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV).
This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B (HBV) vaccine. Based on the training I have received; I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

DECLINATION:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B,a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

CHECK ONLY ONE:

_____ I DECLINE Hepatitis B vaccine inoculation

OR

_____ I ACCEPT Hepatitis B vaccine inoculation.

Employee's Name:

Printed: _____ Signature: _____

Date: _____

Employment Eligibility Verification

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

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

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

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

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

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

Refer to the instructions for more information about acceptable receipts.

Documents Needed

___ Driver's License

___ Social Security Card

___ Proof of Professional Licensure

___ Proof of Applicable Certification(s)

___ Auto Insurance