APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE
EQUAL OPPORTUNITY EMPLOYER

PERSONAL INFORMATION

DATE _____

NAME (LAST NAME FIRST)		SOCIAL SECURITY NO. — —	
PRESENT ADDRESS	CITY	STATE	ZIP CODE
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
PHONE NO. ( )	REFERRED BY		

EMPLOYMENT DESIRED

POSITION	DATE YOU CAN START	SALARY DESIRED
ARE YOU EMPLOYED? ☐ YES ☐ NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? ☐ YES ☐ NO	
EVER APPLIED TO THIS COMPANY BEFORE? ☐ YES ☐ NO	WHERE?	WHEN?

EDUCATION HISTORY

NAME & LOCATION OF SCHOOL		YEARS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

GENERAL INFORMATION

SUBJECTS OF SPECIAL STUDY/RESEARCH WORK OR SPECIAL TRAINING/SKILLS	
U.S. MILITARY OR NAVAL SERVICE	RANK

FORMER EMPLOYERS (LIST BELOW LAST FOUR EMPLOYERS, STARTING WITH LAST ONE FIRST)

DATE MONTH AND YEAR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

REFERENCES GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	BUSINESS	YEARS KNOWN

AUTHORIZATION

"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 grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws."

DATE _____ SIGNATURE _____

INTERVIEWED BY _____ DATE _____

DO NOT WRITE BELOW THIS LINE

REMARKS

NEATNESS			CHARACTER	
PERSONALITY			ABILITY	
HIRED	FOR DEPT.	POSITION	WILL REPORT	SALARY WAGES

APPROVED: 1. _____ EMPLOYMENT MANAGER 2. _____ DEPARTMENT HEAD 3. _____ GENERAL MANAGER

This application for employment is sold only for general use throughout the United States. Adams assumes no responsibility and hereby disclaims any liability for the inclusion in this form of any questions or requests for information upon which a violation of local, state, and/or federal law may be based. It is the user's responsibility to ensure that this form's use complies with applicable laws, which change from time to time.

ALL FLORIDA HOME HEALTH SERVICES, INC.

Reference/Facility Name: _____

Address: _____

City/State/Zip Code: _____

Your name has been given as a reference by the applicant listed below. Your assistance is important in the thorough screening of our applicant. This information is confidential. We are enclosing a self-addressed stamped envelope for your convenience.

Sincerely,

_____ _____

Applicant's Signature

I hereby authorize the following information to be released to ***All Florida Home Health Services, Inc.***

Date of employment: From _____ To _____

_____

Name of Applicant: _____ Social Security No. _____

Circle One: RN LPN HHA PT RT OT MSW Other _____

Evaluation Check:	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality of Work				
Quantity of Work				
Attitude				
Dependability				
Punctuality				
Personal Appearance				

Reason for leaving: _____ Wage Rate: _____ Eligible for re-employment: YES / NO

If no, please explain: _____

To your knowledge does this applicant have any disability that would adversely affect the performance of his/her duties: YES / NO If yes please explain : _____

Do you recommend this applicant: YES / NO If no please explain: _____

In your opinion will this candidate be suitable for independent assignment? YES / NO

If no please explain _____

How would you rate this employee's technical skills: POOR FAIR GOOD EXCELLENT

Signature: _____ Title _____ Date: _____

ALL FLORIDA HOME HEALTH SERVICES, INC.

Reference/Facility Name: _____
Address: _____
City/State/Zip Code: _____

Your name has been given as a reference by the applicant listed below. Your assistance is important in the thorough screening of our applicant. This information is confidential. We are enclosing a self-addressed stamped envelope for your convenience.

Sincerely,

_____ _____
Applicant's Signature

I hereby authorize the following information to be released to ***All Florida Home Health Services, Inc.***

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Name of Applicant: _____ Social Security No. _____

Circle One: RN LPN HHA PT RT OT MSW Other _____

Evaluation Check:	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality of Work				
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Dependability				
Punctuality				
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Reason for leaving: _____ Wage Rate: _____ Eligible for re-employment: YES / NO
If no, please explain: _____
To your knowledge does this applicant have any disability that would adversely affect the performance of his/her duties: YES / NO If yes please explain : _____
Do you recommend this applicant: YES / NO If no please explain: _____
In your opinion will this candidate be suitable for independent assignment? YES / NO
If no please explain _____

How would you rate this employee's technical skills: POOR FAIR GOOD EXCELLENT

Signature: _____ Title _____ Date: _____

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes**, which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screening conducted by: Date of Prior Screening: _____

- ☐ Agency for Healthcare Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Elder Affairs
- ☐ Department of Financial Services
- ☐ Department of Children and Families

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

CONFIDENTIALITY STATEMENT

I have been formally instructed regarding Agency policy and procedures for maintaining the confidentiality of all information contained in client/personnel files and records, as well as any other proprietary information regarding the agency that is obtained verbally.

I understand that, except as needed to conduct business, client and/or personnel information/proprietary information may not be discussed with anyone, either inside or outside the Agency.

I understand that medical records will not be removed from the Agency office unless the client has signed a "Release of Information Form", and the removal of such information is approved by the Agency Administrator and/or designee.

I understand that any breach of confidentiality may be grounds for immediate termination of employment.

Employee:_____ Date:_____

Witness:_____ Date:_____

EMERGENCY NOTIFICATION

EMPLOYEE NAME:_____ DATE:_____

Category:_____

In case of an emergency notify next of kin:

NAME:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Area Code and Telephone: (____)_____

SECOND EMERGENCY CONTACT (Friend or relative not living with you)

NAME:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Area Code and Telephone: (____)_____

EMPLOYEE SAFETY CHECKLIST

DATE: _____

EMPLOYEE: _____

Employee will initial each box when instruction is completed and all questions/concerns have been answered.

1.	General safety policy and program	[ ]
2.	Safety rules—general	[ ]
3.	Safety rules—specific to job	[ ]
4.	Employee counseling (discipline for safety policy violation)	[ ]
5.	Fire prevention, location of fire fighting equipment, and location of exits	[ ]
6.	Disaster Planning/Emergency Preparedness	[ ]
7.	How, when, and where to report injuries	[ ]
8.	Housekeeping and cleaning up spills	[ ]
9.	When and where to report unsafe conditions	[ ]

On _____, I reviewed the above checked items relating to the safety rules and safe work procedures for the Agency.

Employee Signature: _____

Administrator/Designee Signature: _____

Disclosure of Interests

The following questions are designed to assist Governing Body members, Professional Advisory members and staff in determining the nature and extent of any outside interest that might possibly involve conflict of interest with the affairs of the organization. Please read each question carefully and then answer briefly and concisely in the space that follows. In the event that you have any doubts as to what the question means, answer it to the best of your ability and identify the reason for doubt.

Glossary

Competitor:	A person offering for sale or selling products and/or services in competition with this organization.
Family:	Spouse, parents, children, brothers, sisters.
Purchaser:	Any person who buys, rents, or otherwise procures, has bought, rented or procured, or in any way has received from this organization any goods, materials, wares, merchandise, supplies, machinery, equipment, or professional and/or other service.
Person:	An individual, firm, partnership, trust, corporation, or other business entity.
Vendor:	Any person who sells, rents, agrees to furnish, has offered to sell, rent, or agree to furnish, or has sold supplies, machinery, equipment, real estate, credit, insurance, or service, profession or otherwise, to or on behalf of the organization.

1. **Ownership, Entertainment, Gifts, Loans:**

A. Do you or any member of your family directly or indirectly own, or during the past 24 months preceding the date hereof, have you or any member of your family owned, directly or indirectly, any interest whatsoever in, or shared in the profits of income of a *vendor, purchaser, or competitor?*

Yes _____ No_____

If "Yes" Explain:_____

B. During the 24 months preceding the date hereof, have you or any member of your family received, directly or indirectly, any compensation, entertainment, gifts, credits, loans, or anything of value from a *vendor, purchaser, or competitor?*

Yes _____ No _____

If "Yes" Explain:_____

2) **Employment Status:**

A. Are you or any member of your family presently an officer, director, employee or consultant of, or otherwise employed or retained by, any *vendor, purchaser, or competitor?*

Yes _____ No_____

If "Yes" Explain:_____

B. During the 24 months preceding the date hereof, have you or any member of your family been an officer, director, employee, or consultant of, or otherwise employed or retained by, any *vendor, purchaser, or competitor?*

Yes _____ No_____

If "Yes" Explain:_____

3) **Related Staff Members:**

A. Are any present staff members of this organization related to you either by blood or other legal family relationships?

Yes _____ No_____

If "Yes" Explain:_____

I certify that the above questions have been answered to the best of my ability, and of my own free will, and in the interest of cooperating with the agency. I also agree that if at any future time I should become aware of any conflict arising, that is not mentioned herein, I shall contact the Governing Body.

_____ _____

Signature Position

_____

Date

ORIENTATION CHECKLIST: PROFESSIONAL STAFF

Employee:_____ **Title:**_____

Date Completed Orientation: _____

I. GENERAL ORIENTATION

____ Introduction to Agency Staff
____ Tour of Agency
- a) Location of administrative offices
- b) Location of fire extinguishers
- c) Location of emergency lights/exits
- d) Location of first aid box
- e) Emergency evacuation routes

____ Agency Mission/Goals/Objective/Philosophy/Organizational Structure.
____ Standards of Ethical Conduct/Cultural Diversity/Sensitivity/Ethical Considerations
____ Conflict of Interest/ Nondiscrimination Policies
____ Scope of Services
____ Employment Policies/Job Descriptions/Competency/Evaluations/Supervision
____ Employee/Patient Complaint Policy/Grievance Form
____ Confidentiality:
- A) client information including HIPPA/PHI/ePHI
- B) Staff information
- C) business information

____ Alzheimer information and information sheet/Communication barriers
____ Professional Boundaries
____ Billing and Payroll
____ Office Policies
____ Compliance Plan/Conduct training
____ Medicare Fraud/Abuse
____ Acceptable payer source
____ Convey charges to client

II. CLINICAL ORIENTATION

____ Clinical policies and procedures
____ Admission/Transfer/Discharge Criteria/Polices and Procedure
____ Service and Care limitations
____ Client assessment of Oasis/Plan of Care
____ Client education
____ Clinical Records/timeframes/documentation requirements/security records, contents, computer office and home/maintenance/ storage
____ Assignments/Scheduling
____ Handling Client/Employee Cancellations
____ Incident/Accident reporting
____ Client Rights and Responsibilities
____ Advance Directives/Living Will
____ Medical Emergencies
____ Client Referrals to Other Programs
____ QI Program
____ On call policies
____ Abuse reporting, neglect/exploitation, and suspected abuse/neglect/exploitation of adults and children
____ Working with special populations Alzheimer and Associated Disorder
____ Resource Area/Community Resources

Professional Orientation checklist
Page two

III SAFETY/RISK MANAGEMENT/INFECTION CONTROL

____ Unusual Occurrence Reporting
____ OSHA Standards Bloodborne Pathogens/Right to know law
____ Infection Control measures/PPE/Universal Precautions
____ Biohazardous/Infectious Waste
____ Hazardous Waste Management Plan
____ HIV/HB Update
____ TB Exposure Control Plan
____ Agency CEMP
____ Care of Environment/Equipment
____ Employee Illness and Accident Reporting
____ FDA Med Watch Program
____ Emergency Preparedness
____ Disaster Plan/Drills
____ Fire Plan/Drills
____ Waived testing for RN/LPN only

Declaration:
I have read and understand the policies and procedures for this Agency and have had the opportunity to have all of my questions/concerns addressed to my complete satisfaction. I further acknowledge receipt of the Agency's Employee Handbook.

I agree to abide by and uphold all rule, conditions, policies and procedures, and have been advised that failure to do so may result in termination of employment.

I also agree that as a requirement of employment, regardless of status (e.g.: full time, part time, Per Diem, etc.) I will provide the Agency with a fourteen (14) day written notice of intent to terminate employment.

I have received orientation from the ADM and DON of the agency and have signed my orientation receipt.

_____

SIGNATURE

_____

WITNESS

Employee Handbook
Acknowledgement of Receipt and Understanding

I hereby certify that I have read and fully understand the contents of the Employee Handbook. Furthermore, I have been given the opportunity to discuss any information contained therein or any concerns that I may have. I certify that my employment and continued employment is based in part upon my willingness to abide by and follow the Agency's policies, rules, regulations and procedures. My signature below certifies my knowledge, acceptance and adherence to the Agency's policies, rules, regulations and procedures and that the Agency's offer of employment was based on my promise to abide by and follow said policies, rules, regulations and procedures.

I further certify that my application and subsequent acceptance of employment is true and bona fide, and I am honestly interested in working in the position(s) for which I have been employed. Furthermore, I certify that I have sought and obtained employment with this Agency solely to provide me with the benefits of a job and for no other purpose.

I acknowledge that the Agency reserves the right to modify or amend its policies at any time, without prior notice. These policies do not create any promises or contractual obligations between this Agency and its employees. At this Agency, my employment is at will. This means I am free to terminate my employment at any time, for any reason, with or without cause, and this Agency retains the same rights. I further understand and agree that the Owner/President of this Agency is the only person who may make an exception to this, including the at-will status of my employment, and it must be in writing and duly executed by the Owner/President of this Agency.

If applicable to my employment, I have read and understood the notice regarding polygraph tests and my rights under this state's law.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the references and/or employers listed on my employment application, or any other documents I have provided to this Agency, to give the Agency any and all information concerning my previous employment and pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing such information to this Agency. I agree and understand that this Agency and its agents may investigate or seek information concerning my background and/or previous employment, whether of record or not. I further agree and understand that if employed, the Agency may at any time seek any information from whatever source, which in its discretion, it deems relevant to my employment. I also understand that any investigation or information sought regarding my previous employment or consumer records may not be completed or in possession of this Agency and thus my continued employment may be affected by such information once received. I hereby acknowledge, confirm, convey, agree and grant this Agency's right to act on any additional information received including, at the Agency's sole discretion, termination of my employment.

NO DRUG USE POLICY: This Agency does not hire persons who use illegal drugs. All persons seeking employment or employed with this Agency may be required to take and pass a screen for illegal drugs, and may be subject to periodic tests for illegal drugs. I hereby voluntarily consent to provide a urine specimen (or blood specimen as required for alcohol testing only) at a collection facility designated by this Agency, and further consent to have the specimen tested at a laboratory selected by this Agency. I hereby certify that I:

(**check one**) do _____ or do not _____ use illegal drugs.

Signature _____ Date _____

EMPLOYEE CONFIDENTIALITY
AND
NON-COMPETITION AGREEMENT

In consideration of my employment or continued employment by _____ (the "Agency"), together with its affiliates and subsidiaries, and any subsidiaries or affiliates which hereafter may be formed or acquired, and in recognition of the fact that as an employee of the Agency I will have access to the Agency's customers and to confidential and valuable business information of the Agency and its parent Agency, if applicable, together with its affiliates and subsidiaries, and any subsidiaries or affiliates which hereafter may be formed or acquired, I hereby agree as follows:

1. The Agency's Business. The Agency Business is Home Health Care. The Agency is committed to quality and service in every aspect of its business. I understand that the Agency looks to and expects from its employees a high level of competence, cooperation, loyalty, integrity, initiative, and resourcefulness. I understand that as an employee of the Agency, I will have substantial contact with the Agency's customers and potential customers.

I further understand that all business and fees, including consulting, risk management and other services produced or transacted through my efforts, shall be the sole property of the Agency, and that I shall have no right to share in any commission or fee resulting from the conduct of such business other than as compensation referred to in the paragraph entitled "Compensation and Benefits" hereof. All checks or bank drafts received by me from any customer or account shall be made payable to the Agency, and all premiums, commissions, or fees that I may collect shall be in the name of and on behalf of the Agency.

2. Duties of Employee. I shall comply with all Agency rules, procedures, and standards governing the conduct of employees and their access to and use of the Agency's property, equipment, and facilities. I understand that the Agency will make reasonable efforts to inform me of the rules, standards, and procedures which are in effect from time to time and which apply to me.

3. Compensation and Benefits. I shall receive the compensation as is mutually agreed upon, which may be adjusted from time to time, as full compensation for services performed under this Agreement. In addition, I may participate in such employee benefit plans and receive such other fringe benefits, subject to the same eligibility requirements, as are afforded other Agency employees in my job classification. I understand that these employee benefit plans and fringe benefits may be amended, enlarged, or diminished by the Agency from time to time, at its discretion.

4. Management of the Agency. The Agency may manage and direct its business affairs as it sees fit, including, without limitation, the assignment of duties and responsibilities, the assignment of sales territories, notwithstanding any employee's individual interest in or expectation regarding a particular business location or customer account.

5. Termination of Employment. My employment may be terminated by the Agency or me at any time, with or without notice or cause. Upon termination of my employment, I shall be entitled to receive incentive payments in accordance with the provisions of the Agency's Incentive Plan, as it may be modified by the Agency from time to time, less any adjustments for amounts owed by me to the Agency. I understand that I may also receive additional compensation at the discretion of the Agency and in accordance with the published Agency Personnel Policy on Termination Pay.

6. Agreement Not to Compete with the Agency.

A. As long as I am employed by the Agency, I shall not participate directly or indirectly, in any capacity, in any business or activity that is in competition with the Agency.

B. In consideration of my employment rights under this Agreement and in recognition of the fact that I will have access to the confidential information of the Agency and that the Agency's relationships with its customers and potential customers constitute a substantial part of its goodwill, I agree that for One (1) year from and after termination of my employment, for any reason, unless acting with the Agency's express prior written consent, I shall not, directly or indirectly, in any capacity, solicit or accept business from, provide consulting services of any kind to,

or perform any of the services offered by the Agency, for any of the Agency's customers or prospects with whom I had business dealings in the year next preceding the termination of my employment.

C. I agree not to go into business as a direct competitor of Agency within a radius of _____ miles of _____ for a period of _____ following the expiration or termination of this agreement or following termination of employment and notwithstanding the cause or reason for termination.

7. Unauthorized Disclosure of Confidential Information. While employed by the Agency and thereafter, I shall not, directly or indirectly, disclose to anyone outside of the Agency any Confidential Information or use any Confidential Information (as hereinafter defined) other than pursuant to my employment by and for the benefit of the Agency.

The term "Confidential Information" as used throughout this Agreement means any and all trade secrets and any and all data or information not generally known outside of the Agency whether prepared or developed by or for the Agency or received by the Agency from any outside source. Without limiting the scope of this definition, Confidential Information includes: any customer files, customer lists, any business, marketing, financial or sales record, data, plan, or survey; and any other record or information relating to the present or future business, product, or service of the Agency. All Confidential Information and copies thereof are the sole property of the Agency.

Notwithstanding the foregoing, the term Confidential Information shall not apply to information that the Agency has voluntarily disclosed to the public without restriction, or which has otherwise lawfully entered the public domain.

8. Prior Obligations. I have informed the Agency in writing of any and all continuing obligations that require me to withhold or not disclose any information or that limit my opportunity or capacity to compete with any previous employer.

9. Employee's Obligation to Cooperate. At any time upon request of the Agency, at the Agency's expense, I shall execute all documents and perform all lawful acts the Agency considers necessary or advisable to secure its rights hereunder and to carry out the intent of this agreement.

10. Return of Property. At any time upon request of the Agency, and upon termination of my employment, I shall return promptly to the Agency, all copies of all Confidential Information or Developments, and all records, files, blanks, forms, materials, supplies, and any other materials furnished, used, or generated by me during the course of my employment, and any copies of the foregoing, all of which I recognize to be the sole property of the Agency.

11. Special Remedies. I recognize that money damages alone would not adequately compensate the Agency in the event of a breach by me of this Agreement, and I therefore agree that, in addition to all other remedies available to the Agency at law or in equity, the Agency shall be entitled to injunctive relief for the enforcement hereof. Failure by the Agency to insist upon strict compliance with any of the terms, covenants, or conditions hereof shall not be deemed a waiver of such terms, covenants, or conditions.

12. Miscellaneous Provisions. (Check appropriate paragraph. Have employee initial)

- [ ] This Agreement contains the entire and only agreement between me and the Agency respecting the subject matter hereof and supersedes all prior agreements and understandings between us as to the subject matter hereof; and no modification shall be binding upon me or the Agency unless made in writing and signed by me and an authorized officer of the Agency. **Initials:** _____

- [ ] I acknowledge that there may be more than one agreement between me and the Agency respecting the subject matter hereof. In this event, this Agreement will be treated as an integral part of the sum of these agreements. In the case of duplication, respecting the subject matter hereof, my obligations shall consist of the sum of my obligations within said agreements. I am fully responsible for notifying the Agency of any conflict between said agreements immediately upon my discovery of such. No modifications shall be binding upon the Agency or me unless made in writing and signed by me and an authorized officer of the Agency. **Initials:** _____

My obligations under this Agreement shall survive the termination of my employment with the Agency regardless of the manner of or reasons for such termination, and regardless of whether such termination constitutes a breach of this Agreement or of any other agreement I may have with the Agency. If any provisions of this Agreement are held or deemed unenforceable or too broad to permit enforcement of such provision to its full extent, then such provision shall be enforced to the maximum extent permitted by law. If any of the provisions of this Agreement shall be construed to be illegal or invalid, the validity of any other provision hereof shall not be affected thereby.

This Agreement shall be governed and construed according to the laws of Florida, and shall be deemed to be effective as of the first day of my employment by the Agency.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD ALL OF ITS PROVISIONS AND THAT I AGREE TO BE FULLY BOUND BY THE SAME.

Employee: _____ Date: _____

Accepted by: _____ Date: _____
(Name of Officer) Title

ELECTRONIC DOCUMENTATION & SIGNATURE AUTHENTICITY AGREEMENT

I understand that the agency staff may use electronic signatures on all computer- generated documentation. An electronic signature will serve as authentication on patient record documents and other agency documents generated in the electronic system.

For the purpose of the computerized medical record and other documentation for agency purposes, I acknowledge the combined use of my Electronic Signature Passcode and Log In authentication password will serve as my legal signature. I understand that I will be required to update my password regularly for security purposes. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of electronic signature, my documentation on the field-based or office computer. I understand that I am responsible for the security and accuracy of information entered into my organization's Well Sky application, and as such, I will

- Not share or otherwise compromise my electronic signature credentials (Log In authentication password or Electronic Signature Passcode)
- Exit the online application at the end of each working day or whenever the computer is not in my immediate possession
- Not save my Log In password and Electronic Signature Passcode on the computer, but will enter them upon each access of the application
- Review all of my documentation online prior to submitting to the agency server

Employee Signature _____ Date _____

Witness Signature _____ Date _____

NOTIFICATION OF INTRODUCTORY PERIOD

EMPLOYEE: _____

JOB TITLE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF HIRE: _____

PROBATIONARY DATE: _____ TO _____

I, _____, in accepting employment withthe Agency accept and understand the first 90 days of employment will be considered my introductory period. If for any reason my employment is terminated during this period, I understand and accept this account will not be charged with any unemployment benefits I may be eligible to receive under the State Unemployment Compensation Law.

I also understand and accept that at the end of the 90 day period, I will receive a written evaluation of my work performance. Should the Agency fail to provide this written evaluation, it shall be understood and accepted by all involved that the introductory period will have been completed satisfactorily.

_____

Employee's Signature Date

_____

Administrative Signature Date

JOB DESCRIPTION

REGISTERED NURSE

REPORTS TO:

Director of Nursing

JOB SUMMARY:

Professional member of home health team who provides skilled nursing visits in patient's home under the direction of plan of treatment established with physician and input from patient/care giver.

DUTIES AND RESPONSIBILITIES:

1. Provides initial and on-going assessment of client needs using the OASIS data elements incorporated into the Comprehensive Assessment.
2. With input from patient/care giver and in conjunction with physician, formulates and implements plan of care.
3. Evaluate effectiveness of care plan and make necessary adjustments.
4. Provides for the emotional and physical comfort and safety of client taking into consideration their rights and cultural background.
5. Receives and transcribes physician orders.
6. Notifies physician and Agency supervisor of unusual reactions and/or changes in clients condition.
7. Documents all appropriate observations and treatments in keeping with Agency policies and procedures.
8. Participates in case conferences, team meetings, staff meetings, and Performance Improvement activities as assigned.
9. Provide any skilled nursing service for which appropriately trained which is prescribed under the plan of care.
11. Provide 60 day summary of skilled services and client outcomes to physician and Agency supervisor in keeping with Agency policies and procedures.
12. Adheres to all Agency policies and procedures including but not limited to the HIPAA Privacy rule.

13. Maintains strict confidentiality of all patient, employee and Agency information.

14. Other duties as assigned by supervisor and for which (s)he is qualified.

QUALIFICATIONS:

1. Must be a graduate of an approved school of nursing.

2. Currently licensed in the State of Florida as a Registered Nurse in home care for 2 years with one year supervisory experience

Job description is reviewed at least annually by the Governing Body/PAC. Changes are discussed with employee as they occur.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/ or experience to carry out these duties.

_____ _____

Employee's Signature Date

OCCULT BLOOD TEST

COMPETENCY EVALUATION

EMPLOYEE NAME: _____ Date: _____

1 Instruct patient on procedure for Occult Blood test		
2. Instruction patient to avoid non-steroidal and inflammatory drugs for 2 days prior to and during collection of specimen		
3. Washes hands; dons gloves, prepare test as per manufacturer protocol		
4 Float the test pad on top of the toilet water		
5. Wait 2 minutes you should see no blue-green color on the test pad.		
6. After the patient has a bowel movement, remove another test pad from the large pouch and float it onto the toilet water		
7 Within 2 minutes, look for a blue-green color on the test area of the test pad		
8 Record the results chart.		
9. Flush the toilet		
10 Positive Control test -Flush the toilet -Open positive control test and sprinkle its contents into the toilet -Wash your hands -Wait 1 min; drop the last test pad into the toilet Within 2 min, a blue-green cross should appear		
11 Inform to MD of positive or negative results		
12 Instruct patient on proper storage of product ie: keep dry, and away from heat, etc		
13 Document result in clinical record if applicable		

Signature of Employee: _____ Date: _____

Signature/Title of Evaluator: _____ Date: _____

URINE DIPSTICK/KETONES

COMPETENCY EVALUATION

EMPLOYEE NAME: _____ DATE: _____

PERFORMANCE CRITERIA		
1. Instruct patient on procedure for Urine Dipstick/Ketones		
2 Prepare procedures as per manufacturer protocol: Washes hands Dons gloves. Check 'Use By' date (printed) and 'Opened' date (written) on vial Remove test strip from vial Firmly hold end farthest away from Test Pad Pass Test Pad through urine stream After 15 seconds, match Test Pad to color chart on vial label . Discard used Test Strip in appropriate container.		
3 If moderate or large ketones present, verbalizes knowledge to contact MD immediately with results.		
4 Document results as appropriate		

Signature of Employee: _____ Date: _____

Signature/Title of Evaluator: _____ Date: _____

GLUCOMETER

COMPETENCY EVALUATION

EMPLOYEE NAME: _____ Date: _____

[illegible]	[illegible]	[illegible]
1 Washes hands; dons gloves		
2. Turns on glucose meter		
3 Prepares meter by validating the proper calibration with strips to be used as manufacturer; checks expiration dates; records results on Quality Control Log		
4. Prepares the finger to be lanced by having client wash hands.		
5 Selects finger; cleanses with alcohol pad		
6 Pricks the client's finger lateral to the fingertip using lancet type device obtaining a large hanging drop of blood		
7 Applies blood to strip area		
8. For meters with a wipe system: -Times the blood contact with the strip -Wipes off blood with a firm stroke using -A cotton ball at appropriate time -Inserts strip into meter for final result/result		
9. For meters with a "no wipe system", allow blood to remain on the strip until results appear on meter		
10 Cover lanced finger with gauze/tissue until bleeding subsides		
11 . Disposes of lancet in puncture resistant container		
12. Removes glove; washes hands.		
13. Document calibration results on form.		
14 Equipment Used: Product: _____ Serial#: _____		

Signature of Employee: _____ Date: _____

Signature/Title of Evaluator: _____ Date: _____

HEPATITIS B VACCINATION CONSENT

* I have read the information concerning Hepatitis B vaccination.

* I understand the benefits and risks of the Hepatitis B vaccination and have had the opportunity to ask questions.

1. The vaccine will be administered in a serious of three (3) doses: the initial dose, the second dose a month later, and the right dose six months after the first. I understand I must complete the series for full immunization.

2. If I receive the vaccine, I have a 90-95% change of developing antibodies to the Hepatitis B surface antigen and therefore immunity to the infection of the Hepatitis B virus.

3. The vaccine may not be affective, if I am already incubating the Hepatitis B virus.

4. The duration of immunity is unknown at this time and I may require a booster in five (5) years.

5. The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A or non-A/non-B agents.

6. After receiving the vaccination minor side effects, such as infection site soreness and redness, low-grade fever, malaise and nausea, have been reported.

I, _____, request vaccination with the Hepatitis B vaccine.

HEPATITIS B VACCINATION DECLINATION

I, _____, decline vaccination with the Hepatitis B vaccine.

By so doing, I understand that due to my occupation's exposure to blood or other infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I choose to be vaccinated with the Hepatitis B vaccine, I can receive the vaccine series at no charge at that time.

_____ _____

Signature Date

_____

Witness

(Hepvac)

EMPLOYEE HEALTH RELEASE FOR DENIAL OF T.B. SIGNS

The early signs and symptoms of tuberculosis are as follows:

- Cough
- Night Sweats
- Fever
- Loss of Weight
- Loss of Appetite
- Coughing Blood

I have read the above information and do not now have these symptoms. If these symptoms develop I will contact my supervisor immediately for follow-up.

Employee Signature _____ Date _____

Witness _____ Date _____

Form **W-4**
(Rev. December 2020)
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

2021

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 widow(er)**
☐ **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, when to use the estimator at *www.irs.gov/W4App*, 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) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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 and 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)

General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350