APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY EMPLOYER

Equal access to employment is available to all persons. Those applicants requiring reasonable accommodation for the application and/ or interview process should notify the Personnel Director.

- You must fully and accurately complete this Application of Employment. Incomplete applications will not be considered.
- Please fill in all information and complete all questions using blue or black ink. Do not indicate "see resume".

PERSONAL INFORMATION **DATE _____**

Name: _____
First Last Middle

Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security No. _____

Contact Details: _____ _____ _____
Home Mobile Email Address

Emergency Contact Numbers:

1.) _____
Name Relationship Telephone No.

2.)_____
Name Relationship Telephone No.

Are you 18 years or older? YES _____ No _____

If hired, you will be required to submit proof of your identity and legal authorization as a condition of employment in accordance with the Immigration Reform and Control Act of 1986. Can you supply the required documentation to verify your lawful right to work in the United States? YES_____ No _____

Do you currently have any relatives employed at AHHC? Yes_____ No _____

Have you ever been convicted of a crime? Yes _____ No _____

If YES, please explain: _____
_____

Position Applied for: _____

Date Available for Work: _____ Desired Salary: _____

Full-Time: _____ Part –Time _____, If part-time, Days Available: _____

Are you employed now? _____ Have you ever been employed by AHHC? Yes____ No _____

If Yes, give dates: From: _____ To: _____

Referred by: _____

Education Background:

Name of: School	Address:	Years attended	Date Graduated	Degree
1.				
2.				
3.				
4.				

Job-Related Skills: *(Please list any skills or qualifications that may be relevant to the position for which you are applying.)* Subject of Special Study/ Research work or special training/skills/certifications including Military Services: _____

_____

_____

Employment History: *(Please complete this section even if you are submitting a resume. You may include military service and any verifiable work performed on a volunteer basis.)* Provide the following information from your past and current employers, assignments or volunteer activities – starting with the most recent (use additional sheets if necessary.)

Name of Employer_____
Address_____ Tel. No._____
Title_____ Name of Immediate Supervisor _____
Job duties: _____
Starting Date: _____ Ending Date: _____
Starting Salary:_____ Ending Salary: _____
Reason for Leaving _____
May we contact for reference? Yes_____ No _____ Later _____

Name of Employer_____
Address_____ Tel. No._____
Title_____ Name of Immediate Supervisor _____
Job Duties: _____
Starting Date: _____ Ending Date: _____
Starting Salary:_____ Ending Salary: _____
Reason for Leaving _____
May we contact for reference? Yes_____ No _____ Later _____

Name of Employer_____
Address_____ Tel. No._____
Title_____ Name of Immediate Supervisor _____
Job Duties: _____
Starting Date: _____ Ending Date: _____
Starting Salary:_____ Ending Salary: _____
Reason for Leaving _____
May we contact for reference? Yes_____ No _____ Later _____

References:

Give the name of three business/ work references that have direct knowledge of your job skills and work abilities, not related to you, whom you known at least one year. If not applicable, list three school or personal references who are not related to you.

Name	Address	Telephone	Years Acquainted
1.			
2.			
3.			

I certify that all information submitted by me on this application is true and complete. And I understand that of any false information, omissions or misrepresentations are discovered, my application may be rejected and if I am employed, my employment may be terminated at any time. I give the employer the right to conduct and obtain information from all references, employers, educational institutions and to otherwise verify the accuracy of the information contained in this application. I hereby release from liability the employer and its representatives for seeking, gathering and using such information and all other persons, corporations or organizations for furnishing such information.

The employer does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by local, state or federal law.

If I am hired, I understand that I am free to resign at any time, with or without cause and the employer reserves the same right to terminate my employment at any time, with or without any cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no representative of the employer, other than an authorized officer, has the authority to make assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer.

I understand that it is this company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the ADA and Section 504 of the Rehabilitation Act.

I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization.

In consideration of my employment, I agree to conform to AHHC's rules and regulations, and I agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at anytime by AHHC.

I have read and fully understand the foregoing and seek employment under these conditions.

Signature of Applicant: _____ Date: _____

EMPLOYEE REFERENCE (Confidential)

For : _____ (Supervisor's Name)
_____ Company
_____ Address
_____ Phone

This applicant has applied for _____ position and has given you as a reference. We would appreciate your completion of this form found on the bottom part of this page, so that we may evaluate his/her qualification. The information submitted will be confidential.

I hereby give my authorization for the release of the information.

[] Employee Evaluation [] Co-Worker Evaluation [] Personal Evaluation

Applicant's Signature _____ Date _____

**********Please start your comment below **********

Job Title: _____
Reason for Termination: _____
Eligible for Hire: Yes ___ No ___ (If No, state reason)_____

Characteristics of Applicant (Please circle the rating)

Characteristics	Excellent	Above Average	Average	Below Average	Poor
Personal					
Appearance	5	4	3	2	1
Initiative	5	4	3	2	1
Attitude	5	4	3	2	1
Professional					
Rapport with other workers	5	4	3	2	1
Rapport with clients	5	4	3	2	1
Organizational skills	5	4	3	2	1
Attention to details	5	4	3	2	1
Ability to Respond quickly & react	5	4	3	2	1
Dependability					
In reporting for work	5	4	3	2	1
In completing assignments	5	4	3	2	1
Technical *(Please check only what is applicable)*					
Clinical skills (for RN/PT/OT/MSW/CNA)	5	4	3	2	1
Administrative Skills (for	5	4	3	2	1
Marketing Skills	5	4	3	2	1
I.T.	5	4	3	2	1
Others	5	4	3	2	1
Ability in taking directions	5	4	3	2	1

Remarks *(outstanding traits/weakness to know when considering this applicant for named position):*_____
_____
_____

Signature & Date _____ Title: _____

EMPLOYEE REFERENCE (Confidential)

For : _____ (Supervisor's Name)
_____ Company
_____ Address
_____ Phone

This applicant has applied for _____ position and has given you as a reference. We would appreciate your completion of this form found on the bottom part of this page, so that we may evaluate his/her qualification. The information submitted will be confidential.

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Applicant's Signature _____ Date _____

**********Please start your comment below **********

Job Title: _____
Reason for Termination: _____
Eligible for Hire: Yes ___ No ___ (If No, state reason)_____

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Organizational skills	5	4	3	2	1
Attention to details	5	4	3	2	1
Ability to Respond quickly & react	5	4	3	2	1
Dependability					
In reporting for work	5	4	3	2	1
In completing assignments	5	4	3	2	1
Technical *(Please check only what is applicable)*					
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Marketing Skills	5	4	3	2	1
I.T.	5	4	3	2	1
Others	5	4	3	2	1
Ability in taking directions	5	4	3	2	1

Remarks *(outstanding traits/weakness to know when considering this applicant for named position):*_____
_____
_____

Signature & Date _____ Title: _____

EMPLOYEE REFERENCE (Confidential)

For : _____ (Supervisor's Name)
_____ Company
_____ Address
_____ Phone

This applicant has applied for _____ position and has given you as a reference. We would appreciate your completion of this form found on the bottom part of this page, so that we may evaluate his/her qualification. The information submitted will be confidential.

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[] Employee Evaluation [] Co-Worker Evaluation [] Personal Evaluation

Applicant's Signature _____ Date _____

**********Please start your comment below **********

Job Title: _____
Reason for Termination: _____
Eligible for Hire: Yes ___ No ___ (If No, state reason)_____

Characteristics of Applicant (Please circle the rating)

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In reporting for work	5	4	3	2	1
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Others	5	4	3	2	1
Ability in taking directions	5	4	3	2	1

Remarks *(outstanding traits/weakness to know when considering this applicant for named position):*_____
_____
_____

Signature & Date _____ Title: _____

PERSONNEL ORIENTATION CHECKLIST

Employee Name: _____

Checklist	Date Completed	Orientation by Whom	Personnel Initials
Tour of Office/ Introduction of agency Personnel			
Introduction to work stations			
Personnel File:			
A. professional License / Certifications			
B. Driver's License			
C. Proof of Vehicle Insurance			
D. Physical Exam and Drug Test			
E. CPR Certification			
F. Application			
G. Signed Job Description			
H. Universal Body Substance Precaution Orientation			
I. Criminal Background Check			
Name and Photo Identification			
Orientation Content for all personnel include:			
A. General Orientation to Organization			
B. Review of Organizational Chart			
C. Human Resources Processes			
D. Management Welcome including Mission, Philosophy & Vision			
E. Introduction to Home Care			
F. Services Provided by Agency			
G. Safety Review (if applicable)			
H. Infection Control (if applicable)			
I. Performance Improvement Process			
J. Confidentiality			
In addition to the above, all clinical personnel receive Orientation to the following:			
A. Type of Care/ Services delivered in the patient's environment			
B. Available Community Resources			
C. Equipment Management			
D. Home Safety Issues			
E. Storage, Handling and Access to Supplies Medical gases and drugs			

F. Identification, Handling and Disposal of Hazardous or Infectious Materials			
G. Infection Control Practices			
H. Actions in Unsafe Situations			
I. Other Patient Care Services Responsibilities			
J. Specific tests to be performed by the agency personnel			
K. Advance Directive			
L. Appropriate4 Policies and Procedures			
M. Screening for Abuse and Neglect			
N. Guidelines for appropriate referrals, including timeliness			
O. Emergency Preparedness			
P. Information regarding services provided by other members of the agency personnel			
Q. Home care procedure:			
1. Documentation			
2. Scheduling			
3. Supervision			
R. Other			

Orientation was completed on the following date above stated and the orientee is able to perform those skills and/or behaviors as of this date.

Employee Signature: _____ Date: _____

Preceptor Signature: _____ Date: _____

CLINICAL COMPETENCY CHECKLIST

Employee Name : _____

Evaluator : _____

COMPETENCY AREA	Proficiency	Procedure Reviewed	Preceptor's Signature
Ability to complete Documentation related to the following functions			
Admission to Agency			
• Comprehensive Assessment including OASIS • Develop Care Plan based on Assessment • Utilizes Nursing Process Approach • Referrals to other disciplines • Within 48 hours			
Coordination of Services			
• Case Management • Delivers services according to Plan of Care • Obtains Order to modify Plan • 60 day summary • Refers/uses community resources			
Transfer / Discharge of Client			
• Discharge Planning • Community Resources • Discharge Summary			
Regulatory Compliance			
• Medicare Qualifying Criteria			
Knowledge of Medication Management and Document Assessment, Teaching and Assessed Effects			
• Cardiac medications • Respiratory medications (Inhalers, Nebulizers) • Diabetic Medications • Anticoagulant therapies and monitoring • Neurologic / Behavioral Medications			
Knowledge of wound assessment and Management of Ulcers and other wounds			
• Measurement of Wounds • Staging of Ulcers • Documentation of Assessment and Progress • Use of Various Wound care treatments • Use of Wound Vacs • Wound Irrigations and Dressings • Wound Drains • Acc wraps, cast care • Sterile and non-sterile Dressing changes • Ulcer prevention Techniques			
Skills in Use of Equipment			
• Electric Beds/ Specialized Beds/ pressure mattress • Infusion pumps • Ambulatory Infusion pumps • Glucometers • C-PAP equipment • Oxygen Concentrators • Home Ventilators			

• Hoyer Lifts • Walker/wheelchair /Assistive Devices • Skill in teaching clients in action and in documentation of the plan • Assess learning needs of client/family • Teaching plan with measurable objectives and time frames • Document client response • Evaluates effectiveness of Plan • Documents responses and progress toward goals • Modifies plan to accommodate client specific needs			
Knowledge of Diabetic Assessment and management care and documentation			
• Insulin type and teaching • Use and care of glucometer • Teaching in areas of diet, exercise and sick day care • Signs and symptoms of hyper / hypoglycemia • Foot and skin care			
Knowledge of IV / Central line Management through care and Documentation			
• To identify and respond to complications and associated with central lines • Measure and document the external length of the catheter with each dressing change • Required Documentation associated with central line management, IV medication administration, flushing, injection cap changed and central line dressing and blood draw via central line venous access device			
Skills in Performing Skilled Procedures			
• Medication Administration • Enteral Feedings • IV Therapy • Mental status Exam • Aphasia Care • Signs and symptoms of hyper / Hypoglycemia • Spinal Cord Injuries • Catheter • Ted Hose • Cast Care • Suture, Staple Removal • Nasogastric Tube Insertion and Care • Jejunostomy tube care			

Others : _____

_____

_____

_____

Employee Signature: _____ Date: _____

JOB DESCRIPTION

Position: SKILLED NURSE

Position Supervises: LPN & HHA

Description:

The clinical nurse has a clinical nursing knowledge, physical assessment, teaching and procedural skills. He/she has the ability to be directly responsible for assessing, planning, providing and documenting nursing care for a designated group of patients in accordance with the physician's plan of care and Advance Home Health Care Ltd.'s policies and procedures. The provisions of quality care is accomplished by implementing, supervising and coordinating services provided and utilizing division to LPN's , Home Health Aides and completes documentation effectively and timely.

DUTIES AND RESPONSIBILITIES

1. Completes referrals and takes physician's verbal orders as necessary in a timely manner. Channels referrals appropriately to the director of nursing for assignment.
2. Makes home visits, performs physical assessments, evaluates patient's needs and consults with physicians if necessary to develop plan of care and documents appropriately and in a timely manner.
3. Assess need for additional health or ancillary services and refers patients for services when appropriate, on a timely basis.
4. Assess family and home environment and makes recommendations which will enhance patient care and promote safety.
5. Involves patients and/or family in developing and revising an individualized care plan including necessary teachings with realistic goals, update plan of care as goals are met or change in intervention as required and documents changes appropriately within five days.
6. Coordinate the multidisciplinary care team and plans for patient care and documents appropriately.
7. Interprets the admission, discharge and other policies of the Agency to patient, physician, family, other health care providers and community as needed.
8. Provides clear written/verbal Home Health Aide and LPN assignments, updates instructions for the aides and LPN's in a timely manner and documents/verbal instructions appropriately.
9. Provides skilled nursing care and assessments to patients in the home environments, according to the plan of care and promptly revises the plan,

as necessary, in consultation with the physician and other team member. Establishes and modifies goals as appropriate.

10. Informs physician of the changes in patient's condition in accordance with AHHC policy or physician's orders and documents communication with physicians appropriately.
11. Initiate appropriate preventive, rehabilitative, comfort, pain management nursing procedures and provides instructions to patients/caregivers and staff in a timely manner. Follows company policies and utilizes company forms in proper documentations.
12. Explains to the patients and family the diagnosis and the nature of the treatment consistent with the physician's orders and plan of treatment.
13. Performs LPN supervisory visits to evaluate competency, at least every 30 days or more frequently, if necessary. Provides skilled services and appropriate instructions to LPN and documents accordingly.
14. Conducts Home Health Aide supervisory visits either when the Home Health Aide is present to observe and assist or when the Home Health Aide is absent to assess relationships and determine whether goals arte being met.
15. Performs specialized care in accordance with the competencies and demonstrates initiative in learning new skills and developing competency.
16. Maintain assigned patient's clinical records including medical profiles, plan of care, case conferences progress notes and other required documentation, conducts patient care conferences every three weeks from the start of care and report unusual occurrences/changes to the attention of the physician. The patient and the family are consulted and informed about all the changes in the care plan.
17. Completes clear, concise and accurate clinical notes which documents skilled services and other required documentation appropriately and submit on a timely basis. Utilizes only universally approved abbreviations.
18. Communicates necessary information to the director of Nursing/ Agency Supervisor.
19. Demonstrate professionalism by maintaining high standards of clinical care and staying current on clinical and medication issues.
20. Attends and participate in multidisciplinary patient case conferences to demonstrate effective coordination and continuity of patient care, as well as schedule case to be brought to the clinical records review committee.
21. Completes nutritional assessments and provides patient/caregiver instructions on diet/nutrition and seeks consultation as necessary.

Employee Signature: _____ Date: _____

EMPLOYEE CONFIDENTIALITY STATEMENTS

I, _____, understand the policies of the Company on the confidentiality of our patient's health care information in written, unwritten, or electronic form. I understand that this information belongs to the patient and I am only providing care and service and must guard the information appropriately. This includes, but is not limited to, keeping patient health care information secure, private and out of public view, not discussing patient-specific issues and information in public areas, and protecting computer data by logging off work stations when not in use. I acknowledge that I have been trained on the legal obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a health care provider. I pledge to abide by HIPPA'S PRIVACY RULES and by any state and/or federal law that provide greater protection on rights to patients.

I hereby agree and pledge that I will access only the information in any manner for me to perform my responsibilities. I agree not to use, disclose or communicate any patient information in any manner whatsoever other than minimum necessary for the provision of our services. I understand that all patient health care information will be released only to those who have a need to know and have signed a confidential agreement, to business associates with signed contracts and/or to individuals or organizations with signed authorization for release. If I have any doubts, prior to release any information, I will discuss my concerns with the Management.

I also understand the unauthorized use or disclosure of protected health care information may result in disciplinary actions up to and including termination of employment.

I understand that my obligation, as outlined above, will continue after my employment or association with the Company ends and that should I violate patient confidentiality, appropriate sanctions will be taken.

My signature below attests to the fact that I have read, understand and agree to abide by the terms of agreement.

_____ _____

Employee Name Printed *Witness Name Printed*

_____ _____

Employee Signature & Date *Witness Signature & Date*

CONFIDENTIALITY OF PATIENT AGREEMENT

By accepting employment with the Company you have obligated yourself to carefully retain from discussing any patient's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. Do not pass on medical information to patients and visitors unless you have been instructed to do so by your supervisor. In addition, all information, see or heard regarding patients, directly or indirectly, is completely confidential and is not to be discussed, even with your family. Your job as an employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings. Information about patients or the agency is not to be given to media. This is essential for protection of both the patient and the Company. Agencies are bound by very strict laws regarding the release of information concerning patients.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT:

_____ _____

Employee Signature *Date*

_____ _____

Witness Signature *Date*

WORKER'S DRIVING RELEASE AND AGREEMENT

Applicant Name: _____

I request authorization to drive my personal automobile while on duty to make visits to the patient's place of residence or on other agency business as assigned and agree to abide by the following agency regulations:

1. To maintain a current and valid Illinois Driver's License.
2. To maintain required state and local vehicle licenses and registrations for any vehicle.
3. To maintain current liability insurance for my vehicle including property damage, bodily injury and uninsured/underinsured motorist bodily injury.
4. To submit to the Company/Agency a copy of my vehicle insurance declaration page indicating the policy period each time my insurance is renewed.
5. To notify the Company/Agency in writing should such coverage be discontinued.
6. To maintain my vehicle in a reliable safe condition and in good running order.
7. To report to the Company/Agency in a timely manner any vehicle accident in which bodily injury occurs while I am driving my vehicle on agency business.
8. To be responsible for all summons for parking or moving violations and for payment of all fines.
9. To not transport patients or their family members while on duty for the Company/Agency, unless specifically authorized to do so by the Company/Agency's Authorized Representative/Administrator or its designee and only when a release and waiver of liability has been signed by the patient or their legal representative.

I have read the foregoing conditions and agree to abide by them. I understand that as a condition of employment I must adhere to the above regulations.

_____ _____
Employee Signature *Date*

_____ _____
Witness Signature *Date*

EMPLOYEE HEALTH EXAMINATION RECORD

Name: _____ Social Security No. _____
Address: _____

TO BE COMPLETED BY APPLICANT

	YES	NO		YES	NO
Asthma	_____	_____	Jaundice	_____	_____
Black Injury	_____	_____	Mental illness	_____	_____
Chronic back pain	_____	_____	Rheumatism	_____	_____
Diabetes	_____	_____	Sinus Problems	_____	_____
Epilepsy	_____	_____	Skin Condition	_____	_____
Fainting spells	_____	_____	PTB	_____	_____
Fractures	_____	_____	Spec. Allergies	_____	_____
Head injury	_____	_____	Spec. Surgeries	_____	_____
Head trouble	_____	_____	Spec. type of injury	_____	_____
Hernia	_____	_____			

I CERTIFY THAT ALL THE ABOVE HEALTH STATEMENTS ARE TRUE AND ALL PREEXISTING ILLNESS(ES), INJURIES AND CONDITIONS HAVE BEEN DISCLOSED.
Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

Ears: _____ Eyes: _____ Nose: _____
Mouth: _____ Teeth: _____ Throat: _____
Extremities: _____ Height: _____ Weight: _____
Vital Signs: _____ TB Skin Test: _____
Chest X-Ray: _____

(Please describe condition and recommendations below)

[ ] FIT FOR EMPLOYMENT [ ] NOT FIT FOR EMPLOYMENT

Name of Physician: _____
Signature & Date of Physician: _____
Address of Physician: _____

INITIAL EMPLOYMENT TB SCREENING RECORD

Applicant Name: _____

Reason for Test: [ ] Initial [ ] Other *(Please specify _____)*

Step One: 5TU PPD Skin test was place on [ ] RFA [ ] LFA [ ] Other
Lot# _____
Date Administered: _____Administered by: _____
(Signature/Title)

Results: [ ] Negative [ ] Positive [ ] Induration/Amount
Date Read: _____ Read by: _____Title: _____

Step Two: 5TU PPD Skin test was place on [ ] RFA [ ] LFA [ ] Other
Lot# _____
Date Administered: _____ Administered by: _____
(Signature/Title)

Results: [ ] Negative [ ] Positive [ ] Induration/Amount
Date Read: _____ Read by: _____Title:_____

Note: Employees must have a current 2 step PPD skin test 90 days before employment or within 2 weeks from hire. PPD skin test is read within 48-72 hours of testing. The 2 step method is completed within 21 days from the first reading. Anyone who has a positive skin test has to have a negative chest x-ray before start of active duty. Negative result employees will be tested once a year using the one step method. Positive PPD employees with a negative x-ray need to fill out a health form annually to report and signs and symptoms related to the TB program. Any problem or question has to be directed to the Infection Control Coordinator. Negative PPD's may be slightly red or bruised but will not be significantly raised and the mark will be less than 5mm in diameter. Positive PPD's will be red, raised and have a wheal greater than 5mm in size. If you think you may see a reaction, using a ballpoint pen, start from the periphery of the test site, and move toward the center. The pen will usually stop at the edge of the reaction site, making measurement easier. Remember, induration is measured, not the redness.

HEPATITIS B VACCINE DECLINATION

(To be filled by the applicant)

Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of contracting 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 and hold harmless the Company/Agency. I understand that by declining this vaccine, I continue to be at risk of contracting 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.

Note:

Please provide proof and attach if:

- *provide written proof of immunity*
- *proof of previous vaccination*
- *proof of medical contraindication.*

_____ _____

Employee Name Printed *Witness Name Printed*

_____ _____

Employee Signature & Date *Witness Signature & Date*

INFLUENZA VACCINE INFORMATION STATEMENT & DECLINATION FORM

(Page 1 of 4)

Rule: (77 Ill. Adm. Code 956)

Title: Health Care Employee Vaccination Code
Effectivity: May 19, 2010

Summary: These rules are part of the Illinois Department of Public Health's efforts to combat influenza. The rules implement Public Act 96-0823, which amended the Department of Public Health Powers and Duties Law to authorize the Department to require any facility licensed by the Department to implement an influenza vaccination program that ensures that employees are offered the opportunity to be vaccinated against seasonal influenza and other novel/pandemic influenza viruses as vaccines become available. The rules will provide health care settings with procedures to implement employee vaccination programs for each influenza season. The 2009-2010 influenza season presents the potential for the simultaneous circulation of both seasonal influenza viruses and the pandemic H1N1 strain. Seasonal and pandemic influenza places a great demand on the health care delivery system by making many people ill over a short period of time, so that every available health care worker may be necessary to provide care. Health care personnel who do not provide direct care must also be protected from influenza, because their work is essential to the efficient and effective delivery of health care. In addition, exposed health care personnel themselves can transmit the disease. Many professional organizations, such as the Centers for Disease Control and Prevention (CDC), the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), and the National Foundation for Infectious Diseases, endorse the universal, annual vaccination of health care workers and health facility employees. The purposes of these rules are to increase vaccination rates, to reduce the incidence of illness among health care workers, and to reduce transmission rates in the population of the State.

Section 956.30 Beginning with 2010 to 2011 influenza season, each health care setting shall ensure that all health care employees are provided education on influenza and are offered the opportunity to receive

seasonal, novel and pandemic influenza vaccine, in accordance with this Section, during the influenza season (between September 1 and March 1 of each year), unless the vaccine is unavailable (see subsection (e))

a) Each health care setting shall notify all health care employees of the influenza vaccination provisions of this Part and shall provide or arrange for vaccination of all health care employees who accept the offer of vaccination. Each health care setting shall provide all health care employees with education about the benefits of influenza vaccine and potential consequences of influenza illness. Information provided shall include the epidemiology, modes of transmission, diagnosis, treatment and non-vaccine infection control strategies.

b) Each health care setting shall develop and implement a program that includes the following:

1) A plan to offer seasonal, pandemic or any other influenza vaccine.
2) The time frame within which health care employees will be offered vaccination; and
3) Any required documentation relating to the health care employee vaccination requirement of this Part.

c) Declination of Vaccine

1) Health care employees may decline to accept the offer of vaccination for reasons including the following:
A) The vaccine is medically contraindicated, which means that administration of influenza vaccine to the person would likely be detrimental to the person's health;
B) Vaccination is against the person's religious beliefs;
C) The person has already been vaccinated; or
D) For any other reason's documented by the person as the basis of the refusal.

2) Health care employees who decline vaccination for any reason indicated in subsection (c)(1) shall sign a statement declining vaccination and certifying that he or she received education about the benefits of influenza vaccine.

d) Unavailability of Vaccine. A health care setting shall not be required to offer influenza vaccination when the vaccine is unavailable for purchase, shipment or administration by a third party, or when complying with an order of the Department that restricts the use of the vaccine. A health care setting shall offer to provide or arrange for influenza vaccination for health care employees as soon as the vaccine becomes available.

e) Documentation

1) Each health care setting shall maintain a system to track the offer of vaccination to health care employees. The system shall include documentation that each person either accepted the offer or declined the offer by signing a declination statement pursuant to subsection (c)(2).
2) If a health care setting is unable to provide or arrange for influenza vaccination for health care employees who wish to be vaccinated, the reasons why the vaccination could not be provided or arranged for shall be documented.
3) Individual declination statements should be handled in a manner that ensures individual confidentiality.
4) Documentation shall be maintained for at least three years.

f) Health care settings may choose to develop and implement more stringent influenza vaccination policies, strategies or programs designed to improve health care employee vaccination rates than those required by this Part and that are consistent with existing law and regulation.

_____ *(EE Initial)* I have read the "Influenza Vaccine Information Statement, date _____. I have had an opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine.

[ ] Intend to be vaccinated vaccination

[ ] Have been vaccinated

Location: _____

Date: _____

[ ] Decline offer of vaccination

(Please initial that apply)

___ Philosophical/Religious beliefs prohibit

___ Medical contraindication to receiving the vaccine.

___ Others

_____

___ I do not wish to say why I decline.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills, on average 36,000 Americans every year.
- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent all disease.
- I have declined to receive the influenza vaccine for the _____ *(Year)* season. I acknowledge that influenza vaccination is recommended by the Center for Disease Control and Prevention (CDC) for all health care employees to prevent infection from and transmission of influenza and its complications, including death, to patients/residents/clients, my co-workers, my family and my community.

I have read and fully understand the information on this declination form.

PRINT NAME: _____

Signature & Date: _____