

DIRECT HOME HEALTHCARE, INC.

Dear OT Applicant:

Thank you for your interest in Direct Home Healthcare, Inc. In order to complete this application, please make sure to sign all forms and provide updated originals (copies to be made at the office) of the following documents:

1. Resume
2. Driver's License
3. OT License
4. CPR and other nursing training certificates
5. Social Security Card
6. Car Insurance
7. Current physical exam with immunization such as Rubella, Rubeola, Varicella, etc.

Upon review of your application and the required documents, we will contact you for an initial interview and orientation. Please note, all documents must be completed before an orientation can be scheduled.

Best of luck!

Director of Clinical Services

EMPLOYEE CHECKLIST

The employee must have the following items in his/her file to be completed. Items with asterisk (*) should be done before/upon hiring. Please check when items are inserted into file.

1. Hire Date
 2. Completed Application
 3. Resume
 4. Job description
 5. Pre-employment interview
 6. Current license applicable
 7. License verification for professionals (yearly)*
 8. Healthcare worker registry verification*
 9. Criminal background authorization form (for CNA or other employees)*
 10. Criminal background check result (for CNA or other employees) *
 11. References
 12. Driver's License
 13. Social Security Card
 14. Copy of auto insurance
 15. CPR card
 16. W-4 information
 17. Orientation checklist – General
 18. Orientation checklist – specific to discipline
 19. Initial competency checklist
 20. On-going competency
 21. 90-day end of probation performance evaluation (for CNA only)
 22. Performance Evaluation
 23. Diploma/Educational transcript
 24. HIPAA Compliance Policy
 25. Confidentiality statement
 26. Conflict of interest disclosure
 27. Work contract agreement
 28. Computer key password statement
 29. Acknowledgement of employees manual
 30. Glucometer Competency Assessment
- To be placed in a separate folder:**
1. Health exam *
 2. Waiver Hep B vaccination
 3. Forms I-9/ copies of required verification
 4. PPD–2 step initially then annually if negative *
 5. CXR if PPD is positive then every 5-7 years
 6. Annual TB questionnaire for positive PPD

DIRECT HOME HEALTHCARE, INC.

HIRE DATE

NAME: _____ Date of Birth: _____

ADDRESS: _____

STATE: _____ ZIP CODE: _____ SOCIAL SECURITY NO.: _____

DATE OF HIRE: _____

REFERENCE:

	<u>Name</u>	<u>Address</u>	<u>Telephone</u>	<u>Years Acquainted</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

NEXT OF KIN:

DIRECT HOME HEALTHCARE, INC.

EMPLOYMENT APPLICATION

Name: _____ (FIRST) (MI) (LAST)			Date: _____
Address: _____			
Date of Birth: _____		Social Security No.: _____	
Contact Phone: Home _____ Cell / Mobile _____			
Email address: _____			
Emergency Contact: Name _____ Relationship _____ Address _____ Phone _____			

Position Desired: _____ Salary Expectation: _____

Applying for: Full time position Part time position

Indicate days and hours available to work: _____

When are you available to start? _____

How did you hear about our Agency? _____

EMPLOYMENT HISTORY List all previous employers, beginning with the most recent. Include all requested information on an additional page if necessary and label with your name.

Employer Name: _____	From: _____ To: _____ Month/Year Month/Year
Address: _____	
Telephone: _____	Job Title: _____
Duties and Responsibilities: _____	<input type="checkbox"/> FT <input type="checkbox"/> PT Ending Salary: _____
May we contact your Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor Name: _____	Phone: _____
Reason(s) for leaving: _____	

Employer Name: _____	From: _____ To: _____ Month/Year Month/Year
Address: _____	
Telephone: _____	Job Title: _____
Duties and Responsibilities: _____	<input type="checkbox"/> FT <input type="checkbox"/> PT Ending Salary: _____
May we contact your Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor Name: _____	Phone: _____
Reason(s) for leaving: _____	

Employer Name: _____ From: _____ To: _____
Month/Year Month/Year

Address: _____

Telephone: _____ Job Title: _____

Duties and Responsibilities: _____ FT PT Ending Salary: _____

May we contact your Supervisor? Yes No

Supervisor Name: _____ Phone: _____

Reason(s) for leaving: _____

Employer Name: _____ From: _____ To: _____
Month/Year Month/Year

Address: _____

Telephone: _____ Job Title: _____

Duties and Responsibilities: _____ FT PT Ending Salary: _____

May we contact your Supervisor? Yes No

Supervisor Name: _____ Phone: _____

Reason(s) for leaving: _____

Employer Name: _____ From: _____ To: _____
Month/Year Month/Year

Address: _____

Telephone: _____ Job Title: _____

Duties and Responsibilities: _____ FT PT Ending Salary: _____

May we contact your Supervisor? Yes No

Supervisor Name: _____ Phone: _____

Reason(s) for leaving: _____

** To list additional employers, please request an attachment.

GENERAL EMPLOYMENT QUESTIONS

1. Are you legal for employment in the United States? Yes No

2. Have you ever been convicted of a crime at any time, other than a minor traffic violation? A conviction (misdemeanor or felony) includes a plea of "guilty" or "no contest." (A "yes" answer will be considered for job related purposes only and will not automatically disqualify you from employment). Yes No
 If "yes", please explain: _____

3. Do you have any relatives working for Direct Home Healthcare Inc.? Yes No

4. Do you have previous employment existing under a different name? Yes No
 If "yes", provide name: _____

DIRECT HOME HEALTHCARE, INC.

EDUCATIONAL HISTORY

	Name and Address of School	Area of Study or Degree	Circle Year Completed			
			1	2	3	4
High School		n/a	1	2	3	4
College or University			1	2	3	4
Other (specify)			1	2	3	4

PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS

NOTE: FOR ANY POSITION REQUIRING RESITRATION, LICENSURE, OR CERTIFICATION, ORIGINAL DOCUMENT MUST BE PROVIDED

Are you currently: Registered Licensed Certified

Eligible for: Registered Licensed Will take Boards (list date): _____

Type	State Issued	Date Expires	Number
Type	State Issued	Date Expires	Number

SPECIALIZED SKILLS

Typing: _____ wpm Data Entry Medical Transcription Shorthand/Dictaphone Computer skills

1. List office machines or mechanical equipment you are capable of using: _____

2. List computer applications you have experience with: (e.g. Microsoft Office, Visitrack, Genie, navigating the Internet, etc.) _____

3. Are you proficient in another language aside from English? No Yes (specify) _____

4. Are you willing to serve as a language translator? No Yes

EMPLOYMENT ACKNOWLEDGEMENT

I understand that any false statements or material omissions made as a part of this application will disqualify me from further consideration for employment and, if discovered later, will be grounds for discharge. I also understand that any offer of employment is contingent upon the results of a pre-employment medical examination, drug screen, criminal background check and reference check. I authorize my former employers to release all information concerning my employment. I further authorize the release of any such information during or after my employment, without prior notification. This authorization releases the aforesaid parties and Direct Home Healthcare Inc (DHHI) from any liability for the collection and reporting of this information.

Direct Home Healthcare Inc does not discriminate in hiring or employment on the basis of sex, color, marital status, religion, sexual orientation, national origin, age, disability, military status, or any other protected category. No question on this application is intended to secure information to be used for such discrimination.

I understand that if I am employed by DHHI, my employment is "at will" and may be terminated by me or by DHHI at any time with or without cause, for any reason. No one other than the President of DHHI has the authority to enter into an agreement contrary to the foregoing and any such agreement must be in writing and signed by both the President and me.

Signature of Applicant: _____

Date of Completion: _____

DIRECT HOME HEALTHCARE, INC.

OCCUPATIONAL THERAPIST

JOB SUMMARY:

An Occupational Therapist (OT) administers occupational therapy to patients on an intermittent basis in their place of residence. This is performed in accordance with physician orders and plan of care under the direction and supervision of the Director of Clinical Services/Nursing Supervisor.

QUALIFICATIONS:

1. Graduate of an Occupational Therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association (AOTA) and/or certified by successfully completing the National Certification examination, or
2. Is eligible for the National Registration Examination of the American Occupational Therapy Association.
3. Currently licensed in the state(s) in which practicing.
4. Two (2) years experience, preferred.

RESPONSIBILITIES:

1. Improves or minimizes residual physical disabilities of the patient.
2. Returns the individual to optimum and productive living within the patient's capabilities.
3. Periodically participates with all other health care personnel in patient care planning.
4. Provides prescribed occupational therapy.
5. Directs and supervises personnel as required.
6. Takes initial history and makes initial evaluation.
7. Performs all skilled procedures.
8. Consults with physicians regarding change in treatment.
9. Writes reports to physicians regarding patient's progress.
10. Instructs patients/family members in home programs and fine motor movement exercises.
11. An initial evaluation, including plan of treatment and goals, must be completed and submitted to the physician for approval. A recertification by physician every 60 days is necessary, if further treatment is to be continued. A progress note is written each visit. A reevaluation is written when expected duration of treatment is reached. A summary is written upon patient's discharge.
12. Periodically presents an inservice to the Agency staff.
13. Assists the physician in evaluating level of function.
14. Helps develop the plan of care and revises as necessary.
15. Prepares clinical and progress notes.
16. Advises and consults with the family and other Agency personnel.
17. Participates in inservice programs.

WORKING ENVIRONMENT:

Works indoors in Agency office and patient homes and travels to/from patient homes.

Job Description – Occupational Therapist (OT)...continued

JOB RELATIONSHIP:

1. Supervised by: Director of Clinical Services/Nursing Supervisor
2. Workers Supervised: Certified Occupational Therapy Assistant and Home Health Aide as assigned

RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical activity.
- Moderate lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.

I have read the above job description and fully understand the conditions set forth therein, and if employed as an Occupational Therapist, I will perform these duties to the best of my knowledge and ability.

Date

Signature

DIRECT HOME HEALTHCARE, INC.

PRE-EMPLOYMENT INTERVIEW

Name: _____

Date: _____

Applying for Position: _____

Years in Practice: _____

Currently working at: _____

Date available to start: _____

List previous home health experience:

Position:

1. _____

2. _____

3. _____

Areas of Expertise (IV's, PICCs, Wound Care, etc.): _____

Employee's expectations of Home Health Agency: _____

Appearance: _____

Professionalism: _____

Verbal Skills: _____

Comments: _____

Date of Hire: _____

If not hired, explain reason: _____

Signature of Interviewer: _____

DIRECT HOME HEALTHCARE, INC.

REFERENCE FORM

Last Name: _____ First Name: _____

Section A: Candidate, please complete Section A only and forward directly to: _____

I, _____, hereby authorize my current and previous employers to release information regarding my work performances to Direct Home Healthcare, Inc. I release all such employers from any liability for issuing this information to Direct Home Healthcare, Inc. Also, I hereby permit Direct Home Healthcare, Inc. to share this information with client facilities.

Application Signature: _____

Section B: (To be completed by Direct Home Healthcare, Inc.)

Name:	SSN:
Position Held:	Specialty/Unit:
Employees Dates:	To:

Section C: (To be completed by Employer Direct Home Healthcare, Inc.) Thank you for completing this form as it assists us in ensuring that all professional accepted into our program are of the highest caliber. Your responses will remain in strictest confidence.

PLEASE RATE THE CANDIDATE ON:	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Clinical skills			
Ability to prioritize			
Flexibility to work different assignment			
Initiative and enthusiasm			
Ability to relate to patients			
Cooperation with staff			
Ability to take charge			
Punctuality			

Comments: _____

ELIGIBLE FOR REHIRE: YES NO

REASON FOR LEAVING: _____

Your Name: _____ Title: _____

Date: _____

DIRECT HOME HEALTHCARE, INC.

REFERENCE FORM

Last Name: _____ First Name: _____

Section A: Candidate, please complete Section A only and forward directly to: _____

I, _____, hereby authorize my current and previous employers to release information regarding my work performances to Direct Home Healthcare, Inc. I release all such employers from any liability for issuing this information to Direct Home Healthcare, Inc. Also, I hereby permit Direct Home Healthcare, Inc. to share this information with client facilities.

Application Signature: _____

Section B: (To be completed by Direct Home Healthcare, Inc.)

Name:	SSN:
Position Held:	Specialty/Unit:
Employees Dates:	To:

Section C: (To be completed by Employer Direct Home Healthcare, Inc.) Thank you for completing this form as it assists us in ensuring that all professional accepted into our program are of the highest caliber. Your responses will remain in strictest confidence.

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Clinical skills			
Ability to prioritize			
Flexibility to work different assignment			
Initiative and enthusiasm			
Ability to relate to patients			
Cooperation with staff			
Ability to take charge			
Punctuality			

Comments: _____

ELIGIBLE FOR REHIRE: YES NO

REASON FOR LEAVING: _____

Your Name: _____ Title: _____

Date: _____

DIRECT HOME HEALTHCARE, INC.

ORIENTATION CHECKLIST - GENERAL

ORIENTATION TO:	YES	NO	DATE/INITIAL
1. Basic Home Safety: bathroom, electrical, environmental and fire			
2. Safety Program:			
a. Risks within Agency and patient's home			
b. Actions to eliminate, minimize or report risks			
c. Incident reporting and procedures to follow			
d. Reporting processes for common problems, failures and user errors			
3. Storage/handling/access to/transport of supplies/medical gasses/drugs			
4. ID/handling/disposal of infectious wastes (blood and body fluids/precautions)			
5. ID/handling/disposal of hazardous waste (cytotoxic/chemotherapy drugs)			
6. Infection Control and Prevention			
a. Personal hygiene (e.g., PPE and hand washing)			
b. Aseptic procedures			
c. Communicable infections (TB, AIDS, etc.)			
d. Cleaning/disinfecting reusable equipment			
e. Precautions to be taken (Standard precautions, airborne transmission, direct/indirect contact, compromised immunity)			
7. Confidentiality of patient information/HIPPA policies and practices			
8. Community resources			
9. Policies/procedures			
10. Responsibilities related to safety and infection control			
11. Advanced directives policies/procedures			
12. Specific job duties/responsibilities and any limitations; performance standards			
13. Screening for alleged or suspected victims of abuse/neglect reporting			
14. Emergency operations plan and role			
15. Equipment use/management relevant to job description			
16. Tuberculosis Program/Plan (OSHA)			
17. Hazardous Materials in the Workplace Program (MSDS) (OSHA)			
18. Bloodborne Pathogen Program (OSHA)			
19. Managing the environment of care: (pt and agency site)			
a. Safety			
b. Fire safety – fire escape, fire alarm system, fire extinguishers – and prevention			
c. Security – Personal safety during home visits			
d. Utilities			
e. Responding to emergencies			
20. Patient rights/responsibilities			
21. Agency complaint mechanism/Medicare state hotline # and purpose			
22. PI program and role			
23. On-call and answering service			
24. Ethical aspects of care, treatment, and services, and process to address ethical issues			

ORIENTATION TO:	YES	NO	DATE/INITIAL
25. Philosophy/mission/purpose/vision/goals			
26. Interpreters/communicating with hearing/speech/visually impaired			
27. Sentinel event policy/process			
28. Physical safety (e.g. body mechanics and safe lifting)			
29. Cultural diversity and sensitivity			
30. Role of the health team			
31. Family/State Medical Leave Act			
32. Organizational structure, lines of authority and responsibility, supervision process			
33. Hours of work; benefits			
34. Documentation requirements			
35. Medical Device Reporting Act			
36. Equal Employment Opportunity Act			
37. Sexual Harassment Act			
38. Salary/hourly wage reimbursement			
39. Unemployment and Workers' Compensation			
40. Malpractice coverage			
41. Assessing and managing pain			

Other _____

(Note: See job-specific Competency Checklist for Skills)

 Name of Employee

 Signature

 Date

 Name of Supervisor

 Signature

 Date

DIRECT HOME HEALTHCARE, INC.

PERFORMANCE APPRAISAL/EVALUATION

	1	2	3	4
Completes initial history and evaluation visit, notifies physician of patient needs and submits orders for physician approval.				
Provides all occupational therapy services according to physician orders.				
Assists the physician in evaluating level of function.				
Informs the attending physician and other team members of changes in the patient's condition and needs.				
Helps develop the plan of care and revises as necessary.				
Involves patient/family in development and updating of plan of care.				
Interacts with other health care providers for coordination of patient care.				
Continually reevaluates needs of patient/family.				
Prepares therapy notes/progress notes for each patient visit in a timely manner.				
Directs and supervises performance of COTA and HHA as indicated.				
Advises and consults with the family and other Agency personnel.				
Completes a recertification every sixty (60) days if further treatment is to be continued.				
Reviews patient's medical record and identifies those patients' conditions relevant to the anticipated treatment program.				
Plans and coordinates the therapy aspects of patient care.				
Maintains medical record notes that reflect patient/family progress/response to treatment.				
Instruction to patient/family in home program with documentation in medical record notes.				
Consults with attending physician to determine whether treatment plan should be continued, changed or terminated.				
Completes a discharge summary upon completion of therapy services.				
Observes confidentiality and safeguards all patient related information.				
Attends staff meetings and patient care conferences as scheduled.				
Completes documentation and paperwork in a timely manner per Agency policy; prepares clinical and progress notes.				
Immediately reports to Nursing Supervisor/Director of Clinical Services any patient incidents/variances or complaints.				
Demonstrates competent performances of technical skills according to established procedures.				
Participates in peer review and PI activities as requested.				
Participates in utilization review of medical records as assigned.				

1 - Does Not Meet Standards

2 - Needs Improvement

3 - Meets Standards

4 - Exceeds Standards

Performance Appraisal/Evaluation – Occupational Therapist (OT)...continued

	1	2	3	4
Understands and adheres to established policies and procedures				
Adheres to Agency standards and consistently interprets and accurately performs all assigned responsibilities.				
Maintains acceptable attendance status, per Agency policy.				
Maintains acceptable level of tardiness, per Agency policy.				
Reports all incomplete work assignments to Nursing Supervisor/Director of Clinical Services.				
Appearance is always within Agency standards; is clean and well groomed.				
Demonstrates effective time management skills through daily documentation and infrequent overtime for routine assignments.				
Participates in inservice programs and presents inservices as assigned.				
Maintains clean and neat work environment.				
Demonstrates sound judgment and decision making.				
Maintains current CPR certification, if required.				
Performs other duties as assigned.				

Comments _____

Employee Signature *Date* *Supervisor Signature* *Date*

1 - Does Not Meet Standards
2 – Needs Improvement

3 – Meets Standards
4 - Exceeds Standards

DIRECT HOME HEALTHCARE, INC.

HIPAA COMPLIANCE POLICY

You will be hearing many staff members say “HIPAA” when talking in public areas. So what is HIPAA? HIPAA stands for HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT. HIPAA is a federal regulation and failure to comply may result in a fine and/or imprisonment.

HIPAA EXPECTS YOU AS A HEALTHCARE WORKER TO RESPECT AND PROTECT A PATIENT’S PRIVATE HEALTH INFORMATION (PHI).

As an employee of Direct Home Healthcare Inc. you need to be aware of your responsibility to protect the patient’s PROTECTED HEALTH INFORMATION.

All patient information (PHI) is on a need-to-know basis and is confidential. It is not to be discussed with anyone except a doctor or nurse behind the nurse’s station or closed doors when appropriate with other employee members.

No information (PHI) is to be left out in the open or carried from one area to another without being covered. This includes charts, rosters, faxes, log books or any other documents containing information or referencing patients.

All signs restricting personnel in certain areas must be observed. Only go into areas of the facility that pertain to your job or “employee only areas.”
(ex. Business office area, MD’s office)

I understand the importance of the HIPAA regulation, have received information about HIPAA and agree to follow the guidelines explained to me. I also understand that consistent failure to follow the guidelines may result in termination.

The sheet attached explains what PHI is and provides examples.

Employee Signature

Date

What is Protected Health Information or PHI?

In a nutshell, PHI is any health information created or received by your employer that identifies a specific person. The main categories of PHI are electronic records, paper records, and spoken communication.

A patient's medical record is one of the most visible pieces of PHI, PHI can include other materials and information that you may not have thought about before. Things like a patient status boards, insurance, cards, codes that document a certain procedure, physician dictation tapes – even calling out a patient's name in the waiting room can count as PHI.

Some kinds of information become PHI only in combination with other pieces of information. A ZIP code alone won't identify a person, but along with other identifiers – like an insurance card and a telephone number – the ZIP code could be an important clue to the person's identity. Therefore, the ZIP code is PHI because it gives you a reasonable basis for connecting information to a person's identity.

Along these lines, any information that reveals the past, current, or likely future state of a person's health counts as PHI.

All health information that identifies an individual is protected under HIPAA. It doesn't matter whether your organization creates the health information or receives it from another source, like a lab or an ambulance service. You must treat it just as carefully as information generated by your facility.

Individual Identifiers can include:

- Names
- Zip code
- Date of Birth
- Telephone numbers
- Fax number
- E-mail addresses
- Social Security Numbers
- Medical Records numbers
- Health Plan beneficiary numbers
- Account numbers
- Device identifiers and serial numbers
- Finger and voice prints
- Photographs

DIRECT HOME HEALTHCARE, INC.

CONFIDENTIALITY STATEMENT

Disclosure of confidential information gained through your employment by Direct Home Healthcare Inc. is stated as act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient's illness, family, financial condition or personal peculiarities is strictly confidential. When a patient's history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

Name of Applicant / Employee

Date

Signature of Applicant / Employee

Name of Witness (Company Representative)

Signature of Witness

DIRECT HOME HEALTHCARE, INC.

CONFLICT OF INTEREST DISCLOSURE

(Please check the applicable paragraph and complete this statement as appropriate.)

_____ I hereby affirm that I know of no issues that would present a conflict of interest arising from any situation related to my involvement/association with Direct Home Healthcare, Inc.

_____ I may have a conflict of interest arising from the following situation:

(Describe the potential conflict, including both the other entity in which you have an interest and the dealings it has with Direct Home Healthcare, Inc. and the appropriate date(s) the conflict arose.

I understand that the Conflict of Interest Policy prohibits my involvement in transactions in which I have a conflict. Therefore, in any instance in which I may be required to participate in a situation impacted by such conflict, I will notify the direct of Patient Care services/Administrator of the conflict of interest and will abide by the resultant decision.

Name

Title

DIRECT HOME HEALTHCARE, INC.

COMPUTER PASSWORD STATEMENT

I understand the need and responsibility to maintain a high level of security with computer access. I will not allow anyone to use my computer password and accept full responsibility for the security of my computer password.

Signature

Date

DIRECT HOME HEALTHCARE, INC.

ACKNOWLEDGEMENT OF EMPLOYEE'S MANUAL

I hereby acknowledge that I have read and understood the Employee's Manual of Direct Home Healthcare Inc.

Signature

Date

DIRECT HOME HEALTHCARE, INC.

**DECLINATION OF HEPATITIS B VACCINATION, WAIVER, RELEASE
OF ALL CLAIMS AND INDEMNITY AGREEMENT**

Please read carefully as this is a legally binding document. Please understand that in refusing vaccination and signing this document you will be waiving and releasing on behalf of yourself, your spouse, and your dependents, all claims as a result of disease, death or for injuries, including but not limited to the aggravation of any pre-existing ailment or condition: disability and disfigurement; pain and suffering, medical care, treatment and services, lost earnings, profits and salaries; lost earning capacity; the reasonable expense of necessary help in the home; as well as any property damage that might be sustained arising directly or indirectly out of your refusal to receive the vaccination.

Acknowledgement of Risk of Refusal to Receive Vaccinations Clause:

I understand that due to occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine when completing my pre-class medical work-up. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Waiver of Claim for Injury Clause:

I do hereby fully release, hold harmless, discharge and defend Direct Home Healthcare, Inc. as well as any and all of its officers agents, servants, employees, independent contractors and volunteers from any and all claims as a result of disease, death or from injuries, including but not limited to the aggravation of any pre-existing ailment or condition: disability and disfigurement, pain and suffering; medical care, treatment and services; lost earnings, profits and salaries, lost earning capacity; the reasonable expense of necessary help in the home; as any and all property damage I, my spouse, or my dependents might sustain arising directly or indirectly out of my refusal to participate in the above-captioned Hepatitis B Vaccination Program.

I have read and fully understand the Waiver, Release of All Claims and Indemnity Agreement. I understand that the terms hereof are contractual and are not a mere recital.

Participant's Signature

Date

Print Name

Witness Signature

Date