

NURSES TOUCH HOME HEALTH PROVIDER, INC.

EMPLOYEE'S CHECKLIST (CLINICAL)

OFFICE: _____

NAME: _____ HOME PHONE #: _____

ADDRESS: _____

CELL PHONE: _____ PAGER: _____

POSITION: _____ START DATE: _____

INTERVIEW DATE: _____

- APPLICATION FOR EMPLOYMENT
- RESUME
- JOB DESCRIPTION SIGNED
- W-4 WITHHOLDING TAX FORM (SIGNED AND DATED WITH DEDUCTIONS)
- I-9 FORM, SIGNED (SECTIONS 1, 2, AND 3 COMPLETED)
- JOB VERIFICATION SENT: _____ COMPLETED: _____
- ORIENTATION COMPLETED AND SIGNED
- ACCEPTANCE LETTER SIGNED
- HEPATITIS VACCINE PROOF OR DECLINATION SIGNED
- CHILD & ADULT ABUSE REPORTING FORM SIGNED
- HIPPA CONFIDENTIALITY FORM SIGNED

THE FOLLOWING ITEMS MUST BE TRACKED AND UPDATED PER FEDERAL AND STATE REGULATIONS. ALL PHYSICALS AND TB MUST BE COMPLETED WITHIN THE SIX MONTHS PRIOR TO HIRE OR WITHIN 10 DAYS OF STARTING WORK.

CHECKED ITEMS HAVE BEEN PHOTOCOPIED AND ARE IN THE EMPLOYEE FILE

- PHYSICAL COMPLETED/EXPIRATION DATE: _____
- TB COMPLETED/ EXPIRATION DATE: _____
- CPR CARD EXPIRATION DATE: _____
- PROFESSIONAL LICENSE EXPIRATION DATE: _____
- PROFESSIONAL LIABILITY INSURANCE, (IF APPLICABLE): _____
- DRIVERS LICENSE EXPIRATION DATE: _____
- AUTO INSURANCE EXPIRATION DATE: _____
- COPY OF SOCIAL SECURITY CARD: _____