Always Designing for People™

Employee Information Form

Please fill out all required fields below. You must also complete these additional forms: I-9, Federal W-4 and State W-4.

Required fields in RUN Powered by ADP®

BASIC INFORMATION

First Name * | MI | Last Name *

Address 1 * | City *

Address 2 | State * | Zip *

Phone Number | Mobile Number

Email Address (Required for Employee Access)

Date of Hire * (/ /)

Date of Birth * (/ /)

Social Security Number * (– –)

Gender * ☐ Male ☐ Female

Pay Rate (check one) * ☐ Hourly ☐ Salary

Amount * $.

Pay Frequency (check one) * ☐ Weekly ☒ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly

DEDUCTIONS

Deduction Name	Amout Per Pay Period
	$.
	$.

DIRECT DEPOSIT INFORMATION

Bank Routing Number *

Bank Account Number *

Account Type (check one) * ☐ Checking ☐ Savings

Direct Deposit Distribution (check one) * ☐ Full Amount ☐ Partial $ $. ☐ Partial % . %

Bank Routing Number

Bank Account Number

Account Type (check one) ☐ Checking ☐ Savings

Direct Deposit Distribution (check one) ☐ Full Amount ☐ Partial $ $. ☐ Partial % . %

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BASIC INFORMATION

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Address 2 | State * | Zip *

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Date of Hire * (/ /)

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Social Security Number * (– –)

Gender * ☐ Male ☐ Female

Pay Rate (check one) * ☐ Hourly ☐ Salary

Amount * $.

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DEDUCTIONS

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Bank Routing Number

Bank Account Number

Account Type (check one) ☐ Checking ☐ Savings

Direct Deposit Distribution (check one) ☐ Full Amount ☐ Partial $ $. ☐ Partial % .

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

Employee Name: _____
Print Name

EMPLOYMENT AGREEMENT

1. The employee will carry out the duties and responsibilities listed in the job description/ list of assigned tasks, and signed by employee and employer.

2. Following are the hours the employee will work:

Monday	_____	Friday	_____
Tuesday	_____	Saturday	_____
Wednesday	_____	Sunday	_____
Thursday	_____		

3. The employee will have the following time off:
_____

4. The employer will pay the employee $ _____.___ per hour.

5. When leaving, the employee will give the approximate time of return and, if possible, leave a phone number where he/she can be reached. Also, when the employee will be late in returning, he/she will call to let the employer know.

6. The employee is responsible for paying for long-distance telephone calls made/received by the employee.

7. The employee will not be paid for scheduled hours not worked unless the time not worked is covered by a benefit as provided by the employer.

8. Both parties to this agreement will respect each other's individuality and treat each other accordingly. Both will attempt to be flexible and work at solving problems as they arise.

9. At least 2 weeks notice will be given by employee regarding termination of this agreement.

Other agreements/ benefits:
_____
_____
_____
_____

_____ _____
Employer Signature ***Date***

_____ _____
Employee Signature ***Date***

Ty's Healthy Healers
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New Hire Training websites

Training Videos:

Driving Training- ONLY if you have a drivers License.
https://www.phly.com/losscontroltraining/drivertraining/index.html
** We provide the certificate

PCA Training- www.pahomecare.org – Chose 4 videos that are home health related.
After each video answer the questions and print the certificate. I will need a copy of each certificate.

Mandated Abuse Prevention - https://www.youtube.com/watch?v=H5LTi8zIJx0
** We provide the certificate

Osha - https://www.youtube.com/watch?v=_1yhNtCnxyM
** We provide the certificate

CLEARANCES:

Child Abuse - https://www.compass.state.pa.us/cwis/public/home - ** We need a copy of your certificate

Criminal History – epatch.state.pa.us ***Click on Submit A new record check!! ** We need a copy of your certificate

Prices for clearances: When initially hired you are responsible for the cost. When they are due for renewal in 2 years the company will pay but you will not receive a copy at that time.

Fbi Fingerprints - $25.25
Criminal History - $22.00
Child Abuse - $13.00
Clear Checks - $24.99
Driving Record - $12.00
CPR - $ 30.00 will complete after hired if you are not certified
2 Step TB - $54.00 you may also see your family Dr. if you have Insurance. If not we will send you to occupational Health to be completed.

***** I will need a copy of everything sent back to me once finished.

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REPORTING: ABUSE / NEGLECT / EXPLOITATION

EMPLOYEE NAME: _____
PRINT NAME

REPORTING:

- **ABUSE**
- **NEGLECT**
- **EXPLOITATION**

All agency staff are required to report suspected abuse/neglect/exploitation and develop a plan to minimize the risk of such. The care health employee is responsible to report & document:

- A child's susceptibility to abuse includes self-abuse and neglect.
- Elderly individuals as children are susceptible to abuse as well.
- Physical components, such as impairments and the ability of patient/caregiver to provide adequate care.
- Mental impairments, such as mental retardation, Alzheimer's disease, disorientation, confusion, etc.
- Emotional status, such as passive personality, depression, etc.
- Physical environment, such as safety in or outside the home.
  The employee is responsible to report all incidents to Administrator and/or Supervisor. A written report may be forwarded for Social Services with the request for referral. The Supervisor will review the situation and investigate to determine if this is a reportable incident. If, so it will be reported to the appropriate agency or Adult/ Child Protection Agency by the Supervisor/Administrator or an appropriate designee.

*** I have read and understand the information above. As a home health employee it is my responsibility to report & document any suspected abuse, neglect, or exploitation.**

_____ _____

Signature ***Date***

CLGS-32-6 (05/17)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be used by employers when a new employee is hired or when a current employee notifies employer of a name or address change. Use the Address Search Application at dced.pa.gov/Act32 to determine PSD codes, EIT rates, and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS **(No PO Box, RD or RR)**			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK **(No PO Box, RD or RR)**			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES, and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

dced.pa.gov/Act32

Ty's Healthy Healers
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Agency Phone: (814) 459-1393 Agency Fax: (814)240-5768

Employee Name: _____
Print Name

HEALTH & SAFETY AGREEMENT

I do understand the physical requirements of my job and understand proper lifting and moving techniques which I am expected to use in moving and lifting objects and/or patients.

I have been informed and do fully understand that any injury claimed by me while on the job must be reported immediately to my supervisor and documented on an Accident/Incident Report form. I understand that unless and incident report is completed immediately and signed by me, the agency may not consider a voluntary payment of any medical bills or any other benefits as a result of my injury. I further understand that if the accident/injury is proven to be a result of my failing to follow policy/procedure, the agency may not be expected to cover medical payments.

I do fully understand that I am not encouraged to lift or transfer any object or patient by myself unless I know that I can safely lift or transfer alone. If I believe there is no one readily available to assist me in lifting or moving patients or equipment while on duty, I am to wait until I can obtain assistance before moving or lifting.

I have had the opportunity to review and have all questions answered regarding *Health & Safety.*

_____ _____
Employee Signature ***Date***

_____ _____
Agency Representative ***Date***

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

Employee Name: _____
Print Name

SEXUAL HARASSMENT

Ty's Healthy Healers does not tolerate **Sexual Harassment,** as it is a form of gender-based discrimination.

Definition:
Under Title VII of the Civil Rights Act of 1964, any type of discrimination based on an individual's gender (male or female) is illegal. Sexual harassment is considered to be a form of gender discrimination. According to the Equal Employment Opportunity Commission, sexual harassment is "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to the conduct enters into employment decisions and/ or the conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment."

The Agency will not tolerate any form of sexual harassment from any of its employees. The Agency encourages that any behavior which could be construed as sexual harassment be reported immediately to the supervisor and/ or Administrator. There is no need to fear retaliation. Both females and males can be sexually harassed when exposed to unwelcome sexual advances or to a pattern of verbal abuse, threatening, crude, impolite, or unprofessional conduct.

- Quid pro quo sexual harassment is also against company policy.
- The Agency encourages and urges an employee to come forward and discuss any sexual harassment that may have occurred with an Administrator.
- Every complaint will be taken seriously and investigated immediately. Investigations will be documented.
- Any employee involved a sexual harassment complaint will have a full opportunity to give a full account of their recollection of the incident or incidents.
- The incident(s) will be investigated thoroughly and appropriate action will be taken.

_____ _____

Employee Signature ***Date***

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

NON-COMPETE AGREEMENT

As an employee of Ty's Healthy Healers, the employee acknowledges that they will be in receipt of confidential information. This information shall include but not be limited to, procedures manuals, in-house policies, patient lists, patient's medical records, financial information and billing records, certifications and applications, actual and prospective markets an patient's, business plans and marketing strategies, customer lists, sales and marketing data, operating systems, income statements, asset and liability information, financial projections and any other confidential information gathered, revealed, acquired or generated by or for Ty's Healthy Healers. Each employee shall protect and hold in confidence the confidential information to anyone except with the express written consent of **Tyteouna Cooley**, Administrator. The employee acknowledges and understands the competitive sensitivity of the confidential information and the potential for significant material harm that could result to Ty's Healthy Healers in the event that confidential information is disseminated to others, in particular competitors. Therefore, the employee agrees that the appropriate remedy would be an immediate injunction against the violating employee in joining and prohibiting the use and continued dissemination of the confidential information. Further, each employee agrees that the dissemination of the confidential information would cause damages for which damages could not be readily ascertained and would constitute a breach of duty owed by the employee to Ty's Healthy Healers. Each employee agrees to pay Ty's Healthy Healers in any action to enforce this confidentiality agreement or cost of litigation, including attorney's fees and other damages found by the trier of fact.

As consideration for employment and for the release of this confidential information, employee agrees not to compete against Ty's Healthy Healers or to utilize any of the confidential information for a period of two (2) years from the date of their employment terminated with Ty's Healthy Healers. This Non-Compete Agreement shall be limited to Erie County and contiguous counties. This Non-Compete Agreement is not intended to prohibit employee from working as a nurse, therapist or other position in the health service industries but is intended to prohibit employee from working with a competitor of Ty's Healthy Healers in the home health industry and utilizing any of the confidential information of Ty's Healthy Healers or contacting any of Ty's Healthy Healers patients. Employee agrees and warrants that they will not contact, engage, discuss, negotiate or contract with any patient or family member of a patient for those purpose of developing or promoting home health care services of said patient. All parties acknowledge that this confidential information is of a proprietary nature to Ty's Healthy Healers and if the confidential information was revealed to the general public or to a competitor, the revelation would destroy or impair the expected success of Ty's Healthy Healers.

*** ANY CONTROVERSY OR CLAIM ARISING OUR OF OR RELATING TO THIS AGREEMENT SHALL BE SUBMITTED TO ARBITRATION BEFORE ONE (1) ARBITRATOR IN ERIE COUNTY, PENNSYLVANIA, IN ACCORDANCE WITH THE COMMERCIAL ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION JUDGEMENT UPON THE AWARD RENDERED BY THE ARBITRATOR MAY BE ENTERED BY ANY COURT HAVING JURISDICATION THEREOF. ARBITRATION SHALL BE THE EXCLUSIVE, FINAL AND BINDING METHOD OF RESOLUTION OF ANY CLAIM OR CONTROVERSY BETWEEN TY'S HEALTHY HEALERS AND EMPLOYEE ARISING FROM THIS AGREEMENT.**

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

_____	_____
Employee Name	***Date***
_____	_____
Agency Representative	***Date***

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
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APPLICATION FOR EMPLOYMENT

Client hire date_____ **Client Company**_____

Personal information Date_____

Name_____ Social security #_____

Maiden Name_____

Alias_____

Present address _____
Street city state zip

Permanent address _____
Street city state zip

Previous Addresses in the last 7 years

_____
_____
_____
_____
_____

Phone #_(_____)_____ If you are under 18, can you furnish a work permit? ☐Yes ☐ No

Employment desired ☐full time ☐part time ☐Temp ☐Seasonal

Position_____ Date you can start_____ Salary_____

Are you employed now?_____ If so may we inquire of your present employer? ☐Yes ☐No

Ever applied for this company before? ☐Yes ☐No Where_____When_____

Are you on layoff and subject to recall? ☐Yes ☐No. Will you travel if required? ☐Yes ☐No

Will you relocate if job requires it? ☐Yes ☐No. Will you work overtime if required? ☐Yes ☐No

Are you able to meet the attendance requirements of this position? ☐Yes ☐No. Have you ever been

Bonded? ☐Yes ☐No.

Have you ever been convicted of a crime? If so do you currently have an open court case:
Explain _____
_____
_____
_____
_____
_____
_____

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EMPLOYMENT APPLICATION PAGE 2

Driver's license number_____ State_____

Education		Name and location Of School	# of years Completed	Did you Graduate?	Subjects Studied
Academic	Currently Attending				
	Last Completed				
Trades of Business	Currently Attending				
	Last Completed				

Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with this company._____
_____
_____

Do you know any foreign languages? List:

Date Month and Year	Name and address of employer	Salary	Job	Reason for Leaving
From				
To				
From				
To				
From				
To				

References: Give the names of three persons not related to you to whom you have known at least 1 year

Name	Address	Phone	Yrs acquainted

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
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EMPLOYMENT APPLICATION **PAGE 3**

INITIAL **Conditions of Employment – please read carefully**

_____ Reporting to work with impaired abilities; or the possession, consumption or distribution of drugs or alcohol on company premises and/or worksites, shall be grounds for disciplinary action, including discharge. A condition of employment includes willingness on the part of the applicant or employee to agree to physical examination, polygraph and/or substance testing. If required by the company. We are committed to operating a drug free workplace. Violations of our drug and alcohol policy will result in dismissal.

_____ It is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service if I have been employed. Furthermore, I understand that just as I am free to resign anytime, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

_____ I give the employer the right to investigate all police, driving, and personal records and references, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

_____ The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state or federal law.

_____ Any controversy of any kind arising between the parties under this agreement or otherwise (or any agent, officer, director or affiliate of any party), including but not limited to common law, statutory, tort or contract claims, will be submitted to mediation and failing settlement in mediation, to binding arbitration. Unless otherwise agreed a mediation and arbitration designated by staff professionals will govern any mediation and arbitration. The parties will select the mediator or arbitrator from the designated company Panel of mediators and will notify the designated company, in writing, to initiate the selection process. The arbitration will be subject to and governed by the provisions of the Federal Arbitration Act. 9 U.S.C. Section 1-et seq. The parties hereto stipulate that this agreement involves matters affecting interstate commerce.

_____ This application is current for 60 days. At the conclusion of this time if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

_____ _____

Signature of Applicant **Date**

****By signing I understand that everything I have said is true and accurate and that any omissions or inaccuracies could impact the status of any prospective or future employment.*

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UNIVERSAL PRECAUTIONS
Training Document

Name: _____ Date: _____
PRINT NAME

✓ LESSON 1- BLOOD BORNE INFECTION

Definition of exposure
Spread of HIV infection in the general population
Symptoms and effects of HIV infection
Spread of Hepatitis B, including number of infections, hospitalization, and deaths caused by HBV each year.
Symptoms of effects of HBV infection and HBV vaccination
The hepatitis B virus and HIV virus can transmitted in the workplace
It is estimated that there are 1 and ½ million HIV carriers in the U.S.
There may be as many as one million carriers of HBV

✓ LESSON 2 – TRANSMISSION OF BLOOD BORNE INFECTION

Sources of blood borne infections in the workplace
Four primary ways of getting blood borne infections outside the workplace
Three primary ways of getting blood borne infections at work
Risky jobs, tasks, and work practices

✓ LESSON 3 – EXPOSURE CONTROL

The HBV vaccine for all workers who come into contact with blood or other potentially infectious body fluids on the job.
The definition of Universal Precautions
The steps that should be taken after an exposure incident in order to prevent infection
My rights in case of exposure and / or infection
I have the right to have HBV vaccinations provided to me free of charge if I am at risk for infection. If I refuse it at this time, I have the right to be vaccinated free of charge at any time in the future provided I am still at risk for infection.

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Name: _____
PRINT NAME

Training Documentation on Universal Precautions (continued)

✓ LESSON 4 –USING PERSONAL PROTECTIVE EQUIPMENT

Types of personal protective equipment (PPE) required for different tasks or situations
Key requirements for selecting, providing, using, and disposing of or cleaning PPE
Limitations of personal protective equipment

✓ LESSON 5 – WORK PRACTICE CONTROLS

Disposing of used needles or other sharps
Working with lab materials
Decontaminating work areas, instruments, and equipment
Identifying and handling regulated waste
Hand washing and other personal hygiene and health practices

*** I have received training covering all of the above topics and been informed of my rights accordingly.**

_____ _____
Employee Signature *Date*

Employee Handbook Acknowledgment

I acknowledge that I have received and reviewed the employee handbook. I understand and recognize that there may be changes to the information, policies, and benefits in the handbook. I understand that Tys Healthy Healers may add new policies to the handbook as well as replace, change, or cancel existing policies. I understand that I will be informed of handbook changes and that handbook changes can only be authorized by Tys Healthy Healers management.

I understand that I became an employee of Tys Healthy Healers voluntarily. I understand and acknowledge that there is no specified length to my employment, that this handbook does not create an express or implied contract of employment, and that my employment is at will. I understand and acknowledge that "at will" means that I may terminate my employment at any time, with or without cause or advance notice. I also understand and acknowledge that "at will" means that Tys Healthy Healers may terminate my employment at any time, with or without cause or advance notice..

I understand that it is my responsibility to read and comply with all policies included within the employee handbook. I further understand that I should consult my supervisor regarding any questions I may have.

Employee Signature

Employee signature	*Date*
Printed Name	*Employer Representative*

Ty's Healthy Healers
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Employee Name: _____

ANNUAL TUBERCULOSIS QUESTIONNAIRE

For personnel who have a known positive PPD and previously negative chest x-ray, you are requested to complete this questionnaire with either a yes or no.

HAVE YOU NOTICED ANY OF THE FOLLOWING?

1. Unexplained fevers	☐ **Yes** ☐ **No**
2. Night Sweats	☐ **Yes** ☐ **No**
3. Unintentional weight loss	☐ **Yes** ☐ **No**
4. Cough	☐ **Yes** ☐ **No**
5. Hoarseness	☐ **Yes** ☐ **No**
6. Bloody Sputum	☐ **Yes** ☐ **No**
7. Have you completed INH therapy?	☐ **Yes** ☐ **No**
8. Have you ever had a BCG vaccine?	☐ **Yes** ☐ **No**
9. Have you had an x-ray while employed here?	☐ **Yes** ☐ **No**

_____ _____

Employee Signature ***Date***

Follow-up needed **___ Yes ___No**

Comments: _____

_____

_____

_____

Agency Representative: _____ ***Date***_____

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 520-1723 Agency Fax: (814) 878-0032

EMPLOYEE SAFETY !

Employee Name: _____
Print Name

CELLULAR PHONE USE

Ty's Healthy Healers Does Not Permit employee's whilst on company time to talk on the cellular phones while driving a vehicle. This is very dangerous and should be avoided any time. It is mandatory that I must pull over and stop my vehicle each time I conduct agency business per cellular phone.

The agency is not responsible for any moving violations, accidents or other incident that may occur while I am using my cellular phone and driving.

I have read and understand the above information of the agency regulation regarding cellular phone use and I will comply.

_____ _____
Employee's Signature ***Date***

_____ _____
Agency Representative ***Date***

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 520-1723 Agency Fax: (814) 878-0032

CONFIDENTIALITY OF INFORMATION AGREEMENT

EMPLOYEE NAME: _____
PRINT NAME

Confidentiality of Information

- All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered, maintained, or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

- In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for client care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for the following this Confidentiality Policy Agreement & The Guidelines, Both Written and Verbal.

_____ _____
Employee Signature ***Date***

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
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BACKGROUND CHECK CONSENT

NAME: _____ ***DATE:*** _____

I, _____, have had no prior convictions of an offense described in the Pennsylvania Criminal Offenses which would potentially bar employment as listed below:

Prohibitive Offenses Contained in Act 169 of 1996 as Amended by Act 13 of 1997
Criminal Offense

Offense Code	Prohibitive Offense	Type of Conviction
CC2500	Criminal Homicide	Any
CC2502A	Murder I	Any
CC2502B	Murder II	Any
CC2502C	Murder III	Any
CC2503	Voluntary Manslaughter	Any
CC2504	Involuntary Manslaughter	Any
CC2505	Causing or Aiding Suicide	Any
CC2506	Drug Delivery Resulting in Death	Any
CC2702	Aggravated Assault	Any
CC2901	Kidnapping	Any
CC2902	Unlawful Restraint	Any
CC3121	Rape	Any
CC3122.1	Statutory Sexual Assault	Any
CC3123	Involuntary Deviate Sexual Intercourse	Any
CC3124.1	Sexual Assault	Any
CC3125	Aggravated Indecent Assault	Any
CC3126	Indecent Assault	Any
CC3127	Indecent Exposure	Any
CC3301	Arson and Related Offenses	Any
CC3502	Burglary	Any
CC3701	Robbery	Any
CC3901	Theft	
CC3921	Theft By Unlawful Taking	
CC3922	Theft By Deception	
CC3923	Theft By Extortion	
CC3924	Theft By Property Lost	
CC3925	Receiving Stolen Property	Any
CC3926	Theft of Services	One (1) Felony
CC3927	Theft By Failure to Deposit	or
CC3928	Unauthorized Use of a Motor Vehicle	Two (2)
CC3929	Retail Theft	Misdemeanor

CC3929.1	**Library Theft**	**within the 3900 Series**
CC3929.2	**Unlawful Possession of Retail or Library Theft Instruments**	**(CC3901-CC3934)**
CC3930	**Theft of Trade Secrets**	
CC3931	**Theft of Unpublished Dramas or Musicals**	
CC3932	**Theft of Leased Properties**	
CC3933	**Unlawful Use of a Computer**	
CC3934	**Theft from a Motor Vehicle**	
CC4101	**Forgery**	**Any**
CC4114	**Securing Execution of Documents by Deception**	**Any**
CC4302	**Incest**	**Any**
CC4303	**Concealing Death of a Child**	**Any**
CC4304	**Endangering Welfare of a Child**	**Any**
CC4305	**Dealing in Infant Children**	**Any**
CC4952	**Intimidation of Witnesses or Victims**	**Any**
CC4953	**Retaliation Against Witness or Victim**	**Any**
CC5902B	**Promoting Prostitution**	**Felony**
CC5903C	**Obscene or Other Sexual Materials to Minors**	**Any**
CC5903D	**Obscene or Other Sexual Materials**	**Any**
CC6301	**Corruption of Minors**	**Any**
CC6312	**Sexual Abuse of Children**	**Any**
CS13A12	**Acquisition of Controlled Substance by Fraud**	**Felony**
CS13A14	**Delivery by Practitioner**	**Felony**
CS13A30	**Possession with Intent to Deliver**	**Felony**
CS13A35 (i),(ii), (iii)	**Illegal Sale of Non-Controlled Substance**	**Felony**
CS13A36	**Designer Drugs**	**Felony**
CS13Axx*	**Any Other Felony Drug Conviction Appearing on a PA Rap Sheet**	**Felony**

I UNDERSTAND THAT THE HOME HEALTH AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT.

I, THE UNDERSIGNED, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

_____ _____

SIGNATURE OF EMPLOYEE *SIGNATURE OF SUPERVISOR*

Ty's Healthy Healers *(BACKGROUND CHECK CONSENT FORM, PAGE 2)*

Employee Direct Deposit Banking Authorization Form
RUN Powered by ADP®

A more human resource.®

This form can be filled out online and printed.*
Please complete all fields.

Company Information

Company Name: _____ Date: _____

Employee Information Authorization

Important! Please read and sign before completing and submitting.

I hereby voluntarily authorize the Company named above (hereafter "Employer"), either directly or through its payroll service provider, to deposit any amounts owed me, by initiating credit entries to my account (s) at the financial institution (s) of my choice (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Employer, either directly or through its payroll service provider, to my account. To the extent permitted by law, in the event that Employer or its payroll service provider deposits funds erroneously into my account (s), I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

To the extent permitted by law, I understand that I have the right to refuse consent or revoke authorization of direct deposit at any time without fear of retaliation, and I have the right to receive any payment owed to me by other means. This authorization is to remain in full force and effect until Employer and Bank have received written notice from me of its termination in such time and manner as to afford Employer and Bank reasonable opportunity to act on it.

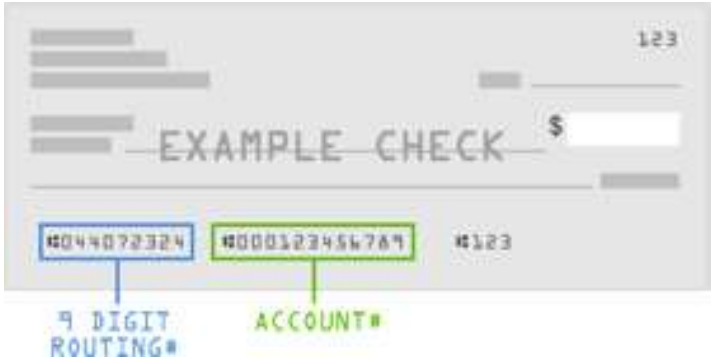
Legal Name: _____
(Last Name, First Name, Middle Initial)

Signature: _____ Date: _____

Deposit/Account Information

For a checking account, attach a voided check, not a deposit slip. If you don't have a check, ask your bank to give you the Routing Number (the nine-digit American Bankers Association (ABA) number that identifies both the Company's bank and the Federal Reserve Bank) for your account.

Note: If you have a paycard, set it up as a checking account, not a savings account. Contact the paycard issuer for the account number/routing number information.



Employee Direct Deposit Banking Authorization Form
RUN Powered by ADP®

1. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☐ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☐ Full Net Amount

2. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☐ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☐ Full Net Amount

3. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☐ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☐ Full Net Amount

4. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☐ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☐ Full Net Amount

Take advantage of Employee Access® in RUN Powered by ADP® to let your employees manage their own direct deposits.

***Attention Payroll Contact**: Employers must keep each original Employee Direct Deposit Banking Authorization form on file as long as the employee is using direct deposit, and for two years thereafter. Employers may be subject to certain federal and state direct deposit notice, authorization and record retention requirements. Please review your applicable federal, state and local laws. This form is provided for convenience only and is not meant and should not be construed as legal, HR, financial, insurance, tax or accounting advice. You should consult with your own legal counsel, human resource, accounting or other professional advisor for circumstances pertaining to your business.

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

Name of Employee: _____
Print Name

DISCLAIMER AND WAIVER OF LIABLITY

I acknowledge and will adhere to the rules and regulations as set forth by the PA Department of Health, Division of Home Health. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination. I therefore hold the home health care agency, its shareholders, directors and officers, harmless from any falsified documents.

I have read and understand the above information. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination.

Employee's Signature	**Date**
Agency Representative	**Date**

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

Date _____

✓ EMPLOYEE REFERENCE CHECK

Ty's Healthy Healers has my authorization to check my references.

PRINT EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

Company Contacted: _____

Mr. / Mrs.: _____ is seeking employment with our company. It is our policy to ask for references prior to employment. Please complete this form for our records ***and sign below***. We would greatly appreciate your assistance.

PLEASE VERIFY EMPLOYMENT DATES:

From: _____ To: _____

ELIGIBLE FOR REHIRE? ☐ **YES** ☐ **NO**

COMMENTS:

_____
_____
_____
_____

INFORMATION WAS RECEIVED BY: ☐ **Phone** ☐ **Mail** ☐ **Fax**

Name of company _____

* (IF FAXED) **Company Contact Signature** _____

_____ _____
Signature of Agency Representative & Title *Date*

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

Employee Name: _____

Print Name

DRUG TESTING POLICY

Agency employees may not possess, distribute and or use alcoholic beverages or controlled substances. Including inhalants while on premises of property controlled by the Agency or while in the course of conducting company business or engaged in any company sponsored activity.

Patients or visitors may not possess, distribute and or use alcoholic beverages or controlled substances, while on the premises of the property controlled by the Agency.

Any employee who has knowledge of a person or persons violating this policy must report it to his/her supervisor immediately.

Based on reasonable cause, the agency may conduct searches or inspections of an employees personal belongings and may be asked to take a drug test. Refusal to consent may result in termination.

*** I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.**

_____ _____

Employee Signature ***Date***

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

EMPLOYEE DRESS CODE

Employee Name: _____ **Date:** _____
Print Name

Ty's Healthy Healers strives to present a professional and safe health care image to patients' families, the community, and other Health Care professionals. Ty's Healthy Healers staff members adhere to the following standards in their dress appearance.

1. Al staff will wear an approved Ty's Healthy Healers name badge when providing patient care.

2. Clothing shall be clean, neat, and well maintained.
   Allowed Clothing: Loose comfortable clothing, scrubs, walking shorts that are at least mid thigh in length, hemmed blue jeans, plain T-shirt, and casual street wear. Appropriate undergarments should be worn.
   Not Allowed: mini skirts, short shorts, tank tops, halter-tops, midriffs, cut offs, jeans of any kind, or T-shirts of any kind.

3. Shoes should be conservative and comfortable. We encourage closed toed shoes for personal safety and infection control while providing patient care. No flip-flops, crocs or thong sandals.

4. When attending school with a patient, the employee will be provided with a copy of the schools dress code and must adhere to it.

5. Nurses should keep A clean lab coat available to wear over their clothes when accompanying patients to any medical appointment. (These may be unexpected).

Ty's Healthy Healers
725 French Street, Erie, PA, 16502
Agency Phone: (814) 459-1393 Agency Fax: (814) 240-5768

Employee Name: _____
Print Name

Dress Code (continued)

6. Ty's Healthy Healers employees will try to meet the requests of parents or primary caregivers within reason.

7. Employees are expected to keep their hair dry, neat, and clean. Long hair must be styled so it does not come in contact of the patient. Mustaches and beards must be clean and trimmed.

8. Perfume should be conservative. Strong odors can be offensive to patients.

9. Jewelry represents a safety hazard, so it must be worn with discretion, i.e. wedding rings, rings without large mountings, small earrings or studs. Visible piercing, except for earrings, should be removed when providing patient care. Both professionalism and safety should be considered when wearing jewelry.

10. Fingernails are to be kept clean, trimmed and moderately short for patient safety.

*** If an employee is sent home to change clothes due to inappropriate attire, the employee will be sent home on his/her own time and may result in disciplinary action.**

**** Interpretation of compliance to this dress code policy is subject to the discretion of the Administrator, Supervisor, or acting supervisor.***

_____ _____

Signature ***Date***

Tys Healthy Healers

AUTHORIZATION FOR BACKGROUND CHECKS

I instruct and authorize ___Tys Healthy Healers_____ to obtain a consumer report(s) (or background check report(s)) on me, including any investigative consumer reports and any consumer credit reports.* I also agree that a copy of this form is valid like the signed original.

The consumer reporting agency (CRA) ADP Screening and Selection Services, Inc. (ADP SASS) will conduct the background check and prepare the background check report for the Company. ADP SASS is located at 301 Remington Street, Fort Collins, CO, 80524, and can be reached by phone at 800-367-5933, or at www.adpselect.com.

I understand that, as allowed by applicable law, the Company may rely on this authorization to order additional background check reports, including investigative consumer reports and any consumer credit reports* (1) during my employment or time as a volunteer or independent contractor, as applicable, and (2) from any CRA other than ADP SASS without asking me for my authorization again. I understand the Company may order background check report(s) under my legal name and any other names I may have used.

I also instruct and authorize the following persons, agencies, and entities to disclose to ADP SASS and its agents all information about or concerning me, as allowed by law, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; motor vehicle records agencies; all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. As allowed by law, such disclosures may contain the following information pertaining to me: credit history*; public records; a Social Security number verification; driving records; military service; credentials/certifications; worker's compensation injuries; and verification of prior employment and education.

***I understand that I am instructing and authorizing the Company to obtain a consumer credit report only to the extent permitted by law. If I reside or anticipate being employed in New York City, I understand that I am not being asked to authorize a consumer credit report by signing this document.**

By signing below, I understand that I am agreeing to the terms contained in this document.

If you live or work for the Company in California, Minnesota or Oklahoma: Check this box if you would like a free copy of your background check report: ☐

Please print your full legal name:

Last Name _____ First _____ Middle _____

_____ _____/_____/_____

Signature Today's Date (Month/Day/Year)

If required, notarize here. When using an embossed seal, please shade with a pencil before faxing.

Subscribed and sworn before me:

_____
Notary Public Signature

_____
Date

_____
My Commission Expires

BACKGROUND CHECK INFORMATION

The information requested below is collected solely for the purpose of aiding the Consumer Reporting Agency (CRA) in completing a background check on you.

_____ _____ _____ _____
First Name Middle Name (required) Last Name Suffix

Email Address: _____

For Identification Purposes Only: Date of Birth ____/____/_____ (Month/Day/Year)

Social Security Number _____

Driver's License Number _____ State Issuing License_____

Enter Nickname(s) Used_____

Enter Any Other Names Used (including maiden names):

First Name _____Middle Name _____Last Name_____
First Name _____Middle Name _____Last Name_____
First Name _____Middle Name _____Last Name_____

Addresses Within The Past Seven Years (*use a separate sheet as needed*)

Present Street Address _____

City/State/ZIP _____

Prior Street Address _____

Prior City/State/ZIP _____

From _____/_____/_____ (Month/Day/Year) To _____/_____/_____ (Month/Day/Year)

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with “RE” notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B, Reverification and Rehire (formerly Section 3)

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

USCIS Form I-9 Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.