9933 Lawler Avenue Ste. 122 Skokie, IL. 60077
Tel: 847-257-0130 Fax: 847-257-0231

EMPLOYMENT APPLICATION FORM

DATE OF HIRE: ______

POSITION APPLYING FOR: ______ FILING DATE ______ SOCIAL SECURITY #: ______

LAST NAME: ______ FIRST NAME: ______ MI: ___

ADDRESS: ______ TELEPHONE #: ______

NAME OF NEXT OF KIN: ______ RELATIONSHIP TO NEXT OF KIN: ______

ADDRESS OF NEXT OF KIN: ______ TELEPHONE #: ______

The following is requested in compliance with Equal Employment Opportunity Commission regulations and will only be used for statistical purposes.

DATE OF BIRTH: ______ SEX: MALE ______ FEMALE ______

AS AN ADULT, HAVE YOU EVER BEEN CONVICTED OF AN OFFENSE OTHER THAN A MINOR TRAFFIC VIOLATION? NO___ YES ___

IF YES, EXPLAIN: ______

______

______

DRIVER'S LICENSE NO. ______ CLASS ______ STATE ______ EXPIRATION ______

AT-WILL EMPLOYMENT. I acknowledged that if hired, I will be an at-will employee. I will be subject to dismissal or discipline without notice or cause, at the discretion of the employer. I also understand that this means I am free to quit my employment at any time, for any reason, without notice. I understand that no representative of the company, other than the president, has authority to change the terms of an at-will employment and that any such change can occur only in a written employment contract.
________ Initials

I hereby authorize all of my previous employers and current employer (if applicable) and schools named in this application to furnish any details relevant to the verification of the information I have submitted. I hereby release all such persons.Ventities from any liability regarding the provision or use of such information. I understand that false statements in this application will be cause for its rejection, or for barring me from any selection process or for striking my name from the eligible list, or for my discharge after appointment.

I consent any medical examination required by 5 Star HC Inc. at any time to determine my ability to perform the duties of my job and I understand that my employment may be conditioned upon satisfactorily passing a physical examination. I understand that I may be required to satisfactorily complete a drug screening as a condition of employment.

I do solemnly swear (or affirm) that all answers given and statements made on this application are true and complete to the best of my knowledge sand beliefs. I understand that this application is not intended to be a contract of employment.

I further agree upon employment to furnish all documents qualifying my employability as 5 Star HC Inc. May designate.

Signature of Applicant ______ Date ______

EDUCATION/SKILLS

ARE YOU A HIGH SCHOOL GRADUATE? YES ____ NO ___

NAME OF HIGH SCHOOL: ______________________________ CITY/STATE: __________________________

DATES ATTENDED: FROM ____/____/_______ TO ____/____/_______

COLLEGE: LIST BELOW EACH COLLEGE OR UNIVERSITY YOU HAVE ATTENDED. BE SURE TO RECORD DATES AND CREDIT RECEIVED. INDICATE CLEARLY IF SEMESTER OR QUARTER HOURS.

COLLEGE/UNIVERSITY	CITY/STATE	DATES ATTENDED	MAJOR	DEGREE REC'VD

POST GRADUATE STUDIES: LIST BELOW EACH UNIVERSITY AND PROFESSIONAL SCHOOL YOU HAVE ATTENDED. BE SURE TO RECORD DATES ATTENDED AND DEGREES RECEIVED.

UNIVERSITY/PROFESSIONAL SCHOOL	CITY/STATE	DATES ATTENDED	FIELD OF STUDY	DEGREE REC'VD

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS: EVIDENCE OF ANY CURRENT LICENSURE, REGISTRATION OR CERTIFICATION MUST BE PRESENTED IN PERSON AT THE TIME OF FILING THIS APPLICATION).

1. PROFESSIONAL LICENSE # : ______________________________ EXPIRED ON: ______________________

2. OTHER: ____ EXPIRED ON: ______________________

____ EXPIRED ON: ______________________

LANGUAGE SKILLS OTHER THAN ENGLISH:

Language	Speak	Read	Write

LIST ALL SPECIAL SKILLS: Check and describe all that apply.

____ Shorthand – Approximate W.P.M. _______

____ Typing – Approximate W.P.M. _______

____ Computer Skills, Describe: ___________________________

____ Office Machines, Describe: ___________________________

EMPLOYMENT HISTORY

Describe under the heading given below any employment or occupation you have ever had which includes experience that tends to qualify you for the position sought. Begin with your most recent (or present) employment and work backward to your first one. Applicants may be required to furnish satisfactory proof of experience claimed. If more space is needed, attach a separate sheet or resume.

1) Firm Name: ______________________ Length of Employment: From ___/___/_____
Type of Business: ______________________ To ___/___/_____
Firm Address: ______________________ Hours worked per week: ________
City: __________ State: ________ Zip: ________ Monthly salary: ______________
Job Title: ______________________ Tel: ( ) ______________
Supervisor: ______________________ Total time Employed: Years ______ Months ______

Duties: ____

____

____

____

Reason for leaving: ____

2) Firm Name: ______________________ Length of Employment: From ___/___/_____
Type of Business: ______________________ To ___/___/_____
Firm Address: ______________________ Hours worked per week: ________
City: __________ State: ________ Zip: ________ Monthly salary: ______________
Job Title: ______________________ Tel: ( ) ______________
Supervisor: ______________________ Total time Employed: Years ______ Months ______

Duties: ____

____

____

____

Reason for leaving: ____

3) Firm Name: ______________________ Length of Employment: From ___/___/_____
Type of Business: ______________________ To ___/___/_____
Firm Address: ______________________ Hours worked per week: ________
City: __________ State: ________ Zip: ________ Monthly salary: ______________
Job Title: ______________________ Tel: ( ) ______________
Supervisor: ______________________ Total time Employed: Years ______ Months ______

Duties: ____

____

____

____

Reason for leaving: ____

FOR OFFICE USE ONLY. DO NOT WRITE BELOW:

MINIMUM QUALIFICATIONS

_________ APPROVED _________ DISAPPROVED

COMMENTS ____

____

____

____

____

____

____

____

____

____

1ST ______________________ 2ND ______________________
date & initials date & initials

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Tel. 847-257-0130 Fax. 847-257-0231

EMPLOYEE AGREEMENT FORM

Patient Abuse Policy

I have been informed as to the criminal liability for failure to report any known case of patient abuse to this agency. I agree and will report any such abuse in accordance with Senate bill #9 as stated in the Patient Abuse Policy of this agency.

Statement of Confidentiality

I understand the importance of observing strict confidentiality policy. Therefore, I agree not to discuss/release any information obtained within the agency regarding any 5 Star Healthcare, Inc. clients/patients, their medical record, condition with any individual not directly associated with that client. I also agree that any information that is released regarding the patient's record will only be done with proper authorization and/or in accordance with established agency policy for the release of the information. My signature indicates that I understood and agreed to abide by the aforementioned of the Disciplinary Policy Procedure up to and including possible **IMMEDIATE DISMISSAL** from 5 Star Healthcare, Inc.

Drug Screening

I hereby authorize 5 Star Healthcare, Inc. to administer a mandatory pre-employment and random drug screen if deemed necessary. I release the administration and nurses from any and all implications in regards to the result of the drug screen.

Should a prohibited substance (including a metabolite of the prohibited material) be detected, this policy will be deemed to have been violated and the company reserves the right to discipline, up to and including immediate termination, irrespective of when or where their prohibited substance entered the employee's system. I have read and understood this policy.

Release of Information

I certify and declare under penalty of perjury of state and federal law that the information contained in my employment application is complete, true and accurate. I acknowledge that falsification or omission of information may result in immediate dismissal or retraction of any offer of employment.

In consideration of 5 Star Healthcare, Inc., review of my application for employment, I hereby voluntarily consent to and authorize bearing this release or copy thereof, to obtain a consumer report for employment purposes. I agree that this consumer report may include any of the following:

- Employment Verification, Education Verification, Credentials Verification
- Personal Identity Verifications, Past Employment Verification, Reference Checks
- Criminal Records, Civil Cases, Motor Vehicle Records, Credit Report

I authorize all persons and organizations that may have information relevant to this research to disclose such information to **5 Star Healthcare, Inc.** A copy of this authorization is valid as original.

I understand that I have prescribed rights as a consumer under the federal Fair Credit Reporting Act (FCRA), and may have additional rights under relevant state law. I hereby certify that I have been presented with a summary of my rights as a consumer under the Fair Credit Reporting Act.

Consent for Conviction Information Request

The Uniform Conviction Information Act (UCIA) mandates that all criminal history record conviction information are collected and maintained by the Illinois State Police, Bureau of Identification to be made available to the public pursuant to 20 ILCS 2635/1 et seq. As prospective applicant, I authorize this agency to request information related to this act. I am fully aware that any adverse report may cause to deny my employment with this agency.

Hepatitis B Virus Vaccination Consent. (Please initial each applicable statement)

_____I understand that the nature of my job makes it reasonably anticipated that I may have percutaneous, mucus membrane or non-intact skin exposure to blood or other potentially infectious body fluids in the course of my work, therefore, I am entitled to receive the HBV vaccine series at no cost during work hours. I understand that taking the HBV vaccine will reduce my risk of developing serious liver disease as a result of occupational exposure to HBV.

_____I understand that my decision to accept or decline HBV vaccine will not affect my employment or any benefits available to me through employment.

_____I elect to receive the HBV vaccination series provided by this agency.

_____I have received training on the risk of infection with HBV on the job and have given the opportunity to be vaccinated with HBV vaccine. However, I decline HBV vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring HBV.

_____I have received the complete 3-dose series of HBV vaccine.

_____Antibody testing has revealed that I am immune to HBV.

_____It is contraindicated as evidenced by the attached statement from my physician.

____

Signature of Applicant

9933 Lawler Avenue Ste. 122 Skokie, IL. 60077
Tel: 847-257-0130 Fax: 847-257-0231

CONTRACT AGREEMENT

I, ____________________________, agree to work for 5 Star Healthcare, Inc. as a

_____________________________ on a per visit rate of $_______________ on the

following conditions:

1. I will report to the office at least once a week to complete my paperwork, do follow-up calls, and coordinate with the rest of the health team members as needed.
2. I understand that it is the agency that makes arrangements in providing services
3. I will abide by the policies and rules of the agency
4. I will be responsible for the implementation of the plan of care as directed by the physician and supervising RN.
5. I agree that the information about my pay is confidential.
6. I understand that 5 Star Healthcare, Inc. does not guarantee a specific number of patient case load.
7. I understand that salaries employees have priority of patient caseloads over part-time employees.
8. I understand that part-timers are not entitled to any company benefits.
9. I understand that the terms of this contract are subject to change as deemed necessary by 5 Star Healthcare, Inc.

_________________________________   _________________________________

5 Star Healthcare, Inc. Representative   Employee

Employee Handbook Acknowledgement

This is to acknowledge that I have received a copy of the personnel policies and procedures. I agree to read and become familiar with its contents. I understand that this handbook is not an express or implied contract of employment and that it does not create any rights in the nature of an employment contract.

The information contained in this handbook is subject to change from time to time; I understand that this handbook supersedes any previously issued editions.

Print your name ______________________________

Signature ___________________________________

Date _______________________________________

Personnel Policy and Procedures Effective: February 1, 2006

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶**START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	- -		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: ____________

OR

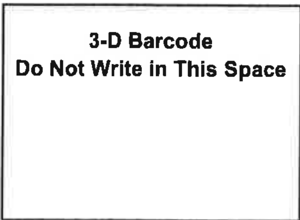
2. Form I-94 Admission Number: ____________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________

Country of Issuance: ____________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)



Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion 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)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	**OR** **List B** Identity	**AND** **List C** Employment Authorization
Document Title:	Document Title:	Document Title:
Issuing Authority:	Issuing Authority:	Issuing Authority:
Document Number:	Document Number:	Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		
Document Title:		**3-D Barcode Do Not Write in This Space**
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _______________ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative	
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name	
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   - **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 alien's nonimmigrant status 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.
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

OR

LIST B
Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
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

AND

LIST C
Documents that Establish Employment Authorization

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. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Illinois Department of Public Health

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: (217) 785-5133

Health Care Worker Background Check

Disclosure and Authorization for Criminal History Records Check

I hereby authorize the Illinois Department of Public Health (IDPH), IDPH's designee that train or test health care workers, staffing agency, or the health care employer to request a criminal history records check and I further authorize the Illinois State Police (ISP) to release information relative to the existence or non existence of any criminal record which it might have concerning me to the requestor solely to determine my suitability for employment or continued employment. I further authorize any agency which maintains records relating to me to provide same on request to the ISP or IDPH. I certify that the ISP and any agency, including IDPH, their employees or officers who furnish this information shall be held harmless from any and all liability which may be incurred as a result of releasing such information. I further acknowledge that a health care employer shall not be liable for the failure to hire or to retain an applicant or employee who has been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25)

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment or, if discovered after employment begins, could result in discipline up to and including my termination of employment.

I understand that the information requested below regarding sex, race, height, eye color, and date of birth is for the sole purpose of identification and the gathering of the above-mentioned information about me accurately, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my social security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name ______________________ Full Middle Name ______________________ Last Name ______________________

Mailing Address ____

Physical Address if different ____

Other Names Used: ____________________________________ Telephone _____-_____-_____

States Where You Have Lived? ____

☐ Male ☐ Female Date of Birth ____________ Height ______ Eye Color __________ Social Security Number _____-_____-_____

Race
- **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
- **B** Black or African American (Not Hispanic or Latino)
- **H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- **I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
- **U** Of undeterminable race. Of Untold mixture.
- **W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect, or Theft? ☐ Yes ☐ No If "Yes", give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes", give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on IDPH's Health Care Worker Registry as a result of this criminal history records check:

______________________________ (Signature) ______________ (Date)

As the parent or guardian of the above named individual, who is under the age of seventeen, I give my consent for this named individual to have a criminal history records check.

______________________________ (Signature of Parent or Guardian when applicable) ______________ (Date)

9933 Lawler Avenue Ste. 122 Skokie, IL. 60077
Tel. 847-257-0130 Fax. 847-257-0231

REFERENCE INQUIRY

NAME OF EMPLOYER: ______________________________

ADDRESS: ______________________________

ATTENTION: ______________________________

I am requesting and authorizing you to release all information requested by 5 STAR HEALTHCARE, INC., as well as an evaluation of my performance during my employment.

Signed: ____________________

Print Name: ____________________

Social Security No.: ____________________

VERIFICATION OF EMPLOYMENT

Position Held: ____________________

Dates of Employment: ________________ to ________________

Employee Evaluation:	A	B	C
1. Overall Competency			
2. Communication Skills			
3. Disposition & Personality			
4. Ability to follow instructions			
5. Desire to succeed			
6. Motivation			

Rating Scale:

A = Exceeded job requirements **B** = Satisfied job requirements **C** = Did not satisfy job requirements

Comment: ______________________________

____

Release By: ____________________ Date: ______________

Title: ____________________

JOB DESCRIPTION

Licensed Practical Nurse (LPN)

JOB SUMMARY:

A qualified Licensed Practical/Vocational Nurse administers skilled nursing care 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 Registered Nurse. Services are furnished in accordance with Agency policies.

QUALIFICATIONS:

1. Graduate of a state approved school of practical (vocational) nursing and currently licensed in the state(s) in which practicing.
2. Minimum of one (1) year experience in nursing, preferred.
3. Acceptance of philosophy and goals of this Agency.
4. Ability to exercise initiative and independent judgment.

RESPONSIBILITIES:

1. Understands and adheres to established policies and procedures.
2. Implements the nursing care plan for each patient.
3. Provides nursing services, treatments and diagnostic and preventive procedures as assigned.
4. Initiates preventive and rehabilitative nursing procedures as appropriate.
5. Observes signs and symptoms and reports to the physician and RN reactions to treatments, including drugs and changes in the patient's physical or emotional condition.
6. Teaches and counsels the patient and family/significant others regarding the nursing care needs and other related problems of the patient at home.
7. Evaluates with registered nurse the effectiveness of the LPN's/LVN's nursing service to the patient and family under the guidance of the registered nurse.
8. Maintains accurate and complete records of observations, treatments and care of patient.
9. Participates in medical record audit as assigned.
10. Attends staff meetings, patient care conferences and inservices as scheduled.
11. Takes on-call duty, nights, weekends and holidays as assigned.
12. Is responsible for:
    - Submitting any changes in schedule to Director of Clinical Services/Nursing Supervisor on a daily basis.
    - Participating in patient care conferences to discuss the need for involvement of other members of the health team, such as physical therapist or speech language pathologist.
13. Prepares clinical and progress notes.
14. Assists the physician and RN in performing specialized procedures.
15. Prepares equipment and materials for treatments.
16. Observes aseptic technique as required.
17. Assists the patient in learning appropriate self-care techniques.

WORKING ENVIRONMENT:

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

JOB RELATIONSHIPS:

1. Supervised by: Director of Clinical Services/Nursing Supervisor/RNs

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.
- Heavy 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 a Licensed Practical/Vocational Nurse, I will perform these duties to the best of my knowledge and ability.

____________ ____________________________________

Date Signature

Form W-4 (2019)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) **5**

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $

7 I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ **7**

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F	G	
H	Add lines A through G and enter the total here ▶	H	

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	1	$
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 if you're single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . 1 ________

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . 2 ________

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . 3 ________

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . 4 ________

5 Enter the number from line 1 of this worksheet . . . 5 ________

6 **Subtract** line 5 from line 4 . . . 6 ________

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . 7 $ ________

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ ________

9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . 9 $ ________

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

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

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

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

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

Illinois Withholding Allowance Worksheet

General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Enter the total number of boxes you checked. 1 ________

2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. 2 ________

3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled**. You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. 3 ________

4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 4 ________

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Enter the total number of boxes you checked. 5 ________

6 Enter any amount that you reported on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. 6 ________

7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. 7 ________

8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled**. You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. 8 ________

9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 9 ________

IMPORTANT: If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.

✂ - - - - - - - - - Cut here and give the certificate to your employer. Keep the top portion for your records. - - - - - - - - - ✂

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security number

Name

Street address

City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate. ☐

1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 ________

2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 ________

3 Enter the additional amount you want withheld (deducted) from each pay. 3 ________

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature Date

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

Illinois Department of Revenue

Form IL-W-4 Employee's and other Payee's Illinois Withholding Allowance Certificate and Instructions

Note: These instructions are written for employees to address withholding from wages. However, this form can also be completed and submitted to a payor if an agreement was made to voluntarily withhold Illinois Income tax from other (non-wage) Illinois income.

Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employee's Statement of Nonresidence in Illinois, to determine if you are exempt.

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I submit this form?

You should complete this form and give it to your employer on or before the date you start work. You must submit Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional allowance for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have submitted takes effect or until your employer is required by the Department to disregard it. Your employer is required to disregard your Form IL-W-4 if

- you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption, or
- the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax that you may claim on your Illinois Income tax return.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (*e.g.*, your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

Note: For tax years beginning on or after January 1, 2017, the personal exemption allowance, and additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind, may **not** be claimed on your Form IL-1040 if your adjusted gross income for the taxable year exceeds $500,000 for returns with a federal filing status of married filing jointly, or $250,000 for all other returns. You may complete a new Form IL-W-4 to update your exemption amounts and increase your Illinois withholding.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

Note If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

How do I avoid underpaying my tax and owing a penalty?

You can avoid underpayment by reducing the number of allowances or requesting that your employer withhold an additional amount from your pay. Even if your withholding covers the tax you owe on your wages, if you have non-wage income that is taxable, such as interest on a bank account or dividends on an investment, you may have additional tax liability. If you owe more than $500 tax at the end of the year, you may owe a late-payment penalty or will be required to make estimated tax payments. For additional information on penalties see Publication 103, Uniform Penalties and Interest. Visit our website at **tax.illinois.gov** to obtain a copy.

Where do I get help?

- Visit our website at **tax.illinois.gov**
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
  ILLINOIS DEPARTMENT OF REVENUE
  PO BOX 19044
  SPRINGFIELD IL 62794-9044

9933 Lawler Avenue Ste. 122 Skokie, IL. 60077
Tel. 847-257-0130 Fax. 847-257-0231

Health Evaluation History

☐ PRE-PLACEMENT ☐ ANNUAL ☐ PERIODIC

NAME____________________________________

ADDRESS____ **PHONE**__________________

Check the following conditions which you have had or presently have:

	Yes	No	Year
Diabetes			
Gallbladder Disease			
Heart Problems			
Liver Problems			
Kidney Problems			
Lung Problems			
Arthritis			
Asthma			
Cancer			
Seizures			
Fainting			
Tuberculosis			
High Blood Pressure			
Ulcer			
Back Problems			
Nervousness			

Other (Specify) ____________________
____
____

Does any blood relative (living or dead) have any of the following?

	Yes	No
Diabetes		
Heart Trouble		
High Blood Pressure		
Tuberculosis		
Cancer		
Mental Disorder		

Other (Specify) ____________________
____
____
____

Within the past year have you had any of the following?

	Yes	No
Blurred Vision		
Constant Noises in Ear		
Persistent Hoarseness		
Pain or Difficulty in Swallowing		
Shortness of Breath on Exertion		
Persistent Cough		
Coughing Up Blood		
Pain or Tightness in Chest		
Weight Loss Without Dieting		
Frequent Nausea or Vomiting		
Pain in Abdomen		
Bloody or Black Bowel Movements		
Growth or Lump Anywhere on Body		
Sore That Does Not Heal		
Frequent Diarrhea		
Loss of Appetite		
Excessive Fatigue or Weakness		
Frequent Urination		
Blood in Urine		
Swollen Ankles		
Frequent or Prolonged Backache		
Painful Swollen Joints		
Numbness or Tingling of Hands or Feet		
Frequent Headaches		
Dizziness or Fainting		
Nervousness Afftecting Home Life/Work		
Persistent or Recurrent Skin Rash		

WOMEN ONLY

Irregular Menstrual Periods		
Lump in Breast		
Vaginal Bleeding(other than norm. pd.)		
Date of Last Menstrual Period		
Date of Last Papsmear		

MEN ONLY

Difficulty in Starting or Stopping Urine		
Any Swelling or Pain of Testicles		

Allergies (List):____________________
____
____

List any and all medications you are taking:
____
____
____

Have you ever had a positive TB skin test?
yes☐ no☐ year__________

List any major illnesses, surgery, hospitalizations,or child birth:
________________ date____________
________________ date____________
________________ date____________

Do you drink more than 5 cups of coffee tea or caffeinated beverages per day?
yes☐ no☐

do you drink more than 2 alcoholic beverages per day?
yes☐ no☐

List last known immunization or occurrence of disease:

	dates
Tetanus:	
Mumps:	
Rubella:	
Rubeola:	
Hepatitis B:	
Chicken Pox:	

Authorization For Examination

I give my authorization to be examined at The Health Career Institute. The examination will be done by physicians and employess of The Career Institute. I authorize The Health Career Institute to release any information from my records to me, my personal physician or my employer that is necessary to safeguard my health and/or affect the performance of my job with my permission.

I certify that I have provided accurate and complete information regarding my health.

Date__________ Time________ Signed____________________________________

Witness____________________________________

Healthcare, Inc.

Advancing in home health care.

9933 Lawler Avenue Ste. 122 Skokie, IL. 60077
Tel. 847-257-0130 Fax. 847-257-0231

PHYSICAL EXAMINATION

Name: ______________________________ Date: ____________________

Visual Acuity:

	With Correction	Without Correction
Right Eye		
Left Eye		
Both Eye		

Vital Signs: B/P_________ Temp_________ Pulse_________ Resp_________

Check-describe abnormalities in detail:

	Normal	Abnormal	Comment
1. General appearance			
2. Skin (scalp, scars)			
3. Eyes			
4. Ears			
5. Hearing			
6. Lymph Glands			
7. Nasal passages			
8. Mouth/throat			
9. Neck & thyroid			
10. Breasts			
11. Lungs			
12. Heart			
13. Abdomen			
14. Hernia			
15. Spine and back			
16. Joints and extremities			
17. Neurological			
18. Scars/Deformities			
19. Varicosities			
20. Other			

TB skin test Step 1: date__________ result__________ mm at 48/72 hrs
TB skin test Step 2: date__________ result__________ mm at 48/72 hrs
CXR for positive TB skin test: date__________ result __________
Tetanus: date__________
Hepatitis B vaccine: date(initial)__________ (1 month)__________ (6 months)__________

Physician Signature: ________________________________

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HEPATITIS B VACCINATION WAIVER FORM

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring HBV (Hepatitis B Virus) infection. I have read the *Employee Information Sheet: Hepatitis B and Hepatitis B Vaccine* and have had an opportunity to ask questions and understand the risks and benefits of the HBV vaccine.

I have been given the opportunity to be vaccinated at no charge to myself.

Having been so informed, I decline to take the HBV vaccine at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring hepatitis. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated, I can receive the vaccination series at no charge to me.

NAME (Print): ____

SS#: ____________________ AGENCY: ______________________________

EMPLOYEE SIGNATURE: __________________________ DATE:__________

SUPERVISOR: ___________________________________ DATE:__________

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ANNUAL TUBERCULOSIS HEALTH QUESTIONNAIRE FOR PREVIOUS POSITIVE REACTORS

NAME: ______________________________

Employee Health Service records show that you test positive with the TB skin test. Please answer the following questions, which may be indicative of an active tuberculosis infection:

1. Productive cough (lasting more than 3 weeks)? YES / NO
   Tos prodctive (durando mas de tres semanas)?
2. Coughing up blood? YES / NO
   Tosiende sangre?
3. Shortness of breath? YES / NO
   Falta de respiracion?
4. Chest Pain? YES / NO
   Dolor de pecho?
5. Easily fatigued? YES / NO
   Facilmente fatigado?
6. Loss of appetite? YES / NO
   Perdida de apetito?
7. Weight loss? YES / NO
   Perdida de peso?
8. Fever? YES / NO
   Fiebres?
9. Night sweat? YES / NO
   Sudando de noche?
10. TB exposure, infection, or disease? YES / NO
    Contacto con TB, infection, o enfermedad?
11. BCG Vaccine? YES / NO
    Vacuna de BCG?

I understand that I am responsible to notify Employee Health Service if any of the above symptoms occur during the year. A medical evaluation may be necessary at that time.

EMPLOYEE'S SIGNATURE: ______________________ **DATE:** __________

Licensed Practical Nurse Competency Examination
(There are 20 correct items. You need to get 16 out of 20 to pass)

Name: ______________________________ **Date:** __________

1. You are making the first follow up visit to a patient recently discharged from the hospital with a diagnosis of CHF and ANGINA. Lung auscultation revealed rales, 3 pounds of weight gained and 2+ pedal edema. As a home health nurse, you would:
   a. Call 911 to transfer the patient back to the hospital
   b. Schedule a visit for 3 days from today for further evaluation
   c. Check patient complaints with medications and diet and report all findings to the MD and nurse supervisor
   d. Instruct to increase activity and increase fluid intake.

2. Which of the following is not a sign of respiratory failure?
   a. Cyanosis of the lips and nails
   b. Anxiety
   c. Dyspnea at rest
   d. Nausea

3. Patient on antibiotics should be taught on instructions of s/s of drug reaction
   a. Every week
   b. On the initial visit
   c. When symptoms are observed
   d. On the 3rd day

4. When you arrive at the patient's house, the family frantically tells you that the patient has stopped breathing, you
   a. Ask the family to call 9111 and initiate CPR
   b. Check the airway, breathing and circulation
   c. Call your supervisor
   d. None of the above

5. On your follow up visits, you have found out the patient was taking duplicated prescribed medications. One medication was prescribed by the cardiologist and the other by the internist, you
   a. Leave it alone, it is correct because they were both ordered by 2 different doctors
   b. Instruct patient to throw away the oldest prescription
   c. Report the duplication of medication to the internist.
   d. None of the above.

12. Mrs. Khan demonstrated to you how to take insulin. She rolled the insulin bottle back and forth between her palms to mix the insulin. Cleaned the top of the bottle with alcohol wipe. Drew air into the syringe by pulling back on the plunger. The amount of air should be the same as the insulin dose, she said. Took off the needle cap. Pushed the needle through the center of the rubber top of the insulin bottle. Push the plunger in. Turned the syringe upside down. Held the syringe and bottle in one hand while the other hand, she pulled back slowly on the plunger until the right dose is in the syringe. She checked for air bubbles. Double checked the dose in the syringe. Pulled the needle and syringe out of the bottle. Is this procedure correct? (2 points)
    a. Yes
    b. No. Explain____

13. The symptoms for hypoglycemia are: (Circle the correct answer/s)
    a. Alertness
    b. Slurred speech poor coordination
    c. Pounding heart beat
    d. Confusion/ disorientation

14. Seborrheic dermatitis (cradle cap) spreads from an infected person to a non-infected person by physical contact with the infected person or with clothing or bed linens that have touched the infected areas of the body.
    a. True
    b. False

15. A diet that will help manage high blood pressure in persons who are sodium sensitive.
    a. Sodium controlled diet
    b. No concentrated sweet
    c. As tolerated diet
    d. Bland diet

16. To check the fullness of the inhaler in a basin of water, you will note that the inhaler will
    a. Float
    b. Sink
    c. Stay in the middle

17. To instruct to take the inhaler you would advise to shake the inhaler first, clear the throat and blow nose. Place the mouth piece inside your mouth, close lips around it. Inhale deeply and slowly for about 10 seconds. Hold your breath for about several seconds. Remove the mouthpiece and exhale slowly. Is this procedure correct?
    a. Yes, it is correct
    b. No, it is not. Write the correct procedure.

HIPAA PRIVACY AND SECURITY POST EDUCATION TEST

Name: ______________________ SS#: ______________________

Signature: ______________________ Date: ______________________

Please circle the best answer:

1. HIPAA stands for Health Insurance Priority Affiliated Act. T F
2. I only need to worry about HIPAA if I give patient care. T F
3. HIPAA increases the protection of patient information. T F
4. Patients can request changes to their records under HIPAA. T F
5. Sending a fax of patient information is now forbidden. T F
6. If I see a computer logged on with no one around I should turn the computer off. T F
7. Fines related to HIPAA violations are never more than a few hundred dollars. T F
8. HIPAA rules do not affect staff in the doctor's office. T F
9. Discussions of patient's conditions should not occur around. T F
10. Violating HIPAA regulations can lead to discipline up to and including discharge. T F
11. Conversations about patient information does not affect the home health agency office staff. T F
12. I can go to jail for breaking the HIPAA law. T F

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INITIAL COMPETENCY CHECKLIST

RN/LPN NAME ______________________________ **RN** ______ **LPN** _____

Date and RN's signature indicates that the nurse has been checked off on the procedure.

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
1. Urinary catheters:				
a. Foley insertion–male/female				
b. Suprapubic insertion/removal				
2. Central Cath Lines				
3. Enteral Feedings:				
a. Bolus				
b. Continuous				
c. Removal/insertion PEG tubes				
4. Equipment:				
a. IV pumps				
b. Enteral pumps				
c. Oxygen concentrator				
d. Oxygen tank				
e. Nebulizer				
5. IV therapy:				
a. Peripheral/INT				
b. Adm fluids/meds				
c. Dressing change				
6. Irrigations:				
a. Bladder				
b. Colostomy				

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
7. Suctioning				
a. Nasal				
b. Oral				
c. Tracheal				
8. Tracheostomy Care				
9. TPN:				
a. Administration				
b. Labs				
c. Starting/stopping				
d. Additives				
10. Venipunctures				
11. Transporting lab specimens				
12. Wound care:				
a. Aseptic technique				
b. Sterile technique				
13. Standard Precautions:				
a. Gloves				
b. Gowns				
c. Masks/goggles				
d. Shoe covers				
e. CPR resusci masks				

DATE OF INITIAL COMPLETION: ____________________

____
Employee Signature & Title

____
Observer Signature & Title