



Please circle yes or no for the following questions. Please attach an explanation sheet/letter for any questions to which you answer “yes”.

- | | | |
|--|------------|-----------|
| 1. Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? | YES | NO |
| 2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? | YES | NO |
| 3. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? | YES | NO |
| 4. Have you ever been sanctioned or suspended by Medicare or Medicaid? | YES | NO |
| 5. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? | YES | NO |
| 6. Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct | YES | NO |
| 7. Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you | YES | NO |
| 8. Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? | YES | NO |
| 9. Have you ever practiced without liability coverage? | YES | NO |
| 10. Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice Physical Therapy or to perform the essential functions of your position? | YES | NO |
| 11. Have your therapy and/or professional privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? | YES | NO |



NEXT OF KIN

PLEASE FILL OUT THE FOLLOWING INFORMATION CLEARLY AND COMPLETELY SO THAT WE MAY PROPERLY ACTIVATE YOUR PERSONNEL FILE. THANK YOU!!!

Your Name: _____
(Last Name) (First Name) (M. Initial)

Job Title: _____ Date Of Birth: _____ Sex: M F

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone No.: (_____) _____ Fax No.: (_____) _____

Beeper No.: (_____) _____ Cellular No.: (_____) _____

Social Security #: _____ Professional License #: _____ Exp. Date: _____
(if Applicable)

**** In Case Of An Emergency, Please Contact The Following Next-Of-Kin: ****

Name: _____ Relation: _____
(Next-Of-Kin)

Phone No.: (_____) _____ Beeper No.: (_____) _____

(Complete Address)

Physician:

Name: _____ Phone No.: (_____) _____

(Complete Address)

Signature: _____ Date: _____



Signature Verification

I, _____, verify that the signature to follow is my original signature. This signature pattern will typically be found on patient and personnel forms requiring my signature. Deviations from this pattern might include abbreviation of first name, etc.

My signature below gives consent to Pro-Motion Rehab, Inc. to release copies of this form to any institution requiring verification of my signature.

Original Signature

Date

Witness (Please Print)

Date

Witness Signature



T.B. EXPOSURE STATEMENT

I, the undersigned, understand that due to my occupational exposure to bloodborne and airborne pathogens that I am at risk of acquiring Tuberculosis. I understand that I am required to be tested periodically (At least yearly) to ensure that I am free of the M. Tuberculosis Bacterium. I understand that if I do test positive for tuberculosis, I will be removed from any patient/client contact until a physician signs a statement that I am no longer contagious.

To ensure that I do not acquire tuberculosis from a patient or significant other of a patient, I will acquire an NIOSH-approved HEPA respirator if a patient or significant other is thought to have or has confirmed Tuberculosis. The company will contact me in the event a patient is known to have tuberculosis and I will contact the office in the event that the patient or significant other has tuberculosis without the company's knowledge.

I have read the foregoing and will be in compliance for my safety as well as the patient's.

Signature: _____ Date: _____

Witness: _____ Date: _____



Pro Motion Rehab, Inc.
1787 W. US Hwy 64 Suite #3
Murphy, N.C. 28906
Office: 828-837-0400
Fax: 828-837-0404

HEPATITIS B VIRUS VACCINE

BLOODBORNE PATHOGENS

I have been informed of the symptoms and modes of transportation of bloodborne pathogens including the hepatitis B virus (HBV), I know about the infection control program and understand the procedure to follow if an exposure incident occurs.

I understand that the Hepatitis B vaccine is available, at no cost, to employees whose jobs involve the risk of directly contacting blood or other potentially infectious material. I understand that vaccinations shall be given according to recommendations for standard medical practice in the community.

HEPATITIS B VACCINE CONSENT

- I consent to the administration of the hepatitis B vaccine. I have been informed of the method of administration, the risks, complications and expected benefits of the vaccine.
- I have already received the series of Hepatitis B vaccine (HBV) and have no need for further inoculation at this time.

Signature of the Employee

_____/_____/_____
Date

Print Employee's Name

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline the hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccine series at no charge to me.

Signature of the Employee

Date

Print Employee's Name



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**OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA)
STANDARDS FOR HEALTHCARE EMPLOYEES EDUCATION ON
HEPATITIS B (HBV), TUBERCULOSIS (T.B.), AND HUMAN
IMMUNODEFICIENCY VIRUS (HIV)**

I understand in caring for patients that there is a risk for HIV and HBV, and T.B..
I am knowledgeable in the transmission of bloodborne and airborne pathogens.
I have attended a seminar/class on this subject.

- ⊗ I agree to observe all safety precautions and "Universal Precautions".
- ⊗ I understand that all blood, body fluids and certain potentially infectious materials are considered contaminated.
- ⊗ I will wear Personal Protective Equipment when handling blood, body fluids and potentially infectious materials at all times. (i.e.: gloves, gowns, masks, shields, etc.)
- ⊗ I understand that all needles, dressings, supplies and equipment soiled with blood, body fluids and certain potentially infectious materials are considered contaminated and I will dispose of them in an appropriate container.
- ⊗ I will use good handwashing technique at all times.
- ⊗ I will observe Work Practice Controls in the handling of needles and other sharp objects at all times.
- ⊗ I understand that I can obtain the Hepatitis B vaccination at any time.
- ⊗ I have read the policy manual on HIV, T.B., and Hepatitis B.
- ⊗ I will obtain an approved respirator in the event a patient has contagious Tuberculosis
- ⊗⊗ I understand that I must report **ALL EXPOSURE INCIDENTS** to the Director of Professional Services of Pro-Motion Rehab, Inc.. **IMMEDIATELY** at the office in Murphy (828) 837-0400.

Signature: _____ Date: _____

Witness: _____ Date: _____



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DESCRIPTION OF UNIVERSAL PRECAUTIONS

The concept of "universal precautions" is the foundation of most of the recommendations in this document. An understanding of this concept is important, especially to the discussions of testing and confidentiality. Fundamental to this concept is the practice of treating **all** patients as if they are infected with a bloodborne disease and take appropriate protective measures. This practice has been advocated by the centers for disease control (CDC) and is currently mandated by the Occupational Safety and Health Administration (OSHA). Therefore all are required to have policies and procedures that reflect the practices of universal precautions. A brief discussion follows.

The concept of universal precaution evolved out of the practice of identifying patients with known infectious disease and using certain precautions to prevent the spread of these diseases. These precautions typically involve the use of removable barriers (e.g.: gloves) to prevent the caregiver from transporting the infectious agent between patients and also to protect the caregiver. In some instances the use of a separate room is advised. The CDC based on the epidemiology of each disease or category of each disease developed guidelines for the use of such barriers. For example, when caring for patients with enteric diseases such as gastroenteritis, masks are not necessary, but gloves are required when in contact with infective material. Conversely, when treating patients with airborne diseases such as measles, masks are required, but gloves and gowns are not. Diseases transmitted through contact with blood and/or other body fluids require the use of gloves if touching bloody/body fluids and masks or gowns if splashing with blood or fluids is possible. In all cases hand washing following the care of any patient is necessary.

The epidemiological data on the transmission of HIV and Hepatitis B Virus (HBV) indicates that the only occupational risks of infection are through parental (including open wound) and mucus membrane exposures to blood and tissues. Workers can be protected from these risks through the use of barriers and protective equipment that are already commonly used in hospitals and other health care settings.

Experiences with HBV, HIV, and other bloodborne diseases have shown that patients with such infections are often not identifiable when admitted to a health care setting. It has rapidly become the consensus of leaders in infection control that applications of the precautions advocated for the prevention of transmission of bloodborne diseases to all patients is the most reliable means of preventing transmission. These precautions include the use of gloves when touching blood and fluids, mucus membranes, or soiled items or surfaces, and when doing venipunctures or starting iv lines. Mask and eye protection should be worn when there is the possibility of blood and other fluids being splashed onto mucus membrane and gowns are indicated only when splashing is possible.

A system of universal precautions includes other protective measures, such as procedures for the appropriate handling and disposal of needles and other sharp objects, the use of resuscitation devices when necessary, and the exclusion from patient care of personnel with exudative lesions or weeping abnormalities until these conditions are resolved.

These precautions are based on the limited days in which bloodborne diseases are transmitted. Therefore, it is not necessary to routinely use any barriers other than those already discussed (e.g.: coverings, disposable body suits) or to use any barrier during routine patient care not involving exposure to body substances. Neither is it necessary for personnel not engaged in direct patient care (e.g.: transporters, dietary personnel) to wear barriers or refuse to enter a patient room.

The use of extraordinary measures may enhance misapprehension and misunderstanding about the transmission of aids and other infectious diseases and hinder the educational efforts of the institution. In presenting a policy of universal precautions, it is important to ensure that staff understands not only the procedures involved, but the rationale and bases for deciding when to employ the use of specific barrier precautions. For blood spills, clean up using bleach diluted 1:9 with h₂o and use gloves.

I have read the procedure and agency policy on universal precautions and understand that I am responsible for practicing these precautions.

Signature: _____ Date: _____



CONFIDENTIALITY ATTESTATION

I, _____, have been instructed on North Carolina State Public Health Law and Department of Health Regulations regarding the confidentiality of HIV – related information. I understand that each patient entrusted to the care of this company is given assurance that all information is held in strict confidence. Information about a patient’s admission, condition, care or treatment must not be discussed with anyone, except with those who are directly responsible for the care and treatment.

I am aware that, when necessary for the provision of care, HIV information will be disclosed to me from confidential records, which are protected by the state law.

Any unauthorized disclosure may lead to disciplinary action, including but not limited to suspension or dismissal from employment, a fine, jail sentence or both.

Signature: _____ Date: _____



REFERENCE RELEASE FORM

Date: _____

To whom it may concern,

_____ (*Applicants Name*) has applied for a position as a
_____ (*Position for which you applying*) at our company and has authorized
you to provide information concerning past work performance. Your effort in providing us with the necessary
information to perform a thorough screening of this applicant is greatly appreciated. [Signed release below.]

At your convenience, please fill out the enclosed Reference Information Form and questionnaire. Any further
information you can furnish us would also be greatly appreciated.

Sincerely,

Signature (**Rehab Manager or President**)

Title

I, _____ (*Applicant's Name*), hereby authorize PRO-MOTION
REHAB, INC., to obtain information pertaining to my employment.

Signature of Applicant

Date



Pro Motion Rehab, Inc.
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Fax: 828-837-0404

REFERENCE & QUESTIONNAIRE

1. If the stated dates do not correspond with your records, please provide correct dates below.

2. Please comment on Reliability and Attendance. _____

3. Cooperation. _____

4. Comment on patient care skills. (If applicable) _____

5. Ability to work independantly? _____

6. Supervisory Ability and Capacity? _____

7. Organizational Skills? _____

8. Interpersonal Relationships? _____

9. Please comment on any characteristics that we should consider which would influence the assignments we would give this individual. _____

10. Reason for Departure? _____

11. Is this applicant eligible for rehire with your organization? (Circle one) YES NO

***PLEASE FILL OUT REFERENCE QUESTIONNAIRE AND SIGN ATTACHED "REFERENCE VERIFICATION" FORM AND FAX TO NUMBER LISTED ABOVE.**

THANK YOU FOR YOUR COOPERATION AND ASSISTANCE!



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THANK YOU FOR YOUR COOPERATION AND ASSISTANCE!**



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REFERENCE VERIFICATION

EMPLOYEE REFERENCES FOR _____

SUPERVISOR'S NAME AND TITLE _____

COMPANY NAME _____

COMPANY ADDRESS _____

PHONE _____

DATES EMPLOYED FROM _____ TO _____

OTHER COMMENTS: _____

BY _____ DATE _____

SIGNATURE OF ABOVE MENTIONED INDIVIDUAL / SUPERVISOR



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REFERENCE VERIFICATION

EMPLOYEE REFERENCES FOR _____

SUPERVISOR'S NAME AND TITLE _____

COMPANY NAME _____

COMPANY ADDRESS _____

PHONE _____

DATES EMPLOYED FROM _____ TO _____

OTHER COMMENTS: _____

BY _____ DATE _____

SIGNATURE OF ABOVE MENTIONED INDIVIDUAL / SUPERVISOR



WORK GUARANTEE

I, _____, am aware that I am guaranteed a specific number of hours per week. I understand that my employment is contingent upon my prompt and regular attendance and unless previously authorized or in the event of an emergency I will arrive as scheduled. Additionally, I agree to promptly call in the event I am unable to arrive as scheduled. Failure to do so may result in my immediate dismissal.

My signature below certifies that I have read and understand the above statement.

Signature: _____ Date: _____

Witness: _____ Date: _____