PRE-HIRE FORMS

EMPLOYMENT APPLICATION

Availability: check all that you could work

Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐

Date of Application: _____ Date Available for Employment: _____

Position Applying for: _____

Type of Employment Desired:
☐ Per Diem Number of Hours: _____
☐ Part Time Number of Hours: _____
☐ Full Time Number of Hours: _____

_____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL

_____ _____ _____ _____
MAILING ADDRESS CITY STATE ZIP CODE

_____ _____ _____
HOME PHONE NUMBER CELL PHONE NUMBER WORK PHONE NUMBER

_____ _____ _____
DOB SSN EMAIL ADDRESS

_____
LANGUAGE SKILLS OTHER THAN ENGLISH (WRITTEN/SPOKEN)

Have you ever been employed here before? ☐ Yes ☐ No If yes, when? _____
Are you legally eligible for employment in the US? ☐ Yes ☐ No
If not legal citizen: Do you have a green card? ☐ Yes ☐ No
Do you have a social security card? ☐ Yes ☐ No
Has your visa expired? ☐ Yes ☐ No

REFERRAL INFORMATION

How did you hear about us? (Please check)

Newspaper Ad _____ Internet _____
Which newspaper? Which site?

Current Employee _____
We'd like to thank them

Other _____

EMERGENCY CONTACT INFORMATION - Please Print Clearly

Name: _____

Relationship: _____

Home Phone Number: (_____) _____

Work Phone Number: (_____) _____

Cell Phone Number: (_____) _____

Signal Health Group Inc. is an equal opportunity employer. All applicants and employees are considered for employment, advancement, and development based upon their skills, performance and potential. No current or prospective employee will be discriminated against because of race, creed, color, gender, age, national origin, handicap or military status.

Employment History - *Please begin with your most recent or current place of employment.*

Place of Employment: _____ Start Date: _____

Address: _____ End Date: _____

Position: _____ Phone Number: _____

Supervisor: _____ Salary: _____

Reason for Leaving: _____ Final Salary: _____

Place of Employment: _____ Start Date: _____

Address: _____ End Date: _____

Position: _____ Phone Number: _____

Supervisor: _____ Salary: _____

Reason for Leaving: _____ Final Salary: _____

Place of Employment: _____ Start Date: _____

Address: _____ End Date: _____

Position: _____ Phone Number: _____

Supervisor: _____ Salary: _____

Reason for Leaving: _____ Final Salary: _____

Education Name & Location Course of Study Years Completed Date Graduated

High School: _____

College: _____

Other: _____

Other: _____

Military Service

Branch of Service: _____ Dates of Service: _____

Highest Rank Achieved: _____ Currently in a Reserve Unit? ☐ YES ☐ NO

Special Schooling and/or Duties: _____

Licenses and Certifications

	License or Certification	ID Number	Expiration Date	State
1.				
2.				
3.				

Criminal History- By my signature below, I acknowledge/consent to a criminal check on my name.

Have you ever been convicted of violating any law? (Please omit minor traffic violations.)

☐ Yes ☐ No If yes, please list conviction(s), date(s) and location(s). The presence of a criminal record is not an automatic rejection of your application. Certain types of convictions will eliminate you from servicing vulnerable elders in their homes. I attest that the above referenced information is true and accurate to the best of my knowledge. I further give the Agency permission to call any of my cited previous employers or reference candidate for information regarding my character, employment history or work ethics.

_____ _____

Employee Candidate Signature Date

Pre-Hire Home Health AIDE Read/Write/Report Competency

Signal Health Group Inc.

❑ **SECTION A** writing	**** Ask the Applicant to fill in the following 4 lines.**
Name:	
Position Applying for:	
Today's Date:	
Agency Name:	
❑ **SECTION B** reading	**** Ask the Applicant to read aloud the following:**

Mary is my patient who I see every week on Monday and Thursday. Mary's plan of care includes assist with bathing, blood pressure, and reporting all skin changes to the nurse. One day you go to her home and find Mary eating an apple for lunch and when assisting her with bathing, you see a large open cut on her leg you had not seen before.

❑ **SECTION C** verbally report clinical changes	**** Ask the Applicant the following 2 questions & record the answers:**
Is there anything you need to report about Mary:	
Who will you report this to:	

TO BE COMPLETE BY AGENCY PRE-HIRE STAFF:

SCORE (indicate 1 or 2 score for A, B & C)

Section A Score: 1. Completed 2. Unable to complete: _____

Section B Score: 1. Able to read 2. Unable to read: _____

Section C Score:

1. ID item to report & to whom 2. Unable to determine what/to whom to report clinical changes:_____

**** Must have all "1"s for hire.

Agency Hiring Staff Signature_____ Date_____

AGENCY EMERGENCY HIRE AFFIDAVIT

I HAVE NOT BEEN CONVICTED OF ANY OF THE FOLLOWING PENAL CODE OFFENSES, WHICH MAY POTENTIALLY BAR EMPLOYMENT.

I ACKNOWLEDGE THAT IF I AM FOUND TO HAVE BEEN CONVICTED OF ANY OTHER OFFENSES, THEY MAY CAUSE MY EMPLOYMENT TO BE TERMINATED. I UNDERSTAND THAT ALL INFORMATION OBTAINED BY THIS AGENCY REGARDING ANY CRIMINAL HISTORY WILL REMAIN CONFIDENTIAL. I CERTIFY THAT THE INFORMATION ON THIS FORM CONTAINS NO WILLFUL MISREPRESENTATION AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

SIGNATURE OF APPLICANT DATE

_____

APPLICANT'S PRINTED NAME

IF ARRESTED / CONVICTED OF ANY OFFENSE LISTED, PLEASE PROVIDE EXPLANATION:

_____

_____

_____

_____

_____

_____ _____

SIGNATURE OF APPLICANT DATE

INDIANA
CRIMINAL ATTESTATION FORM

I, , acknowledge that a criminal check is being conducted with respect to my employment application. I understand that:

1. If the criminal check shows that I have been convicted of any of the felonies listed below under Part I, I will not be offered employment.
2. If the criminal check shows that I have been convicted of any of the felonies listed below under Part II in the past ten years, I will not be offered employment.
3. I understand also that searches of various website will be undertaken, to include Nurse' Registries, National Sex Offender Registry and the OIG's exclusion list. If I appear in any of these registries as being unsuitable for hire, I will not be offered employment.

PART I DISQUALIFYING OFFENSES
Rape as defined in IC 35-42-41
Criminal Deviate Conduct as defined in IC 35-42-4-2 (includes crimes of violence)
Exploitation of an endangered adult as defined in IC 35-46-1-12
Failure to report battery, neglect, or exploitation of an endangered adult as defined in IC 35-46-1-13.
A felony that is substantially equivalent to a felony listed above in another state.

PART II DISQUALIFYING UNLESS TEN (10) YEARS HAVE PASSED FROM THE DATE OF CONVICTION
Theft as defined in IC 35-43-4
A felony that is substantially equivalent to a felony listed above in another state.

PRINTED NAME:	
ANY ALIAS USED:	
SIGNATURE:	
DATE:	

DUE TO THE LACK OF SUFFICIENT PERSONNEL TO ADEQUATELY AND SAFELY CARE FOR OUR PATIENTS NEEDS, WE ARE HIRING _____. HE/SHE HAS CONSENTED TO A CRIMINAL HISTORY CHECK TO BE PERFORMED AS PART OF OUR HIRING PROCESS. DURING THE WAITING PERIOD ON THE CRIMINAL HISTORY CHECK, THIS DOCUMENT WILL SERVE AS AN ACKNOWLEDGEMENT THAT THE ABOVE-NAMED PERSON STATES THAT THEY HAVE NO CONVICTION OF AN OFFENSE WHICH WOULD BAR EMPLOYMENT.

REFERENCE FORM #1

First and Last Name: _____

Company Name: _____

Address: _____

Phone & Fax Number: _____

The individual listed below has applied for a position with Signal Health Group Inc.

Name: _____ Social Security # _____

The position being applied for is: _____

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: _____ Date of Signature: _____

THIS SECTION TO BE COMPLETED BY PERSON COMPLETING THIS REFERENCE

Employment dates: From _____ to _____ Position: _____

Reason for separation: _____

Would you rehire? _____ If no, why not? _____

Comments: _____

_____

_____ _____

Signature/Title of Reference Date

REFERENCE FORM #2

First and Last Name: _____

Company Name: _____

Address: _____

Phone & Fax Number: _____

The individual listed below has applied for a position with Signal Health Group Inc.

Name: _____ Social Security # _____

The position being applied for is: _____

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: _____ Date of Signature: _____

THIS SECTION TO BE COMPLETED BY PERSON COMPLETING THIS REFERENCE

Employment dates: From _____ to _____ Position: _____

Reason for separation: _____

Would you rehire? _____ If no, why not? _____

Comments: _____

_____

_____ _____

Signature/Title of Reference Date

CORPORATE COMPLIANCE POLICY ACKNOWLEDGEMENT FORM

*Must be signed by all employees

CORPORATE COMPLIANCE POLICY ACKNOWLEDGEMENT

Our Home Care Agency is committed to providing the highest ethical health care and upholding conduct standards and corporate legal compliance.

Our policies and Corporate Compliance Plan clearly support a 'zero' tolerance to any form of fraud or misconduct. This applies to all employees, direct and contracted, regardless of position or title.

I, as an employee of the Agency, acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.

SIGNAL HEALTH GROUP, INC.

EMPLOYEE'S PRINTED NAME**:** _____

EMPLOYEE'S SIGNATURE**:** _____

DATE**:** _____

AUTOMOBILE USE AGREEMENT

This agreement is made this _____ day of _____, 20_____ between the Agency and _____ referred to hereinafter as "Applicant". The duties to be performed by Applicant will require the use of an automobile. The following are the conditions governing automobile use by Applicant:

Use of Insurance Coverage of an Applicant's Automobile:

Applicant shall furnish Applicant's own automobile to perform the duties required under this Agreement and shall keep it maintained and repaired in good driving condition. Applicant shall maintain insurance on the automobile according to minimum amounts specified by the State of Indiana. Applicant certifies by signing below that they currently have and will continue to maintain legal automobile coverage while employed with the Agency and using their car to transport Agency clients.

Release from Liability:

In consideration of working on an Agency assignment, Applicant assumes all risk of accidents or casualties, arising from or related in any way to automobile use by Applicant pursuant to this Agreement. Applicant, Applicant's heirs, executors, administrators and legal representatives, forever releases, acquits and discharges the Agency from all such claims for liability of any nature or character, including property damage, applicant injury and/or death, presented by any applicant(s) claiming injury, including Applicant or agency's clients. In addition, Applicant certifies by signing this agreement that they will not drive an Agency client's vehicle without having the client sign an Agency liability waiver.

In witness of the above, each part to this agreement has caused it to be executed in Indiana on the date indicated below.

Witness:

_____

Signature and Title

_____

Print Name

_____

Date

Applicant:

_____

Signature

_____

Print Name

_____

Date

EMPLOYEE CONSENT FOR INSURANCE VERIFICATION

To Whom it May Concern:

I give _____, my insurance broker, authorization to release to my employer the following information:

1. Automobile insurance policy information.
2. Copies of automobile policies and certificates of insurance.

I also give authorization to advise my employer of any changes in my automobile insurance.

I am aware and acknowledge the information referred to above is not shared with any third parties except the employer if requested at any time for audit. The information is used by the employer to confirm adequate and proper insurance coverage of my automobile while being used during the course of my employment. By signing below, I give the employer consent to collect the information contained herein and use for the purpose specified. By signing below, I also give my consent to my insurance broker to provide the employer with above-mentioned information.

SIGNATURE: _____

PRINT NAME: _____

ADDRESS: _____

_____

STATEMENT OF DRIVING STATUS

CHECK ONE OPTION BELOW:

I, _____, am currently licensed to drive a motor vehicle in the state of INDIANA,

I carry auto insurance on my vehicle, and I have supplied Signal Health Group, Inc. a current copy of my license and auto insurance.

I, _____, declare that I do not have a driver's license in the state of INDIANA and therefore will find other forms of transportation to get to my scheduled visits (i.e. public transportation).

_____ _____

Signature Date

AVAILABILITY LIST

EMPLOYEE NAME: _____

PHONE NUMBER: _____ DOH: _____

AVAILABLE	FROM	TO
Mon		
Tues		
Weds		
Thurs		
Fri		
Sat		
Sun		
List towns you are willing to travel to:		

APPLICANT AUTHORIZATION FOR DIRECT DEPOSITS

SIGNAL HEALTH GROUP, INC.

This authorizes Signal Health Group to send credit entries electronically, or by any other commercially accepted method, to my (our) account(s) indicated below, and to other accounts I (we) identify in the future. This authorizes the financial institution holding the account to post all such entries.

ACCOUNT TYPE:

☐ Checking ☐ Savings

BANK NAME: _____ BRANCH: _____

CITY: _____ STATE: _____

BANK ROUTING # (ABA #): _____

ACCOUNT #: _____

This authorization will be in effect until Signal Health Group receives a written termination notice from myself and has a reasonable opportunity to act on it.

_____ _____

Signature Printed Name

_____

Date

ATTACH VOIDED CHECK HERE

SOCIAL MEDIA POLICY

At Signal Health Group Inc., we understand that social media can be a fun and rewarding way to share your life and opinions with family, friends and co-workers around the world. However, use of social media also presents certain risks and carries with it certain responsibilities. To assist you in making responsible decisions about your use of social media, we have established these guidelines for appropriate use of social media.
This policy applies to all personnel, direct hire or contracted, who provide care and services on behalf of Signal Health Group Inc. to patients on our service.
To be in compliance of HIPAA regulations, it is the policy of our Agency, that, at no time, shall any type of patient information of any kind, be included in any social media utilized by Agency staff.

PROCEDURES:

In the rapidly expanding world of electronic communication, social media can mean many things. Social media includes all means of communicating or posting information or content of any sort on the Internet, including to your own or someone else's web log or blog, journal or diary, personal web site, social networking or affinity web site, web bulletin board or a chat room, whether or not associated or affiliated with Signal Health Group Inc. , as well as any other form of electronic communication.
Before creating online content, consider some of the risks and rewards involved. Keep in mind that any of your conduct that adversely affects your job performance, the performance of fellow associates or otherwise adversely affects members, customers, suppliers, people who work on behalf of Signal Health Group Inc. or the legitimate business interests of Signal Health Group Inc. , or violated any HIPAA privacy laws, may result in disciplinary action up to and including termination.
Carefully read these guidelines, our Agency Ethics Policy, HIPAA Information, and Discrimination Policy, and ensure all of your postings are consistent with these policies. The same principles and guidelines found in our policies and three basic beliefs apply to your activities online:

- **BE Fair**
- **BE Respectful**
- **BE Honest**

Be Respectful
Inappropriate postings that may include discriminatory remarks, harassment, and threats of violence or similar inappropriate or unlawful conduct will not be tolerated and may subject you to disciplinary action up to and including termination. **Online discrimination and harassment is prohibited**.

Be Fair
Always be fair and courteous to fellow associates, customers, members, suppliers or people who work on behalf of Signal Health Group Inc. . Also, keep in mind that you are more likely to resolved work-related complaints by speaking directly with your co-workers or by utilizing our Open Door Policy, than by posting complaints to a social media outlet. Nevertheless, if you decide to post complaints or criticism, avoid using statements, photographs, video or audio that reasonably could be viewed as malicious, obscene threatening or intimidating, that disparage customers, members, associates or suppliers, or that might constitute harassment or bullying or violate any HIPAA laws. Examples of such conduct might include offensive posts meant to intentionally harm someone's reputation or posts

that could contribute to a hostile work environment on the basis of race, sex, disability, religion or any other status protected by law or company policy.

Be Honest & Accurate

Make sure you are always honest and accurate when posting information or news, and if you make a mistake, correct it quickly. Be open about any previous posts you have altered. Remember that the Internet archives almost everything; therefore, even deleted postings can be searched. Never post any information or rumors that you know to be false about Signal Health Group Inc. , fellow associates, members, customers, suppliers, or people working on behalf of our Agency or competitors. And NEVER about clients or patients of our Agency. To do so is in violation of HIPAA privacy laws.

SOCIAL MEDIA GUIDANCE

Maintain the confidentiality of our Agency private & confidential information. This may include information regarding the development of systems, processes, products, know-how and technology and any & all patient information. Do not post internal reports, policies, procedures or other internal business-related confidential communications.

Respect financial disclosure laws. It is illegal to communicate or give a "tip" on inside information to others so that they may buy or sell stocks or securities. Such online conduct may also violate the Insider Trading Policy.

Do not create a link from your blog, website or other social networking site to a Signal Health Group Inc. website without identifying yourself as a Signal Health Group Inc. associate.

Express only your personal opinions. Never represent yourself as a spokesperson for Signal Health Group Inc. . If our Agency is a subject of the content you are creating, be clear and open about the fact that you are an associate and make it clear that your views do not represent those of Signal Health Group Inc. , fellow associates, members, customers, suppliers or people working on behalf of our Agency. If you do publish a blog or post online related to the work you do, make it clear that you are not speaking on behalf of Signal Health Group Inc. . It is best to include a disclaimer such as "The postings on this site are my own and do not necessarily reflect the views of Signal Health Group Inc.."

Refrain from using social media while on work time or on equipment we provide, unless it is work-related as authorized by your manager or consistent with the Company Equipment Policy. Do not use Signal Health Group Inc. email addresses to register on social networks, blogs or other online tools utilized for personal use.

Retaliation is prohibited. Signal Health Group Inc. prohibits taking negative action against any associate for reporting a possible deviation from this policy or for cooperating in an investigation. Any associate who retaliates against another associate for reporting a possible deviation from this policy or for cooperating in an investigation will be subject to disciplinary action, up to and including termination.

Media contacts. Associates should not speak to the media on Signal Health Group Inc. 's behalf without contacting the Administrator. All media inquiries should be directed to them.

EMPLOYEE SIGNATURE: _____ DATE: _____

DRESS CODE

Employee dress should be neat in appearance. Our Agency employees are invited to dress "business casual" in a manner consistent with a professional atmosphere. The impression made on customers, visitors and other employees and the need to promote company and employee safety should be kept in mind.

Our Agency requires it's field staff to wear scrubs. Scrubs both present a professional "medical" image and protect your good clothes from damage and/or wear. Our Agency does not replace clothing damaged from normal on the job usage while providing home care services to our patients.

All field staff must wear their Agency picture ID badge on their person while making home visits. Should your ID be lost or damaged it is your responsibility to come to the office for a replacement.

EMPLOYEE SIGNATURE: _____ DATE: _____

SEXUAL HARASSMENT

Our Agency will not allow any form of sexual harassment within the work environment.
Sexual harassment interferes with work performance and creates an intimidating, hostile or offensive work environment. Sexual harassment influences or tends to affect the career, salary, working conditions, responsibilities, duties or other aspects of career development of an employee or prospective employee. It will not be tolerated.

Sexual harassment, as defined in this policy, includes, but is not limited to, sexual advances, verbal or physical conduct of a sexual nature, visual forms of a sexual or offensive nature (e.g., signs and posters) or requests for sexual favors.

Any intentional sexual harassment is considered to be a major violation of company policy and will be dealt with accordingly by corrective counseling and/or suspension or termination, depending upon the severity of the violation.

- Sexual Abuse/Harassment: Our Agency prohibits and has a zero tolerance Policy for sexual abuse in the workplace or in any organizational related activity bu anyone associated in any way with the Agency. The organization provides procedures for employees, volunteers, family members, board members, patients, victims of sexual abuse, or others to report sexual abuse and disciplinary penalties for those who commit such acts. No employee, volunteer, patient or third party, no matter his or her title or position hasthe authority to commit or allow sexual abuse.

Reporting of Suspected Sexual Abuse: If you are aware of or suspect sexual abuse taking place, it must be immediately reported to the Administrator or another person designated such as a human resource person. If the suspected abuse is to an adult, it shall be reported to the state Adult Protective Services Agency. If it is a child who is the victim it should be reported to the state Child Abuse Agency or you can call the Child Help's National Child Abuse Hotline, 1-800-422-4453. Appropriate family members should be notified of alleged instances of sexual abuse.
The Agency shall also report the alleged sexual abuse incident to their insurance agent.

ANTI-RETALIATION

Signal Health Group Inc. prohibits retaliation made against any employee, volunteer, board member or patient who reports a good faith complaint of sexual abuse or who participates in any related investigation. Making false accusations of sexual abuse in bad faith can have serious consequences for those who are wrongly accused. Our Agency prohibits making false and/or malicious sexual abuse allegations, as well as deliberately providing false information during an investigation. Anyone who violates this rule is subject to disciplinary action, up to and including termination.

Investigation and Follow Up:

Signal Health Group Inc. will take all allegations of sexual abuse seriously and will promptly and thoroughly investigate whether sexual abuse has taken place. The organization will use an outside third party to conduct an investigation. If the organization has a trained internal investigation team in place, the team will be used to investigate the incident. We will cooperate fully with any investigation conducted by law enforcement or other regulatory agencies. It is the organization's objective to conduct a fair and impartial investigation. The Agency provides notice that they have the option of placing the accused on a leave of absence or on a reassignment to non-patient contact.

The organization will make every reasonable effort to keep the matters involved in the allegation as confidential as possible while still allowing for a prompt and thorough investigation.

ILLEGAL DRUG ABUSE / ALCOHOL ABUSE

This policy is implemented because we believe that the impairment of any of our Agency's employees, due to his or her use of illegal drugs or due to alcohol abuse, is likely to result in the risk of injury to patients, other employees, the impaired employee, or to third parties, such as customers or business guests. Moreover illegal drug abuse adversely affects employee morale and productivity.

"Impairment" or "being impaired" means that an employee's normal physical or mental abilities or faculties while at work have been detrimentally affected by the use of illegal drugs or alcohol.

The employee who begins work while impaired or who becomes impaired while at work is guilty of a major violation of company rules and is subject to severe disciplinary action. Severe disciplinary action can include suspension without pay, dismissal or any other penalty appropriate under the circumstances. Likewise the use, possession, transfer or sale of any illegal drugs on company premises or in any Agency storage area or job site is prohibited. Employees who violate this rule are subject to severe disciplinary action including termination. In all instances disciplinary action to be administered shall be at the sole discretion and determination of the company.

When an employee is involved in the use, possession, transfer or sale of illegal drugs in violation of this policy, the company may notify appropriate authorities. Such notice will be given only after such an incident has been investigated and reviewed by the employee's supervisor and the HR director. Our Agency is aware that illegal drug abuse is a complex health problem that has both physical impact and an emotional impact on the employee, his or her family, and social relationships. A drug abuser is a person who uses illegal drugs, as defined above, for non medical reasons, and this use affects job performance detrimentally or interferes with normal social interaction at work. Illegal drug abuse is both a management and a medical problem.

A supervisor/manager who suspects a drug or alcohol abuse case should discuss the situation immediately with his or her Administrator. Because each case is usually different, the handling and referral of the case must be coordinated with the supervisor/manager and the personnel director.

Applicants who have a past history of substance abuse (SA) and who have demonstrated an ability to abstain from the substance, or who can provide medical assurance of acceptable control, may be considered for employment as long as they are otherwise qualified for the position for which they are applying. The Home Health setting is more problematic for past/present history of SA as elders frequently have many medications in their home and Home Health workers generally are alone in the home with the patient increasing the temptation factor. Due to this aspect of our industry, our Agency must have more than the usual "medical assurance of control" over SA. Our Agency will not schedule a worker with a history of SA for 6 months after "medical assurance of control" over SA is received by our office. In this case, the employee enters an unpaid leave of absence status until the 6 month benchmark is achieved. The assignment of cases at this point will occur once a second "continued medical assurance of control" over SA is received by the employee's private MD. Our Agency does not pay for medical care to achieve the status of "medical assurance of control" over SA.

Management has chosen to adopt an alcoholic beverage policy in keeping with the concern for and the risks associated with alcohol use. Alcoholic beverages shall not be served or used on the Agency's premises at any time. Alcoholic beverages shall not be used in conjunction with any company business meeting. Our Agency enforces strict policy related to alcohol and its patients:

1. employee may not purchase alcohol for any patient of any age group
2. employee may not engage socially with an Agency patient at a function where alcohol is being served
3. employee may never function in the capacity of "designated driver" for a patient

Social activities held off-premises and paid for on a personal basis are not affected by this policy. If management considers it appropriate, light alcoholic beverages may be served at company-sponsored events held off-premises and for purely social reasons. The service must be managed in good taste and with good judgment.

The company is concerned with its employee's privacy, especially when matters regarding medical and personal information are involved. As long as the information is not needed for police or security purposes, the company shall maintain employee medical and personal information in confidence and release this information to authorized company personnel on a "need to know" basis. An exception to this policy is when the employee signs a release for the transfer of such information on forms acceptable to the company to designated persons or agencies.

Nothing contained in this section shall eliminate or modify the company's right to terminate any employee at any time for any reason.

EMPLOYEE SIGNATURE: _____ DATE: _____

1.2 Calling Tree Protocol for Emergency Events

Policy Number: EP: 1.2
Effective Date: 1/2019

POLICY:

As part of our Agency Emergency Preparedness Plan, our Agency will create & maintain an Agency Calling Tree to be utilized should our Emergency Preparedness Plan be activated.

PROCEDURE:

The Emergency Disaster Coordinator will oversee the creation of the Agency Emergency Calling Tree.

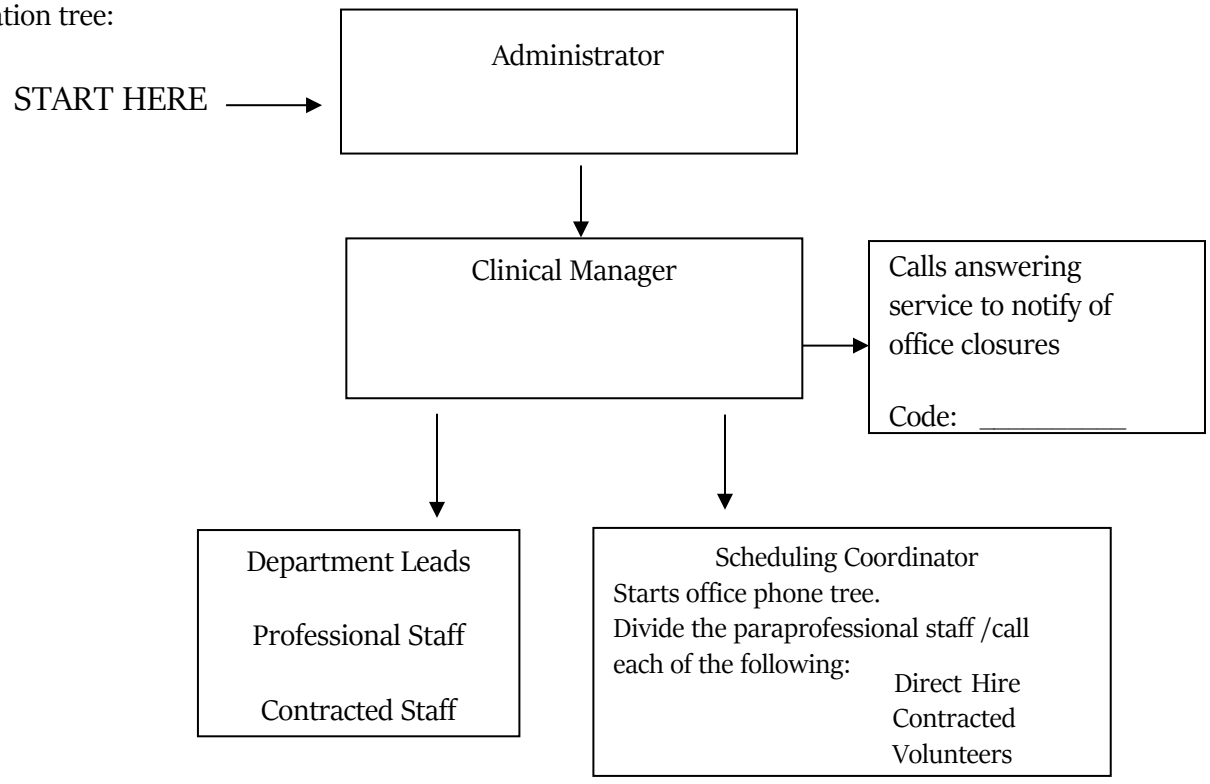
The calling tree will be part of the Agency Emergency Preparedness Plan and be updated at least annually or as needed.

Signal Health Group Inc.

Emergency Calling Tree

The Administrator makes the decision to close offices due to emergency situation.
Weather and Other Emergencies:

Notification tree:



EMPLOYEE SIGNATURE: _____ DATE: _____