

Employment History

List all work experience beginning with your current or most recent position.

❖ Company _____ Employed from _____ to _____

Address _____

Supervisor/Title _____

Telephone _____ May we contact the employer? Yes No

Your Title _____ Reason for leaving _____

Description of Responsibilities _____

❖ Company _____ Employed from _____ to _____

Address _____

Supervisor/Title _____

Telephone _____ May we contact the employer? Yes No

Your Title _____ Reason for leaving _____

Description of Responsibilities _____

❖ Company _____ Employed from _____ to _____

Address _____

Supervisor/Title _____

Telephone _____ May we contact the employer? Yes No

Your Title _____ Reason for leaving _____

Description of Responsibilities _____

Personal References

List three individuals able to give character references. You should include former employers or school administrators, but not relatives.

❖ Name _____

Work Phone _____ Cell phone _____

Address _____

Occupation _____ Relationship to Applicant _____

❖ Name _____

Work Phone _____ Cell phone _____

Address _____

Occupation _____ Relationship to Applicant _____

Emergency Contacts

Name of emergency contact: _____

Relationship: _____ Phone #: _____

Name of emergency contact: _____

Relationship: _____ Phone #: _____

IMPORTANT- PLEASE NOTE

If you are offered a position at Ambiance Home Health Care, Inc., we will need your signature authorizing a criminal background check.

Statement of Purpose

I certify that my application and all attachments are true and complete to the best of my knowledge. I understand that any incorrect, incomplete, or false statements of information furnished by me may, at the discretion of Ambiance Home Health Care, Inc., disqualify me from employment, or cause my dismissal. I hereby authorize Ambiance Home Health Care, Inc., to make a thorough investigation of my past employment and activities. I release from liability Ambiance Home Health Care, Inc., former employers, or any persons supplying such information. The language in the application is not intended to create, nor is it to be misconstrued to constitute a contract of employment.

Signature: **X** _____ Date: _____

YOU ARE WELCOME TO ATTACH A RESUME OR OTHER INFORMATION IF YOU FEEL IT WILL GIVE US FURTHER INSIGHT INTO YOUR QUALIFICATIONS.



Ambiance Home Health Care, Inc.

7815 N. Dale Mabry Hwy Suite 210
Tampa, FL 33614
Phone:(813) 966-6060
Fax:(813) 793-4684

EMPLOYMENT VERIFICATION

ATTENTION: Human Resources / Verifications Department

COMPANY: _____

FAX/EMAIL: _____

Name: _____

Social Security Number: XXX-XX-_____ DOB: _____

****PLEASE COMPLETE THE FOLLOWING:**

Job Title: _____

Start date: _____ **Separation date:** _____

Verified by (printed name): _____

Signature: _____

Title: _____ **Date:** _____

Thank you for your cooperation and prompt attention to this matter. Have a wonderful day!

Please return by fax to (813) 793-4684. Results can also be emailed to
inbox@ambiancehomehealthcare.net.



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Orientation

- Agency Mission, Philosophy, Vision and Plan and Organizational Chart
- TB / Advance Directives
- Types of Care Provided by the Agency including Information Provided to Clients Regarding Charges
- Policies and Procedures / HIPAA
- Personnel Policies
- Job Descriptions
- Handbook/Professional Boundaries of All Disciplines
- Training Specific to Job Descriptions, i.e. equipment
- Cultural diversity
- Ethics, Conflict of Interest and Confidentiality of Patient Information
- Client Rights/ Responsibilities and Grievance Policy
- Supervision and Evaluation
- Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)
- Safety Issues in the Home (Including Security/ fire prevention and Guns in the Home)
- Emergency Preparedness Plan/Actions to Take in the Event of a Disaster
- Actions to Take in Unsafe Situations
- OSHA Requirements, Safety and Infection Control in the Home/Standard Precautions
- Patient Care Responsibilities Including Charges for Service/Care
- Incidences, variance and Occurrences reporting.
- Completion of In-services required at orientation
- Identifying and Reporting Abuse, Neglect, and Exploitation
- Understanding and coping with Alzheimer's Disease and Dementia
- Community Resources
- Exposure Control Plan
- Medicare/Fraud/Abuse/Corporate Compliance, False Claims, False Statements, Whistle Blowing
- Documentation - Record Keeping including OASIS
- Quality Assurance and Corporate Compliance training
- Communications Barriers
- Outcomes and Assessment Information Set (OASIS) and other required documents
- Medical Device/Hazards reporting
- Accreditation/ Regulatory Bodies and requirements
- Corporate compliance
- ID Badge Issued

I have received orientation on the topics listed above.

Name: _____

Signature: _____

Date: _____

Standards and Procedures

This Agency requires adherence to the following Standards and Procedures:

1. All employees/contractors are expected to dress in a manner appropriate to the healthcare environment, or as directed by the patient/client/family. This includes personal hygiene, jewelry, hair and makeup.
2. Please do not smoke in the presence of a patient/client.
3. Always wear your ID Badge. Licensed personnel must always carry their current nursing license and CPR card while on assignment.
4. You are expected to arrive on time to all assignments that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have a problem, incident on the job, do not discuss it with the patient/client, but call the Agency immediately.
6. If the patient/client asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS DISPENSE OR ADMINISTER ANY MEDICATION.**
8. **UNDER NO CIRCUMSTANCES** are you to ask for, or accept any money from your patient/client to take home property that belongs to the patient/client.
9. There shall not be any involvement with the patient/client's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient/client information which is obtained in the regular course of employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with the patient/client/family.
13. As an employee/contractor of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family.
14. It is imperative that all signed notes and documentation be filled out properly and returned to the office as per policy. If the patient/client is unable to sign your note. A family member or responsible party may sign.
15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.
16. Never leave your patient/client unattended.

Policies and Procedures

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the Policy.

I understand that the information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees/contractors, it is not an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meetings and in-service training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIC, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide the identity of the individual is not disclosed. I understand the violation of client/employee confidentiality is subject to civil and criminal penalties.

I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an " At Will " organization and may hire and fire at will.

Confidentiality of Protected Health Information

It is both the Agency's and the employee's/contractor's responsibility to ensure that every patient's health information is protected at all times. By signing below you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health information will be provided to you upon hire.

I understand that I may be handling Protected health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Protection of Health Information

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.
- Patient Protected health Information will be returned to the agency upon acknowledgment of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Confidentiality and Non-Competition Agreement

The Agency requires that the Employee/Contractor avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee/Contractor agrees to refrain from prohibited competition with Agency and to maintain the confidentiality of information regarding employees, clients, and the Agency business.

The Employee/Contractor will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The Employee/Contractor is prohibited from disclosing any degaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee/Contractor is prohibited from engaging in any of the following: induce any Employee/Contractor of the Agency to resign, encourage any client or entity to discontinue any relationship with the Agency, solicit any client of the Agency (current and within the past twelve month period). Enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals, or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee/Contractor is required to return all of the Agency's property including keys, client records, forms, etc. to the Agency.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency. Employee/Contractor will be required to reimburse the Agency for all legal fees, costs, and other expenses.

This agreement is in effect during the Employee/Contractor's employment and for twelve months thereafter. It does not modify the right of the Employee/Contractor to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

Personal Protective Equipment for Safety and Infection Control

I understand a Personal Protective Equipment {PPE Kit} is available in the office and contains the following:

- Barrier Safety Goggles
- CPR Shield Face Barrier
- Fluid Resistant Gown
- Gloves
- Sharps Container
- Biohazard Bag
- Fitted respirator/ 3m8511 n98 5-10479 (Purchased from uline 800-295-5510)

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Hepatitis

I understand that my job may put me at risk to be exposed to blood and other possibly infectious body fluid substances. These substances may put me at risk for the Hepatitis virus (HBV).

I understand that I can get vaccinated with the Hepatitis vaccine by contacting my physician.

I acknowledge that I am at risk of exposure and it is my decision to HOLD HARMLESS THE AGENCY. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease.

Job Acceptance

I have read, understand and agree to the terms specified in this job description for the position I presently hold a copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Printed Name _____

Signature **X** _____ Date _____



Direct Deposit Agreement Form

Please indicate if this is a new request or a change:

Date: _____

New

Change

Authorization Agreement

I hereby authorize **Ambiance Home Health Care, Inc.** to initiate automatic deposits to my account at the financial institution named below. If every **Ambiance Home Health Care, Inc.** to withdraw the overpayment after notifying me.

Further, I agree not to hold **Ambiance Home Health Care, Inc.** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Ambiance Home Health Care, Inc.** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit to **Ambiance Home health Care, Inc.** Employees/Contractors must fill out all the information below and submit it with a copy of a voided check or deposit slip.

Account Information

Name of Financial Institution: _____

Name & Address of Financial Institution _____

Routing Number: _____ Checking Savings

Account Number: _____

Email Address for Notification of Deposit _____

Signature

Print Name: _____

Authorized Signature **X** _____

Please return this form to:

**Ambiance Home Health Care, Inc.
7815 N. Dale Mabry Hwy Suite 210
Tampa, FL 33614
Fax: (813) 793-4684**

**Request for Taxpayer
Identification Number and Certification**
Go to www.irs.gov/FormW9 for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)		
	2	Business name/disregarded entity name, if different from above.		
	3a	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes.		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ <i>(Applies to accounts maintained outside the United States.)</i>
	<input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____			
	3b	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions <input type="checkbox"/>		
	5	Address (number, street, and apt. or suite no.). See instructions.		Requester's name and address (optional)
	6	City, state, and ZIP code		
7	List account number(s) here (optional)			

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number																				
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Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they



Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
<p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. An alien authorized to work until (exp. date, if any)						
If you check Item Number 4., enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative
		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

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



ATTESTATION OF COMPLIANCE with Background Screening Requirements

Authority: This form may be used by all employees to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:

Health Care Provider/ Employer Name:

Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for and been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

- (a) Section 39.205, relating to the failure to report child abuse, abandonment, or neglect.
- (b) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (c) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (d) Section 414.39, relating to fraud, if the offense was a felony.
- (e) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (g) Section 782.04, relating to murder.
- (h) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
- (i) Section 782.071, relating to vehicular homicide.
- (j) Section 782.09, relating to killing of an unborn quick child by injury to the mother.
- (k) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (l) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (m) Section 784.03, relating to battery, if the victim of the offense was a minor.

- (n) Section 787.01, relating to kidnapping.
- (o) Section 787.02, relating to false imprisonment.
- (p) Section 787.025, relating to luring or enticing a child.
- (q) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (r) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (s) Section 787.06, relating to human trafficking.
- (t) Section 787.07, relating to human smuggling.
- (u) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (v) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (w) Section 794.011, relating to sexual battery.
- (x) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (y) Section 794.05, relating to unlawful sexual activity with certain minors.
- (z) Chapter 796, relating to prostitution.
- (aa) Section 798.02, relating to lewd and lascivious behavior.
- (bb) Chapter 800, relating to lewdness and indecent exposure.
- (cc) Section 806.01, relating to arson.
- (dd) Section 810.02, relating to burglary.
- (ee) Section 810.14, relating to voyeurism, if the offense is a felony.
- (ff) Section 810.145, relating to video voyeurism, if the offense is a felony.
- (gg) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
- (hh) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
- (ii) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

- (jj) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- (kk) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
- (ll) Section 826.04, relating to incest.
- (mm) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
- (nn) Section 827.04, relating to contributing to the delinquency or dependency of a child.
- (oo) Former s. 827.05, relating to negligent treatment of children.
- (pp) Section 827.071, relating to sexual performance by a child.
- (qq) Section 831.311, relating to the unlawful sale, manufacture, alteration, delivery, uttering, or possession of counterfeit-resistant prescription blanks for controlled substances.
- (rr) Section 836.10, relating to written or electronic threats to kill, do bodily injury, or conduct a mass shooting or an act of terrorism.
- (ss) Section 843.01, relating to resisting arrest with violence.
- (tt) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- (uu) Section 843.12, relating to aiding in an escape.
- (vv) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
- (ww) Chapter 847, relating to obscene literature.
- (xx) Section 859.01, relating to poisoning food or water.
- (yy) Section 873.01, relating to the prohibition on the purchase or sale of human organs and tissue.
- (zz) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.
- (aaa) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
- (bbb) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
- (ccc) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- (ddd) Section 944.40, relating to escape.

(eee) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(fff) Section 944.47, relating to introduction of contraband into a correctional facility.

(ggg) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(hhh) Section 985.711, relating to contraband introduced into detention facilities.

(iii) Section 435.04(3), The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photo-optical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

- I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).

Date of Decision: _____

- I have been granted an Exemption from Disqualification through the Florida Department of Health.

Date of Decision: _____

****A copy of the Exemption from Disqualification decision letter must be attached****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years by the Department of Financial Services and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature

Title

Date



Ambiance Home Health Care, Inc.

7815 N. Dale Mabry Hwy Suite 210
Tampa, FL 33614

Phone:(813) 966-6060

Fax:(813) 793-4684

Email: inbox@ambiancehomehealthcare.net

HEALTH STATEMENT

Today's Date: _____

In my opinion, based on my exam (Employee) _____,

is physically and mentally able to perform the duties of (Title) _____,

and appears to be free of and is not at risk of communicable diseases, including tuberculosis, which could be a potential threat to patients under the care of the company, other employees, or the employee him/herself.

Physician's Name

X _____
Physician's Signature

2-Step PPD/TB or Chest X-ray:

STEP 1 -

PPD/TB: MUST BE READ WITHIN 48-72 HOURS (RENEW ANNUALLY)

Test Date: _____ Negative: _____ *Positive: _____

Reading Date: _____ Read By: _____

STEP 2 -

PPD/TB: MUST BE READ WITHIN 48-72 HOURS (RENEW ANNUALLY)

Test Date: _____ Negative: _____ *Positive: _____

Reading Date: _____ Read By: _____

Chest X-Rays: PLEASE ATTACH RESULTS (RENEW EVERY 5 YEARS)

X- RAY Date: _____ Negative: _____ *Positive: _____



Personnel File Checklist

<input type="checkbox"/> Professional License	<input type="checkbox"/> Application/Resume
<input type="checkbox"/> CPR Card	<input type="checkbox"/> Employment Verification x2
<input type="checkbox"/> Driver's License	<input type="checkbox"/> Job Description
<input type="checkbox"/> Auto Insurance	<input type="checkbox"/> Orientation
<input type="checkbox"/> CEUs/Training	<input type="checkbox"/> Standards, Policies, Acknowledgements, & Procedures
<input type="checkbox"/> Social Security Card	<input type="checkbox"/> Direct Deposit Form
<input type="checkbox"/> Diploma/Transcripts	<input type="checkbox"/> W-9
	<input type="checkbox"/> I-9
	<input type="checkbox"/> Affidavit of Compliance w/Background Screening
	<input type="checkbox"/> Health Statement
	<input type="checkbox"/> TB/PPD/Chest X-Ray