

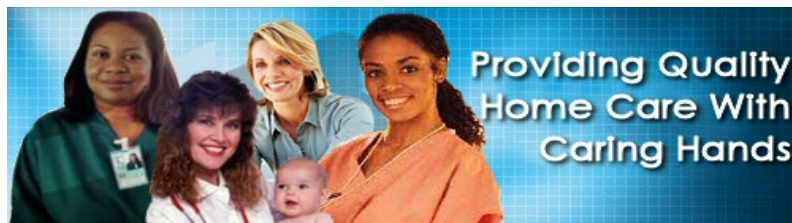


Caring Hands United, Inc.

Employment Application Part #1

DOCUMENTS NEEDED FOR YOUR APPLICATION

Clear Copy of Drivers' license
Copy Of Social Security Card
Copy Of Front and Back of current CPR Card
Copy Of Front and Back of current First Aide Card
Copy Of Front and Back of C. N. A. Card or DHR Letter
Copy of Most Recent (within a year) TB Skin Test



These items are to be submitted along with your completed application. If by chance you do not have everything, please let the HR Representative know so that you can receive further instruction. However we must have a copy of your driver's license, social security card, and C.N.A. certification before you can begin employment.

When filling out the application, leave no spaces blank. If you have questions about the content and you are unsure how to document, please call the office and we will be happy to assist you. Keep in mind that we cannot accept an application that is incomplete.

CARING HANDS UNITED, INC



YELLOW PAGES _____

JOB FAIR (WHERE) _____

NEWSPAPER _____

FAMILY / FRIEND / EMPLOYEE _____ NAME _____ PHONE# _____

NAME _____

ADDRESS _____

TEL # (1) _____ (2) _____

(3) _____ (4) _____

TYPE OF TRANSPORTATION CAR BUS OTHER _____

PLEASE INCLUDE ALTERNATIVE NUMBERS OR REFERENCES NUMBERS AT WHICH YOU COULD BE REACHED

TEL # (1) _____ (2) _____

AREAS WILLING TO WORK / TRAVEL

5-North East Ga.	3-Atlanta Region	4-Southern Crescent	8. Central Savannah Region	7- Middle Georgia	8 Heart of Georgia	12 .Costal
<input type="checkbox"/> Clark	<input type="checkbox"/> Fulton	<input type="checkbox"/> Butts	<input type="checkbox"/> Burke	<input type="checkbox"/> Bibb	<input type="checkbox"/> Laurens	<input type="checkbox"/> Bryan
<input type="checkbox"/> Walton	<input type="checkbox"/> De Kalb	<input type="checkbox"/> Carroll	<input type="checkbox"/> Columbia	<input type="checkbox"/> Baldwin	<input type="checkbox"/> Toombs	<input type="checkbox"/> Bullock
<input type="checkbox"/> Jackson	<input type="checkbox"/> Clayton	<input type="checkbox"/> Coweta	<input type="checkbox"/> Glascock	<input type="checkbox"/> Monroe	<input type="checkbox"/> Treutlen	<input type="checkbox"/> Chatham
<input type="checkbox"/> Greene	<input type="checkbox"/> Rockdale	<input type="checkbox"/> Heard	<input type="checkbox"/> Hancock	<input type="checkbox"/> Putman	<input type="checkbox"/> Wayne	<input type="checkbox"/> Chatham
<input type="checkbox"/> Newton	<input type="checkbox"/> Douglas	<input type="checkbox"/> Lamar	<input type="checkbox"/> Jenkins		<input type="checkbox"/> Pulaski	<input type="checkbox"/> Effingham
<input type="checkbox"/> Barrow	<input type="checkbox"/> Cobb	<input type="checkbox"/> Pike	<input type="checkbox"/> Jefferson		<input type="checkbox"/> Appling	<input type="checkbox"/> Glynn
<input type="checkbox"/> Elbert	<input type="checkbox"/> Fayette	<input type="checkbox"/> Spalding	<input type="checkbox"/> Lincoln	6-West Central	<input type="checkbox"/> Wheeler	<input type="checkbox"/> Liberty
<input type="checkbox"/> Madison	<input type="checkbox"/> Cherokee	<input type="checkbox"/> Upson	<input type="checkbox"/> Richmond	<input type="checkbox"/> Chattahoochee	<input type="checkbox"/> Johnson	<input type="checkbox"/> Long
<input type="checkbox"/> Wilcox	<input type="checkbox"/> Henry		<input type="checkbox"/> Wilkes	<input type="checkbox"/> Crisp	<input type="checkbox"/> Jeff Davis	<input type="checkbox"/> Mc Intosh
<input type="checkbox"/> Jasper	<input type="checkbox"/> Gwinnett	<input type="checkbox"/> Troup	<input type="checkbox"/> Mc Duffie	<input type="checkbox"/> Muscogee	<input type="checkbox"/> Montgomery	
<input type="checkbox"/> Oconee		<input type="checkbox"/> Meriwether	<input type="checkbox"/> Screven	<input type="checkbox"/> Dooly	<input type="checkbox"/> Tattnall	
<input type="checkbox"/> Oglethorpe			<input type="checkbox"/> Taliaferro	<input type="checkbox"/> Sumter	<input type="checkbox"/> Telfair	
<input type="checkbox"/> Morgan			<input type="checkbox"/> Warren		<input type="checkbox"/> Bleckley	
			<input type="checkbox"/> Washington		<input type="checkbox"/> Candler	
					<input type="checkbox"/> Emanuel	
					<input type="checkbox"/> Evans	

COUNTIES AVAILABLE TO WORK;

DAYS AVAILABLE FOR WORK

SUN	MON	TUE	WED	THU	FRI	SAT
-----	-----	-----	-----	-----	-----	-----

LIVE-IN 7A-7P 7P-7A 7A-3P 8A-4P 3P-11P AVAILABLE FOR SHORT SHIFTS YES NO

DO NOT CALL BETWEEN THE HOURS OF _____

REVIEWED BY _____ REFERENCES DATE VERIFIED _____

REFERENCES REVIEW BY _____ HIRE DATE _____

CARING HANDS UNITED, INC



PLEASE NOTE : ALL ANSWERS MUST BE COMPLETE AND LEGIBLE

TITLE OR POSITION APPLYING FOR :

PERSONAL INFORMATION :

3. LAST NAME		SEX	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
4. FIRST NAME		5. Middle Initial	
6. Social Security Number		7. Date Of Birth	
8. Present Address – Number and Street		City	State
			zip
			County
9. Home Tel:	10. Business Tel:	11. Cell Phone	
12. Are you at least 18 yrs of age? Yes <input type="checkbox"/> No <input type="checkbox"/>		13. Are you eligible for employment in the United States? Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. Are you fluent in any language other than English? Yes <input type="checkbox"/> No <input type="checkbox"/>		15. If yes , please specify	

EDUCATION :

16. Check Last Year Completed		8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/>								
17. Name of High School		Did you Graduate		Yes <input type="checkbox"/> No <input type="checkbox"/>						
18. Location		GED		Yes <input type="checkbox"/> No <input type="checkbox"/>		Computer Proficiency			Yes <input type="checkbox"/> No <input type="checkbox"/>	
19. Nursing School / College/ University		Did you Graduate		Yes <input type="checkbox"/> No <input type="checkbox"/>		Major Studies				
		Location:								
20. Technical /Trade or Business School		Did you Graduate		Yes <input type="checkbox"/> No <input type="checkbox"/>		Certification or Diploma:				
		Location :								

21. LICENSES AND CERTIFICATES (Description)	State	Certificate Number	Expiration Date

EMPLOYMENT HISTORY:

Begin with your most recent experience and account for all time during the last **5 years**
If additional space is required attach additional sheets. Attaching a separate resume is recommended

Date / Month / Year	Employers Name	Job Title
From:	Employers Address	
To:		
Total Time on Job		
Years	Months	
Did you Supervise? Yes <input type="checkbox"/> No <input type="checkbox"/>		Supervisor's Name:
If yes, Number of employees		
Reason for Leaving :		Supervisor's Telephone Number:
		Hours per week?
		Monthly Salary
Date / Month / Year	Employers Name	Job Title
From:	Employers Address	
To:		
Total Time on Job		
Years	Months	
Did you Supervise? Yes <input type="checkbox"/> No <input type="checkbox"/>		Supervisor's Name:
If yes, Number of employees		
Reason for Leaving :		Supervisor's Telephone Number:

CARING HANDS UNITED, INC



	Hours per week?
	Monthly Salary

Date / Month / Year	Employers Name	Job Title
From:	Employers Address	
To:		
Total Time on Job		
Years	Months	Did you Supervise? Yes <input type="checkbox"/> No <input type="checkbox"/>
		If yes, Number of employees
Reason for Leaving :		Supervisor's Name:
		Supervisor's Telephone Number:
		Hours per week?
		Monthly Salary

Any "Yes Answers to items 22-28 Must be explained on the line provided after each question.

22. Have you ever been convicted or have been shown by credible evidence to have subjected a child or adult to serious injury as a result of intentional or grossly negligent or neglectful conduct as evident by a oral, written statement to this effect obtained at the time of application? Yes <input type="checkbox"/> No <input type="checkbox"/> (Conviction is not an automatic bar to employment, each case is considered individually)
23. Are you related to any Caring Hands United, Inc employees? Yes <input type="checkbox"/> No <input type="checkbox"/>
24. Have you been previously employed by Caring Hands United, Inc ? Yes <input type="checkbox"/> No <input type="checkbox"/>
25. Name of Personal Reference Years Known Telephone Number
26. Name of Personal Reference Years Known Telephone Number
27. Name of Emergency contact Person Telephone Number
28. May we contact your current or most recent employer? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please state the reason _____

I hereby certify that the statements made in this application are true, complete, and correct to the best of my knowledge and belief and I realize that inclusion of false information or omission of material could result in a DISMISSAL from employment OR REMOVAL of my application for further consideration. I also hereby certify that I am not suffering from a communicable disease or mental health disorder that would hinder my job performance nor have I been charged with a crime involving abuse, neglect, exploitation or deprivation of a child or adult. I hereby authorize all my employers and police / sheriff department unless otherwise stated to release any and all information in regards to my employment request.

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Signature of Applicant _____	Date Submitted _____
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CARING HANDS UNITED, INC



ACKNOWLEDGEMENT OF STATEMENT



Name: _____ Date _____

I hereby certify that I have never shown by credible evidence (e.g. a court or jury, a department investigation, or other reliable evidence) to have abused neglected, sexually assaulted, exploited, or deprived any person or have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by oral or written statement to this effect obtained at the time of application.

Employee signature: _____

Witness: _____

I hereby understand and agree that I will report immediately to my employer any known exposure to tuberculosis on or off the job.

Employee signature: _____

Witness: _____

CARING HANDS UNITED, INC



EMPLOYEE REFERENCE CHECK PLEASE CHOOSE OFFICE TO WHICH YOU WISH TO BE EMPLOYED

{ }	{ }	{ }	{ }
CORPORATE OFFICE ATLANTA OFFICE 1447 PEACHTREE ST NE SUITE 330, ATLANTA, GA. 30309 TEL : 404-873-3888 FAX 404-873-6818	GRIFFIN OFFICE 100 S HILL ST , SUIT 525 GRIFFIN , GA 30223 TEL 770-412-4161 FAX : 770-412-0141	SAVANNAH OFFICE 7025 HODGSON MEMORIAL DR SUIT A , SAVANNAH , GA 31406 TEL 912-352-8088 FAX 912-352-8778	AUGUSTA OFFICE 3633 WHEELER RD SUITE 340, AUGUSTA GA 30909 TEL 706-854-1602 FAX 706-854-1605

TO COMPLETE APPLICATION THIS AREA MUST BE FILLED OUT BY APPLICANT

EMPLOYEE NAME: _____ SSN NUMBER _____
JOB TITLE: _____ EMPLOYMENT DATES; FROM: _____ TO _____
FACILITY / EMPLOYER / AGENCY NAME: _____
SUPERVISOR'S NAME: _____
PHONE NUMBER: _____ FAX NUMBER: _____

I hereby authorize the release of the below listed information to Caring Hands United, Inc. Home Care for evaluation of my application for employment.

APPLICANT SIGNATURE : _____

TODAY'S DATE : _____

HUMAN RESOURCE PLEASE PROVIDE THE FOLLOWING INFORMATION

EMPLOYED: FROM _____ TO _____

CORRECT: INCORRECT : IF INCORRECT EMPLOYED FROM : _____ TO _____

EMPLOYED AS : _____ CORRECT: INCORRECT : IF INCORRECT EMPLOYED AS ; _____

NAME AND TITLE OF PERSON VERIFYING THE INFORMATION

NAME: _____ TITLE: _____

VERIFIED BY TELEPHONE: YES NO DATE : _____

PLEASE RETURN BY FAX TO OFFICE FAX NUMBER IDENTIFIED BY AN (X)

DATE FAXED : _____ DATE RETURNED : _____

CARING HANDS UNITED, INC



EMPLOYEE POLICIES AND PROCEDURES

Every employee or provisional employee is expected to conduct themselves in a professional manner while in the client's home or workplace. You are depended upon to arrive at assigned client's home on time and in proper uniform. Once working, you are expected to provide quality patient care and or services according to your job classification and description. You must follow the policies and procedures of the Medicaid / Medicare program as well as Caring Hands United, Inc.

THE FOLLOWING IS GROUNDS FOR DISMISSAL AND MAY RESULT IN DISQUALIFICATION FOR UNEMPLOYMENT BENEFITS

PLEASE READ AND CHECK OFF:

- All information about the client must be kept confidential (HIPPA policies and procedures must apply to all clients information).
- An unusual amount of cancellations (2 (two) cancellations in 30 days called in after 4pm to on call manager.
- A no-show for a previously confirmed shift (neglecting to call office to cancel shift) will result in 2 months suspension for booking shifts.
- Habitual tardiness as reported by the client.
- Failure to provide all required documentation (CPR, FIRST AIDE, TB certification or completed IN-SERVICES) for personnel files.
- Falsification of records, application documentation or timesheet reporting. Not utilizing Timecentre Clock-in System to clock-in and clock-out.
- Client complaints caused by poor performance on an assignment.
- Insubordination to administrative staff.
- Non-compliance to OSHA/ Infection Control Standards or with Drug Free Workplace Policies.
- Theft of client's property, borrowing money or other items from the client.
- Sleeping while on an assignment, live –in cases need more clarification.
- Illegal possession or attempting to take part in illegal sale and trafficking of illegal drugs or contraband.
- Willful disregard for clients' and Caring Hands United, Inc.'s policy.
- Unauthorized removal of property belonging to client e.g. food, drinks etc.
- Smoking in the client's home or other unauthorized areas.
- Excessive use of cell phone or blue tube while in home while providing client care with excessive incoming and outgoing personal calls(Cell phones are to be used for emergencies or communicating with the Caring Hands United, Inc office).
- Spreading malicious rumors or gossip about co-workers, the clients, or Caring Hands United, Inc.
- Leaving work early without contacting the staffing coordinator.
- Employees cannot accept any gifts or valuables without permission from Caring Hands United, Inc.
- When you are re-assigned as a result of complaints from a client, do not call the client. This will lead to termination from Caring hands United.
- Discussing your personal business with the client will lead to the client reporting your situation to the office staff and may result in termination from the client's home and Caring Hands United, Inc.

REQUIREMENTS FOR CONTINUED EMPLOYMENT WITH CARING HANDS UNITED, INC

- Report to work 15 minutes before the assigned time of arrival to the client's home.
- Must attend orientation session and read orientation handbook .Arrangements regarding orientation will be made for the specific client assigned to work with.
- All services are to be provided in accordance with the Private Home Care and CCSP/SOURCE/ ICWP Policies and Procedures.
- You must call –in 24 hours prior to start of the assigned time to do the home visit, to ensure time enough for the client to be covered by a fill –in home care aide. On weekends, call-outs will be considered an incident of absenteeism. Unless explained by a doctor's note or a verifiable excuse..
- Two absences with-in 30 days that was not pre-scheduled (or called in between the hours of 8am and 4 pm office hours) or called in less than 24 hours will result in a 2 (two) month suspension, for new assignments and removal from assigned clients unless accompanied by a verifiable excuse or doctor's note.
- All employees are expected to maintain telephones and to keep communication open with the staffing coordinator.
- Employees are required to work at least 1 (one) out of 30 (thirty) days to retain an active status, unless prior arrangement have been made with Caring Hands United, Inc.
- It is the employee's responsibility to report all work related injuries to Caring Hands United, Inc. immediately (within 24 hours).Failure to do so may waiver Caring Hands United, Inc responsibilities making the employee responsible for the cost of needed care.

SIGNED BY NEW EMPLOYEES AND WITNESSED DURING THE EMPLOYMENT PROCESS

I _____ (Print Name) have read and understand the above Policies and Procedures set by Caring Hands United, Inc and by signing I agree to uphold these Policies and

EMPLOYEE SIGNATURE

DATE

WITNESS

DATE

CARING HANDS UNITED, INC



CHAMBLEE POLICE DEPARTMENT

R MARC JOHNSON

CHIEF OF POLICE

A State Certified Law Enforcement Agency

CHAMBLEE POLICE DEPARTMENT
CRIMINAL HISTORY CONSENT FORM

I hereby authorized Caring Hands United, Inc, to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or any local criminal justice agency in Georgia

Full Name (Printed)

Address

Sex Race Date of Birth Social Security Number

Signature

Date

Special employment provisions (check if applicable)

- Employment with medically disabled (Purpose code 'M')
Employment with elderly care (Purpose code 'N')
Employment with children (Purpose code 'W')

One of the following must be checked:

- This authorization is valid for 90 /180 (circle one) days from the date of signature
I, give my consent to the above

Named to perform periodic criminal history background checks for the duration of my employment with this company.

PLEASE STAMP ON THIS PAGE IF

- CLEARED ATTACHMENT WARRANT

CARING HANDS UNITED, INC



EMPLOYEE PHYSICAL REPORT

NAME	BIRTH DATE	SEX	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
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PHYSICAL CONDITIONS KNOWN PLEASE ANSWER YES OR NO

PSYCHIATRIC PROBLEMS	YES	NO	WORKERS COMP CASE PENDING YES <input type="checkbox"/> NO <input type="checkbox"/>
DRUG DISORDERS			PHYSICIAN PERMISSION TO WORK IF ANSWER IS YES
COMMUNICABLE DISEASE			FILLED FOR WORKERS COMP BEFORE YES <input type="checkbox"/> NO <input type="checkbox"/>
PHYSICAL LIMITATIONS			ON MEDICAL LEAVE OF ABSENCE FROM ANOTHER JOB YES <input type="checkbox"/> NO <input type="checkbox"/>
BLADDER, KIDNEY DISEASE			HAVE MEDICAL COVERAGE YES <input type="checkbox"/> NO <input type="checkbox"/>
HIGH BLOOD PRESSURE			HOSPITALIZED THIS PAST YEAR YES <input type="checkbox"/> NO <input type="checkbox"/>
HERNIA RUPTURE			HAD SURGERY THIS PAST YEAR YES <input type="checkbox"/> NO <input type="checkbox"/>
CANCER MALIGNANCY			ARE YOU PREGNANT YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES HOW MANY MONTHS
SKIN DISEASE			CHILDBIRTH THIS PAST YEAR YES <input type="checkbox"/> NO <input type="checkbox"/>
HEADACHES FROM HEAD INJURIES			IF YES TO ANY OF THESE QUESTIONS PLEASE EXPLAIN
RHEUMATIC FEVER, HEART DISEASE			
EPILEPSY FAINTING SPELLS			
TUBERCULOSIS			
STROKE, PARALYSIS			
EYE, EAR, THYROID PROBLEMS			
DIABETES			
ASTHMA			
STOMACH, BOWEL PROBLEMS			

IF MEDICAL CONDITION NOT LISTED PLEASE MENTION

--	--

1. ANIMALS DOGS CATS BIRDS OTHER _____

EXPLAIN: _____

- | | | | |
|------------------------|------------------------------|-----------------------------|--|
| 1. NON-SMOKER | YES <input type="checkbox"/> | NO <input type="checkbox"/> | NOTE: SMOKING IS NOT ALLOWED IN OR AROUND CLIENT'S HOME
SOME CLIENT'S ARE ALLERGIC TO SMOKE OF CIGARETTES AND OTHER
HIGH PERFUMED ODORS. PLEASE BE MINDFUL OF THIS FACT. |
| 2. ALLERGIC TO SMOKE | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 3. SMOKES ONLY AT HOME | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |

4. NEEDS SMOKE BREAKS EVERY _____ MINUTES _____ HOURS

REQUIRED FOR HOME CARE WORKERS

TB TEST <input type="checkbox"/> X RAY <input type="checkbox"/>	DATES TAKEN 1. _____ 2. _____ 3. _____	RESULTS 1. POSITIVE <input type="checkbox"/> 2. POSITIVE <input type="checkbox"/> 3. POSITIVE <input type="checkbox"/> NOTE: MUST FILL OUT SYMPTOMS CHECK FORM AND NEED CHEST X RAY	RESULTS 1. NEGATIVE <input type="checkbox"/> 2. NEGATIVE <input type="checkbox"/> 3. NEGATIVE <input type="checkbox"/>	OFFICE USE ONLY : CLEARANCE TO WORK YES <input type="checkbox"/> NO <input type="checkbox"/> INITIAL _____ YES <input type="checkbox"/> NO <input type="checkbox"/> INITIAL _____ YES <input type="checkbox"/> NO <input type="checkbox"/> INITIAL _____ PENDING <input type="checkbox"/> CLEARANCE TO WORK MUST BE GIVEN BY RN/ OR LPN
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CARING HANDS UNITED, INC



SKILLS CHECKLIST

NAME: A = CAN INDEPENDENTLY PERFORM B = FAMILIAR BUT MAY REQUIRE ASSISTANCE C = NO EXPERIENCE	DIRECTIONS: Please select the appropriate experience level for each skill. This information is needed for Caring Hands United, Inc to be able to place you with our homecare clients.
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ACTIVITIES OF DAILY LIVING AND INCIDENTAL LIVING ACTIVITIES

PERSONAL CARE	A	B	C	LIGHT HOUSEKEEPING	A	B	C
Sponge Bath (at sink)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mop Floors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tub Bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dusting / Sweeping / Vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Washing Clothes / Folding Clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed Bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dishes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Errands / Grocery Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Denture Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MEAL PREPARATION	A	B	C
Shave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assist with Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nail and Skin Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prepare Meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Dressing / Undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Special Diets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VITAL SIGNS	A	B	C	CARE EXPERIENCE	A	B	C
Temperature Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Diabetic Client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temperature Auxiliary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Alzheimer Client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse : Radial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Quadriplegic / Paraplegic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse : Apical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Infant / Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of TBI Client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counting Respirations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Client on Bed Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ELIMINATION	A	B	C	INFECTION CONTROL	A	B	C
Use of Bedpan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proper Hand Washing Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Bedside Commode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Personal Protective Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Home Sanitization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measure Urine Output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Garbage Disposal Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Empty Foley Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Cleaning Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOCUMENTATION	A	B	C	MEDICATION ASSISTANCE	A	B	C
Documentation Check Off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication Reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly Note S Check Off Summary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Routes of Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SAFE TRANSFER TECHNIQUES	A	B	C	CLIENT ESCORT / TRANSPORTATION	A	B	C
Hoyer Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Manual Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Electric Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repositioning in Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assist in and out of Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>