***Alliance Staffing***

NC Alliance of Public Health Agencies

New Employee Checklist:

Paperwork to complete and turn in:

* Employment Application
* On-line application **OR**
* Paper application
* I-9 Form (full instructions can be found here: https://www.uscis.gov/sites/default/files/files/form/i-9.pdf)
* I-9 verifying documents (ex: passport, drivers license, SS card, etc.)
* Employee Immunization Record
* Hepatitis B Waiver Form
* W-4 Form
* NC-4 EZ Form (long form available upon request)
* Direct Deposit
* New Hire Form (Confidentiality Agreement, Work History Release, Emergency Contact and OSHA Instructions) OSHA certificates once you have completed the OSHA training
* Driver History form (follow instructions and complete only if driving is a

requirement of this job)

*We must have all documents listed above completed and returned promptly! Omitting paperwork may delay your first paycheck!*

Payroll Information to keep:

* Payroll letter
* Payroll Calendar
* Timesheets

**USCIS**

**Form I-9**

OMB No. 1615-0047

Expires 08/31/2019



**Employment Eligibility Verification**

**Department of Homeland Security**

U.S. Citizenship and Immigration Services

**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form.** **Employers are liable for errors in the completion of this form.**

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1. Employee Information and Attestation** *(Employees must complete and sign Section 1 of Form I-9 no later than the* ***first day of employment****, but not before accepting a job offer.)* | | | | | | | | | | | | | | | | | | | | | |
| Last Name *(Family Name)* | | | | | | | First Name *(Given Name)* | | | | | | | | | | Middle Initial | Other Last Names Used *(if any)* | | | |
| Address *(Street Number and Name)* | | | | | | | | | | | Apt. Number | | | | | City or Town | | | | State | ZIP Code |
| Date of Birth *(mm/dd/yyyy)* | U.S. Social Security Number | | | | | | | | | | | | | | Employee's E-mail Address | | | | Employee's Telephone Number | | |
|  |  |  |  | - |  |  | - |  |  | |  |  |  |

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

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

1

. A citizen of the United States

2

. A noncitizen national of the United States

*)*

*(*

*See instructions*

. A lawful permanent resident

3

. An alien authorized to work until

4

*)*

*See instructions*

*(*

):

expiration date, if applicable, mm/dd/yyyy

(

(

Alien Registration Number/USCIS Number

):

Some aliens may write "N/A" in the expiration date field.

*Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:*

*An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.*

**1.**

Alien Registration Number/USCIS Number:

**2.**

Form I-94 Admission Number:

**3.**

Foreign Passport Number:

Country of Issuance:

**OR**

**OR**

QR Code - Section 1

Do Not Write In This Space

|  |  |
| --- | --- |
| Signature of Employee | Today's Date *(mm/dd/yyyy)* |
| **Preparer and/or Translator Certification (check one):**  I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  *(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)* | |

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Signature of Preparer or Translator | | |  | | | | Today's Date *(mm/dd/yyyy)* | | |
| Last Name *(Family Name)* | | |  | First Name *(Given Name)* | | |  | | |
| Address *(Street Number and Name)* | | | City or Town | | | |  | State | ZIP Code |
|  | |  | | --- | | *Employer Completes Next Page* | | | |  |

Form I-9 11/14/2016 N

**USCIS**

**Form I-9**

OMB No. 1615-0047

Expires 08/31/2019



**Employment Eligibility Verification**

**Department of Homeland Security**

U.S. Citizenship and Immigration Services

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section 2. Employer or Authorized Representative Review and Verification**  *(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")* | | | | |
| **Employee Info from Section 1** | Last Name *(Family Name)* | First Name *(Given Name)* | M.I. | Citizenship/Immigration Status |

**List A OR List B AND List C**

# Identity and Employment Authorization Identity Employment Authorization

|  |  |  |
| --- | --- | --- |
| Document Title |  | Document Title Document Title  Issuing Authority  Document Number  Issuing Authority  Document Number  Expiration Date *(if any)(mm/dd/yyyy)* Expiration Date *(if any)(mm/dd/yyyy)* |
| Issuing Authority |
| Document Number |
| Expiration Date *(if any)(mm/dd/yyyy)* |
| Document Title | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | Additional Information | | |  | | --- | | QR Code - Sections 2 & 3 Do Not Write In This Space | | |
| Issuing Authority |
| Document Number |
| Expiration Date *(if any)(mm/dd/yyyy)* |
| Document Title |
| Issuing Authority |
| Document Number |
| Expiration Date *(if any)(mm/dd/yyyy)* |

**Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.**

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Signature of Employer or Authorized Representative | | | Today's Date*(mm/dd/yyyy)* | | | | Title of Employer or Authorized Representative | | | | | |
| Last Name of Employer or Authorized Representative | | First Name of Employer or Authorized Representative | | | | | | | Employer's Business or Organization Name | | | |
| Employer's Business or Organization Address (Street Number and Name) | | | | | City or Town | | | | | | State | ZIP Code |
| **Section 3. Reverification and Rehires** *(To be completed and signed by employer or authorized representative.)* | | | | | | | | | | | | |
| **A.** New Name *(if applicable)* | | | | | | | | **B.** Date of Rehire *(if applicable)* | | | | |
| Last Name *(Family Name)* | First Name *(Given Name)* | | | | | Middle Initial | | Date *(mm/dd/yyyy)* | | | | |
| **C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below. | | | | | | | | | | | | |
| Document Title | | | | Document Number | | | | | | Expiration Date *(if any*) *(mm/dd/yyyy)* | | |

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

|  |  |  |
| --- | --- | --- |
| Signature of Employer or Authorized Representative | Today's Date *(mm/dd/yyyy)* | Name of Employer or Authorized Representative |

Form I-9 11/14/2016 N

# LISTS OF ACCEPTABLE DOCUMENTS All documents must be UNEXPIRED

Employees may present one selection from List A

or a combination of one selection from List B and one selection from List C.

|  |  |  |  |
| --- | --- | --- | --- |
| **LIST A**  **Documents that Establish**  **Both Identity and**  **Employment Authorization** | **OR** | **LIST B LIST C**  **Documents that Establish Documents that Establish**  **Identity Employment Authorization**  **AND** | |
| **1.** U.S. Passport or U.S. Passport Card |  | **1.** Driver's license or ID card issued by a  State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | **1.** A Social Security Account Number card, unless the card includes one of the following restrictions:   1. NOT VALID FOR EMPLOYMENT 2. VALID FOR WORK ONLY WITH INS AUTHORIZATION 3. VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| **2.** Permanent Resident Card or Alien  Registration Receipt Card (Form I-551) |
| **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machinereadable immigrant visa |
| **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address |
| **4.** Employment Authorization Document that contains a photograph (Form I-766) |
| **2.** Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| **3.** School ID card with a photograph |
| **5.** For a nonimmigrant alien authorized to work for a specific employer because of his or her status:   1. Foreign passport; and 2. Form I-94 or Form I-94A that has the following:    1. The same name as the passport;and    2. An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | **3.** Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| **4.** Voter's registration card |
| **5.** U.S. Military card or draft record |
| **4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| **6.** Military dependent's ID card |
| **7.** U.S. Coast Guard Merchant Mariner Card |
| **8.** Native American tribal document |
| **5.** Native American tribal document |
| **9.** Driver's license issued by a Canadian government authority | **6.** U.S. Citizen ID Card (Form I-197) |
| **7.** Identification Card for Use of Resident Citizen in the United  States (Form I-179) |
| **For persons under age 18 who are unable to present a document listed above:** |
| **8.** Employment authorization document issued by the  Department of Homeland Security |
| **6.** Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI |
| **10.** School record or report card |
| **11.** Clinic, doctor, or hospital record |
| **12.** Day-care or nursery school record |

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

**Refer to the instructions for more information about acceptable receipts.**

Form I-9 11/14/2016 N

**NORTH CAROLINA ALLIANCE OF PUBLlC HEALTH AGENCIES, INC.**

# EMPLOYEE IMMUNIZATION RECORD & HEPATITIS B WAIVER FORM

The Alliance follows the CDC Immunization Guidelines for all of our employees.

***Please complete the form or submit copies of your immunization records from your health care provider.***

Employee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hepatitis B Series**: Yes \_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

No \_\_\_\_\_\_ Declination Form Signed? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

Mmr/MR

***MMR/MR & VARICELLA IMMUNIZATIONS ARE REQUIRED:***

**MMR / MR**: (Measles, Mumps, Rubella)

One of the following is required:

1. Titer indicating immunity

Date: \_\_\_\_\_\_\_\_\_\_\_\_

1. Birth during or after 1957 and documentation of 2 doses of vaccine

Dates: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

1. Birth prior to 1957 and 1 dose of vaccine

Date: \_\_\_\_\_\_\_\_\_

[For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) physician-diagnosed measles or mumps disease.]

**Varicella:**

One of the following required:

1. Titer indicating immunity Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Documentation of 2 doses of vaccine

Dates \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

It is recommended that all HCP be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart.

# [Highly Recommended, not required unless required by work site-Tetanus/Influenza/TB

**Tetanus**:

1. One dose of Tdap vaccine at least 5 years after last Tetanus booster

Date Received: \_\_\_\_\_\_\_\_\_ Date Due: \_\_\_\_\_\_\_\_\_\_\_\_

1. Tetanus (Td) booster every 10 years Last Dose: \_\_\_\_\_\_\_\_\_\_ Date Due: \_\_\_\_\_

**Influenza**

Annual influenza vaccine is highly recommended by Alliance (must be obtained if required by employee’s work site,) \_\_\_\_\_\_Yes \_\_\_\_\_\_No Date:\_\_\_\_\_\_\_\_\_\_

**TB Skin test:**

1. Two-step test if no skin test in the past year.

Date of test #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of test #2: \_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please provide documentation of test in the past year, only one required.

*[If documentation in the past year, only one test is required.]*

Date of last skin test: \_\_\_\_\_\_\_\_\_\_\_ Date of test #2\_\_\_\_\_\_\_\_\_\_\_

*If you do not have these immunizations, you will need to get them unless your worksite follows different guidelines or due to a documented medical condition. NCAPHA will pay for missing immunizations.*

**NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.**

**HEPATITIS B VACCINATION WAIVER FORM**

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring HBV (Hepatitis B Virus) infection.

I have read the Hepatitis B Information Sheet and have had an opportunity to ask questions and understand the risks and benefits of the HBV vaccine.

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

Having been so informed,

\_\_\_\_\_ I request the HBV vaccine.

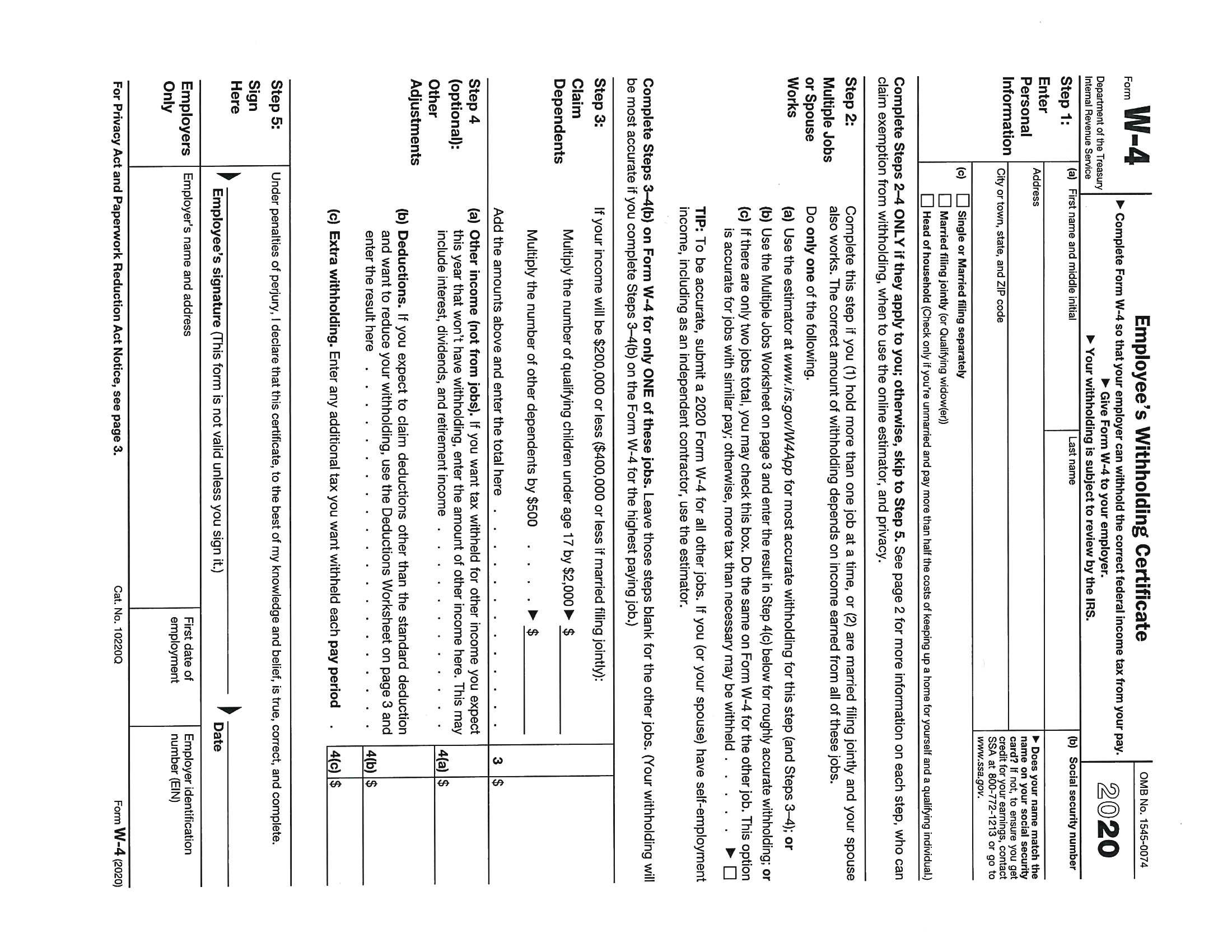
\_\_\_\_\_ I decline to take the HBV vaccine at this time.

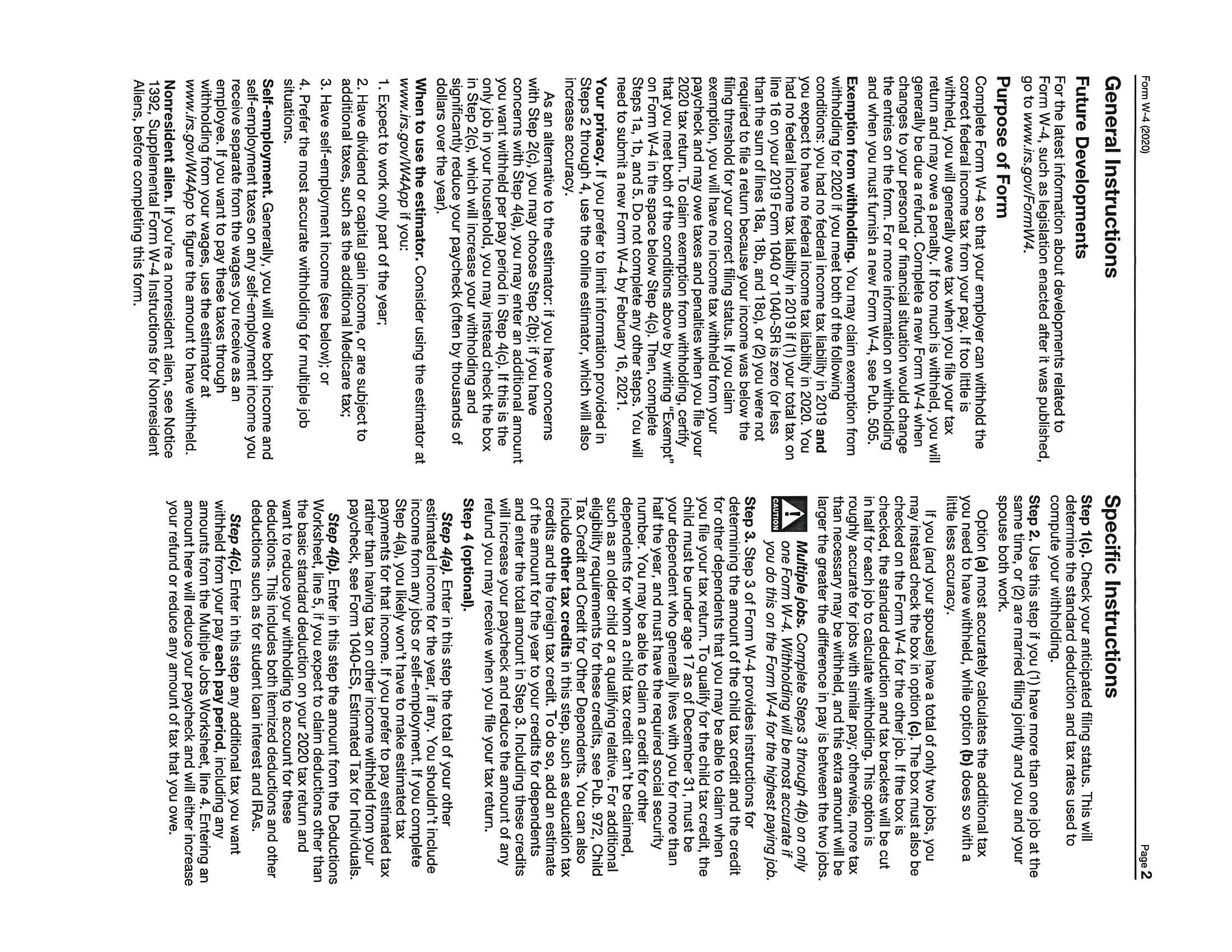
\_\_\_\_\_ I have already had the HBV vaccine.

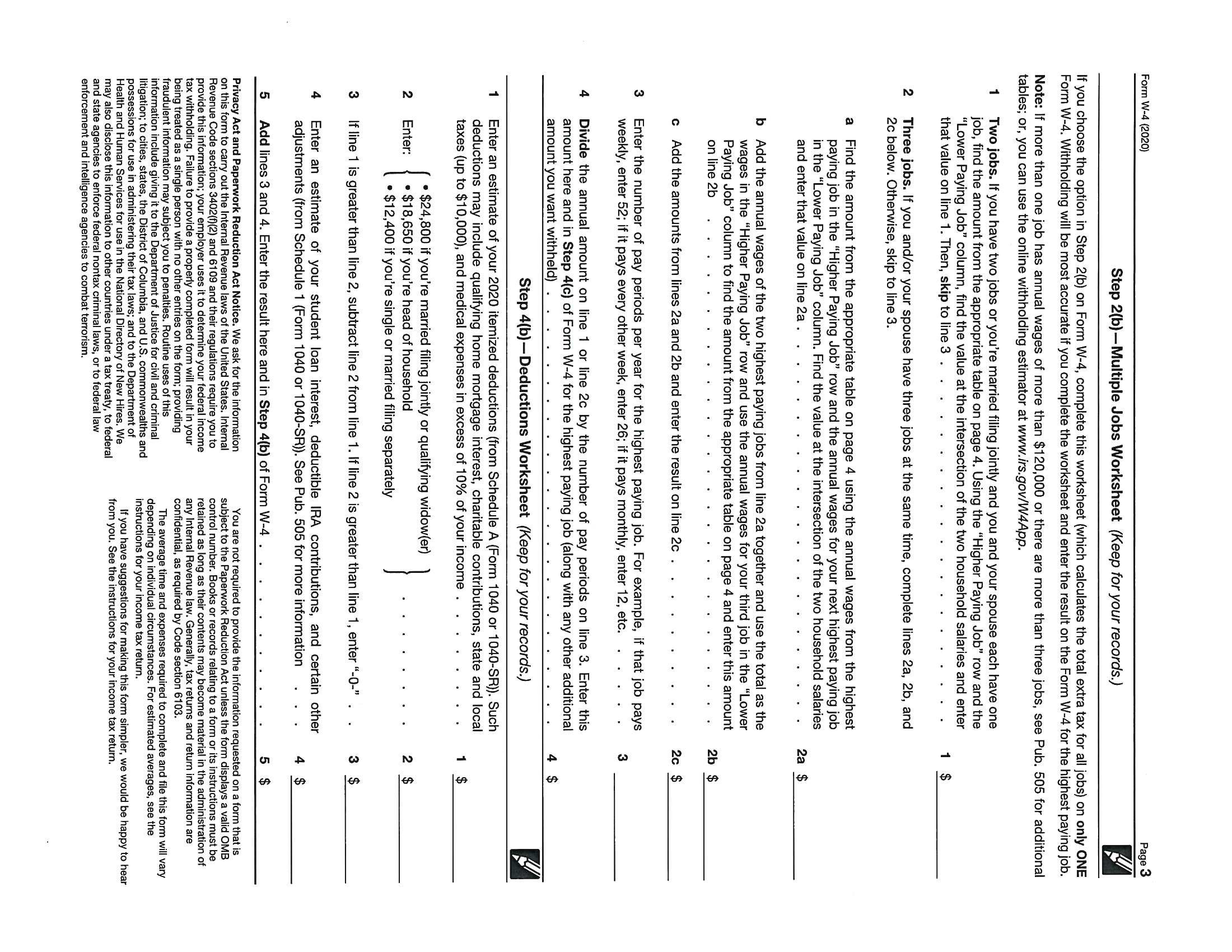
I understand that due to my occupational exposure to blood or other potentially infectious material I may be at risk of acquiring hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to me. However, I decline hepatitis B vaccine at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

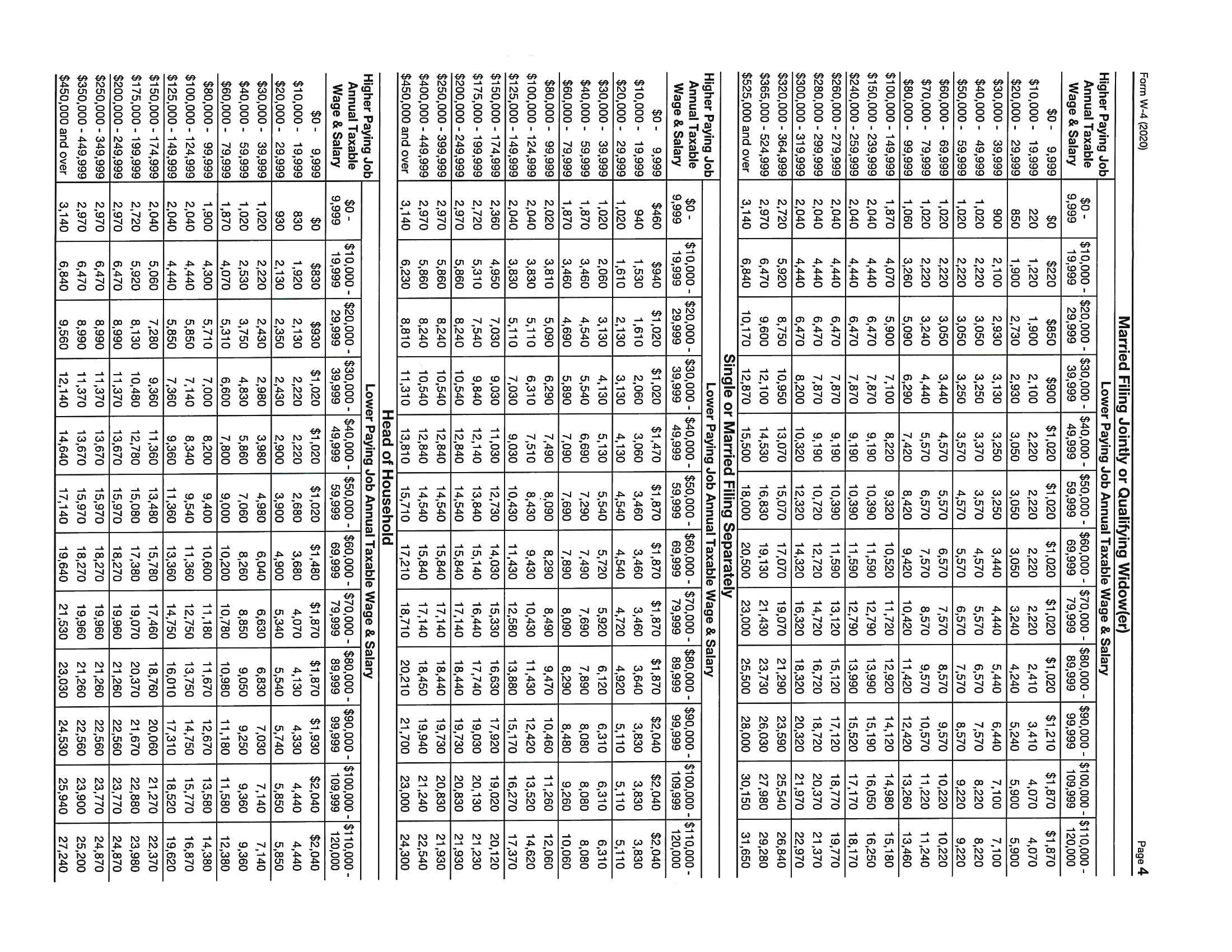
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

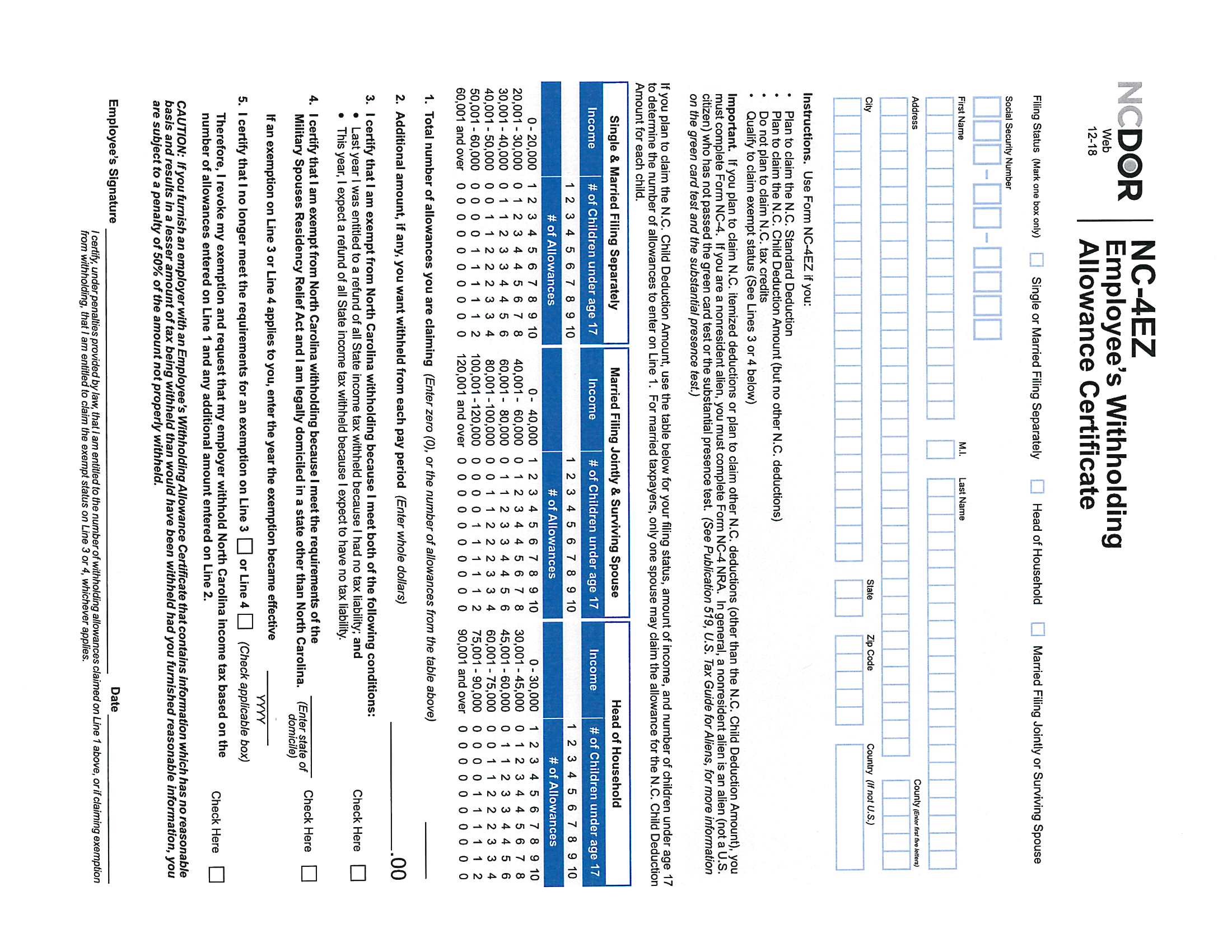
Employee’s signature Date











# Direct Deposit Authorization Form

NC Alliance of Public Health Agencies is pleased to offer direct deposit of employee pay checks to a bank and account of your choice. To arrange for direct deposit:

\_\_\_\_\_\_ Complete the employee portion of this form

\_\_\_\_\_\_ CHECKING ACCOUT: Attach a voided personal check

\_\_\_\_\_\_ SAVINGS ACCOUNT: have your bank complete account and routing numbers

\_\_\_\_\_\_ Return the complete form to the Payroll Department.

**ATTENTION: Your first check will be mailed so make sure that you have given us your correct mailing address when you applied!!!!**

**Your direct deposit should begin within two pay periods after we receive your completed form.**

## \*\*NOTIFY PAYROLL IMMEDIATELY IF YOU CLOSE OR CHANGE BANK ACCOUNTS\*\*

**TO BE COMPLETED BY EMPLOYEE:**

**\_\_\_\_\_\_** New Enrollment \_\_\_\_\_\_ Cancel Enrollment

I hereby authorize NC Alliance of Public Health Agencies to initiate credit and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated below and the depository name below, hereinafter called depository, to credit and/or debit the same as such:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

ACCOUNT TYPE: \_\_\_\_\_\_ **Checking** (attach voided check)

\_\_\_\_\_\_ **Savings** (HAVE BANK COMPLETE –

DO NOT USE DEPOSIT SLIP INFO)

BANK NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCOUNT #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ROUTING #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**NC Alliance of Public Health Agencies (NCAPHA)**

222 N. Person, Ste. #208

Raleigh, NC 27601

(919) 828-6202 Fax: (919) 828-6203

jbrassington@ncapha.org

**NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES.** - **CONFIDENTIALITY**

I understand as an employee of the Alliance and as a patient care provider, I must use discretion when discussing any patient information. Patients and any patient information is discussed on a need to know basis, to only those health care providers involved in that particular case. I will not acknowledge or reveal the names of the clients/patients seen by me to anyone other than those directly involved in the case, reviewers, in response to legal summons or as directed by agency management. As a Staffing Pool employee, I will read, sign, and adhere to the Confidentiality Policy of the agency(s) with which I am working.

I further understand that all medical record information must be safe guarded, that I may copy designated parts of the chart to aid me in caring for patients, however, it is my responsibility to ensure that these materials are safe guarded as well. I understand that I am not to leave any patient materials unprotected and that once a patient has been discharged or is no longer in my care, I am responsible for the safe destruction of that patient's information in my position.

I understand that failure to comply with this policy could result in termination of my employment and legal action.

I have read this policy and understand its content. *[My signature below indicates my acceptance of this policy.]*

*-------------------------------------------------------------------------------------------------------------------------------------------------------*

**WORK HISTORY AUTHORIZATION PERMISSION RELEASE**

I grant NCAPHA my permission from my signature below to request and receive information regarding my previous employment records. (Photocopies of this authorization are valid.)

**-------------------------------------------------------------------------------------------------------------------------------------------------------**

***This is to certify that I have read, understand and agree to all of the above information.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

|  |
| --- |
| **EMERGENCY CONTACT**: |

In case of an emergency, please contact the following person:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **OSHA TRAINING**: |

NCAPHA employees are required to complete 3 online courses through our vendor, Pure Safety. You

will be emailed training instructions to facilitate the training process. To get started:

Access website: http://www.puresafety.com Courses:

Click on Login button at the upper right corner. 1. Bloodborne Pathogens

Enter the following information: 2. Hazard Communications

Company Name: ncapha 3. Workplace Violence Prevention

User Name: e**mployee’s first name.employee’s last name**

Password: ncapha11

For technical questions contact: PureSafety @888-202-3018

**NORTH CAROLINA ALLIANCE of PUBLIC HEALTH AGENCIES (Page 1 of 3)**

***Complete only if the position you are applying for requires on-the job driving.***

## DRIVER HISTORY FORM

Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a valid Driver's License? Yes \_\_\_\_\_ No \_\_\_\_\_

1. In what State are you a Licensed Driver?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you have held a license in any other state during the past 5 years, please provide the following information:

Dates State

From \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been convicted of driving while impaired or under the influence of alcohol and/or drugs within the past three years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you refused to submit to a Blood Alcohol Content (BAC) test within the past three years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s): .

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been convicted of reckless driving, or leaving the scene of an accident, or committing a felony

involving a vehicle within the past three years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## (Page 2 of 3)

1. Have you had your operator's license suspended, revoked or administratively restricted within the past three

years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been convicted or found at fault for any non-fatal accident involving a motor vehicle during the past

three years? Yes ( ) No( ) If Yes, list the date(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been convicted or found at fault for any fatal accidents involving a motor vehicle during the past

three years? Yes ( ) No ( ) If Yes, list the date(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been convicted of any other moving vehicle violations during the past three years? Yes ( ) No ( )

If Yes, list type(s) and date(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the answers provided to the questions on this form are true to the best of my knowledge.

I authorize NCAPHA or its designated representative(s) to obtain information regarding my driving record in any state at any time while I am employed by (or seeking employment with) the company.

I understand that any misstatement of the facts on this form may be grounds for termination of employment.

In the event that my MVR indicates that I am a "High Risk Driver" as defined in the glossary of the Fleet Safety Program, I understand that I may be subject to dismissal.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver's signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Male \_\_\_\_\_ Female \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver's License Number Expiration Date State

**Important Note: Attach photocopy of both sides of driver's license**

**(Page 3 of 3)**

**NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.**

## FLEET SAFETY CHECK SHEET

***[Complete only if the position you are applying for requires on-the job driving.]***

\_\_\_\_\_\_\_ Current N C Drivers License

Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ Documentation of Current Insurance

Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ Vehicle Safety Inspection

Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ The employee has been informed that they are required to notify the supervisor/Alliance if they have any illness, injury, physical condition or use medication that may impair or affect their ability to safely drive a "Motor Vehicle," or if their license is revoked, or they have had administrative restrictions imposed.

\_\_\_\_\_\_\_ Agrees to comply with requirement that all drivers must wear seat belts.

I certify that I have had the Fleet Safety Policy reviewed with me and will follow all state, federal, and local laws involving the use of my vehicle. I further acknowledge that any actions taken by me in the use of my vehicle which are considered unsafe/dangerous may result in termination of my employment.

**Important Note: Please submit copy of current vehicle insurance**

NC Alliance of Public Health Agencies, Inc.

222 N. Person St, Suite 208

Raleigh, NC 27601

919-828-6204

919-828-6203 (fax)

bhughes@ncapha.org

Dear Alliance Employee,

Congratulations and welcome to the North Carolina Alliance of Public Health Agencies.

The Alliance payroll calendar and timesheets are included for you below. Some employees will be given timesheets customized for their specific position. If that is the case then please use the customized timesheet. Our pay periods run from the 1st day of the month through the 15th and the 16th through the last day of the month. Time worked should be recorded on the timesheet in .25 intervals (ex. 5 hours, 15 min = 5.25). Please refer to the payroll calendar for timesheet deadlines.

Also, please note that the timesheets contain a request for patient contact information. This is for those employees such as Dentists, Home Health Nurses, Social Workers, etc. who have direct patient contact. Please use the last column to record the total number of patient contacts and then summarize totals at the bottom. If you do not have direct patient contact, then please leave these lines blank.

**Time sheets received after the due date will be held and paid with the next check cycle.**

Please have the Agency **supervisor sign your time sheet** and either:

**Fax it to (919) 828-6203**

**OR**

**Scan and email it to timesheet@ncapha.org**

If you haven’t already, please submit a **voided check** for set up of direct deposit as soon as possible and allow up to one month for direct deposit to become active. **Your first and possibly second check will be mailed!** Once direct deposit begins entry will be made to your account by the 10th and 25th of the month.

Please contact me with any payroll related questions or concerns at (919) 828-6204.

Sincerely,

Becky Hughes

Finance Director

**NC Alliance of Public Health Agencies, Inc.**

**2020 Payroll Calendar**

|  |  |  |
| --- | --- | --- |
| **Pay Period** | **Timesheets Must Be Received on the Date Listed Below** | **Pay Date** |
| December 16 - 31 | January 2, 2020 | January 10, 2020 |
| January 1 - 15 | January 16, 2020 | January 24, 2020 |
| January 16 - 31 | February 3, 2020 | February 10, 2020 |
| February 1 - 15 | February 17, 2020 | February 25, 2020 |
| February 16 - 28 | March 2, 2020 | March 10, 2020 |
| March 1 - 15 | March 16, 2020 | March 25, 2020 |
| March 16 - 31 | April 1, 2020 | April 9, 2020 |
| April 1 - 15 | April 16, 2020 | April 24, 2020 |
| April 16 - 30 | May 1, 2020 | May 8, 2020 |
| May 1 - 15 | May 18, 2020 | May 22, 2020 |
| May 16 - 31 | June 1, 2020 | June 10, 2020 |
| June 1 - 15 | June 16, 2020 | June 25, 2020 |
| June 16 - 30 | July 1, 2020 | July 10, 2020 |
| July 1 - 15 | July 16, 2020 | July 24, 2020 |
| July 16 - 31 | August 3, 2020 | August 10, 2020 |
| August 1 - 15 | August 17, 2020 | August 25, 2020 |
| August 16 - 31 | September 1, 2020 | September 10, 2020 |
| September 1 - 15 | September 16, 2020 | September 25, 2020 |
| September 16 - 30 | October 1, 2020 | October 9, 2020 |
| October 1 - 15 | October 16, 2020 | October 23, 2020 |
| October 16 - 31 | November 2, 2020 | November 10, 2020 |
| November 1 - 15 | November 16, 2020 | November 25, 2020 |
| November 16 - 30 | December 1, 2020 | December 10, 2020 |
| December 1 - 15 | December 16, 2020 | December 23, 2020 |
| December 16 - 31 | January 4, 2021 | January 8, 2021 |

North Carolina Alliance of Public Health Agencies, Inc.

Timesheet

FAX TO BECKY HUGHES 919-828-6203

Or scan and email to: timesheet@ncapha.org

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month & Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Hours

Home Health

Visits

Home Health

Resumption Visits

Home Health

Admission

Visits

On - Call

Other:

Mileage

Paid Time Off

Number of Patient

Contacts:

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

**TOTAL**

Employee's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Patient Contacts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Home Health Care Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Please remember to have your supervisor sign here!!!!!**

Total Dental Patient Contacts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Also please remember to total your hours, visits, mileage, etc.**

North Carolina Alliance of Public Health Agencies, Inc.FAX TO BECKY HUGHES 919-828-6203

TimesheetOr scan and email to: timesheet@ncapha.org

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month & Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Hours

Home Health

Visits

Home Health

Resumption Visits

Home Health

Admission

VisitsOn - Call

Other:

Mileage

Paid Time Off

Number of Patient

Contacts:

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

**TOTAL**

Employee's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Total Patient Contacts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Total Home Health Care Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Please remember to have your supervisor sign here!!!!!**

Total Dental Patient Contacts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Also please remember to total your hours, visits, mileage, etc.**