EMPLOYMENT CHECKLIST

Name: _____

Date:_____SS #: _____

Document	Check	Date completed/Initial
Application	☐	
Current professional license	☐	
Current CPR Card	☐	
Current First Aid	☐	
W4/W9/I-90/MD 507	☐	
Background Check	☐	
PPD/CXR/Medical/Immunization Record	☐	
Employment Reference Forms (2)	☐	
Driver's License/State ID	☐	
Social Security Card	☐	
US Birth Certificate/US Passport/Permanent Resident Card	☐	
Skills checklist	☐	
Resume/Employment Agreement	☐	
Orientation/Employee Hand Book/Job Description	☐	

Administrator Or Representative: _____

Signature:_____Date: _____

INTERVIEW REVIEW

Applicant Name:_____Date_____

Days and Hours available Mon Tue Wed Thurs. Fri Sat Sun

Review:

Personality:	☐ friendly	☐ average	☐ quiet
Verbal skills:	☐ excellent	☐ average	☐ poor
Communicates:	☐ clear	☐ somewhat clear	☐ not very clear
Flexibility:	☐ very flexible	☐ somewhat	☐ not flexible
Skill level:	☐ higher skilled	☐ moderately skilled	☐ lower skilled
Appearance:	☐ professional	☐ semi-professional	☐ not professional

Good Candidate for employment: ☐ yes no ☐

Overall
Interview:

_____ _____

Interviewer Date

Abik Healthcare Services, Inc.

EMPLOYMENT APPLICATION

ABIK HEALTHCARE SERVICES policy prohibits discrimination on the basis of sex, race, age, nationality, religion, color, disability, marital status, sexual orientation, veteran's status or any other characteristic protected by federal, state, or local laws.

NAME AND ADDRESS

PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION:

NAME:_____
LAST FIRST MIDDLE

ADDRESS: _____

_____
CITY STATE ZIP CODE

HOME PHONE NUMBER (___)_____ _____Cell phone _____

EMAIL ADDRESS: _____

POSITION DESIRED: ☐ **RN** ☐ **LPN** ☐ **CNA** ☐ **CMT** ☐ **PT** ☐ **OT** ☐ **SLP**

What position are you applying for?	Type of Employment (CHECK ONE) FULL TIME:☐ PART TIME: ☐ PRN:

What salary do you expect?	What date are you available to start working?

What hours are you available to work? Please be specific.

From	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
To							

Are you available to work additional hours or a different?

PHONE NUMBER

(_____)_____-_____

EMPLOYMENT STATUS

Is it your intent to continue in your current job(s) if you accept our employment?

Yes: ☐ No: ☐

Are you currently employed?

☐ Yes, ☐ Full Time
☐ No ☐ Part Time

Please list information about your current or most recent employer first. Include military services or any self-employment. You must account for the past three years or the time since you completed school, whichever is shorter. Please give all information requested even if it is included on your resume. If your earnings on previous jobs were as a commission or other basis, estimate your average weekly pay.

Employer	Employer Address	Name of Supervisor	Ending Salary	Job Title	Reason for Leaving	Date From MO/YR	Date To MO/YR	Hrs Worked P/W

EDUCATION

Please provide information about your highest level of education.

Name of School	Address of School	Curriculum	Did you Graduate?

OTHER INFORMATION

Are you legally eligible to work in the United Sates? Yes: ☐ No: ☐	Can you perform the essential functions for the job applied for? Yes: ☐ No: ☐	Have you ever been convicted of a crime or a violation other than a minor traffic violation? Yes: ☐ No: ☐

EMERGENCY CONTACT

Name	**Address**	**Telephone Number**

REFERENCES

Name	**Address**	**Telephone number**

APPLICANTS- Please read the following and address any questions to the Human Resources representative before signing.

I certify that all statements and answers made on this application are true. I understand that if subsequent to employment any such statements and/or answers are found to be false or that information is omitted, such false statements or omissions will be considered grounds for termination of employment.

Applicant Signature:_____ Date: _____

Abik Healthcare Services, Inc.

Criminal Background Check Authorization/Consent

Please read and complete this form in its entirety, and sign in the space provided below. This consent is mandatory, and will be used to complete FBI criminal background check for employment application process only. Thank you.

Name:_____Other Name Used: _____DOB: _____

SEX _____Height___Weight_____Eye color_____Hair color___Race_____ Citizenship: _____SS#:_____Phone: _____ Driver's License #:_____State:_____Expiration:_____ Current Address:_____City_____State:_____Zip Code: _____

I,_____, hereby authorize Abik Healthcare Services to conduct my background check and qualifications for purpose of evaluation whether I am qualified for the position for which I am applying. I understand that Abik Healthcare Services will utilize an approved State of Maryland CJIS authorized firm to assist in checking such information.

I specifically authorize such an investigation and also consent that Abik Healthcare Services may use any company of their choice to obtain such information. I also understand that I may withhold my permission and in such a case, no investigation will be done, and my application for employment will not be processed further.

APPLICANTS REQUIRED TO MAKE DISCLOSURE MUST COMPLETE THE STATEMENT BELOW

I,_____, Hereby declare or affirm under penalty of perjury, that I (check one) ☐ have ☐ have not, been convicted, received a probation before judgement, received a not criminally responsible disposition and that I (check one) ☐ Am not, the subject of any pending criminal charges.

Applicant Signature:_____Date: _____

For Office Use

Authorized Personnel:_____ Date: _____

Position Applied for:_____Authorization #: 0800006826

Abik Healthcare Services, Inc.

REQUEST FOR EMPLOYMENT REFERENCE

Date: _____/_____/_____

TO: Company Name: _____Supervisor Name: _____

Telephone #: _____Fax #: _____

Dear Sir or Madam,

_____is applying to this company for the position of RN / LPN / CNA / PT / OT / ST

I authorize Abik Healthcare Services, to gather any information concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

_____
APPLICANT SIGNATURE

To be completed by Current/Previous Employer:

Position_____Date from_____to_____

Reason for leaving: _____

_____

Would you rehire? Yes☐ No☐ If no, please advise because: _____

_____

PLEASE ADVICE IF: ABOVE AVERAGE, AVERAGE, BELOW AVERAGE, OR COMMENTS.

Please rate the applicant	Above Average	Average	Below Average	Comments
Ability to work with others				
Appearance				
Attendance				
Cooperation				
Job Knowledge				
Judgment				
Quality of work				
Conduct				
Overall Rating				
General Comments:				

Signed_____Title_____Ph._____

Abik Healthcare Services, Inc.

CHARACTER REFERENCE

Name of Applicant: _____

Please Rate the Applicant	Above Average	Average	Below Average	Comment
Appearance				
Cooperation				
Judgment				
Conduct				
Communication Skills				
Reliability				
Attitude				
Honesty				
Flexibility				
Motivation/perseverance				
Ability to handle stress				
General Comments:				

Name of Person providing reference: _____

Telephone #: _____Address:_____

City/State_____Zip Code: _____ Email address: _____

How long have you known the applicant? _____

In what capacity do you know the applicant? ☐ Minister ☐ Friend ☐ Neighbor ☐ Priest ☐ Others (specify)

Name and Title of Person taking the information: _____

Character Reference Verified by _____ ☐ Phone _____

Date of Character Reference Check:_____Sign: _____

To: _____ Employer's Name

_____
Phone Number

CONFIDENTIALITY AGREEMENT

The nature of services provided by Abik Healthcare Services; Inc. requires information to be handled in a private, confidential manner.

Information about our business or our contractual employees or clients will only be released to people or agencies outside Abik Healthcare Services, Inc. with our written consent. Following legal or regulatory guidelines can provide the only exceptions to this policy. All reports, memoranda, notes, or other documents will remain part of Abik Healthcare Services, Inc. confidential records.

The names, addresses, home numbers or salaries of our contractual employees will only be released to people authorized by the nature of their duties to receive such information and only with the consent of management or the contractual employee.

The undersigned contractual employee agrees to abide by this confidentiality agreement.

_____ _____

Employee Signature/Date Witness
Signature/Date

EQUAL EMPLOYMENT OPPORTUNITY

Abik Healthcare Services, Inc. provides equal employment opportunities to all employees and applicants for employment without regard to race, color, religion, gender, sexual orientation, national origin, age, disability, marital status, and amnesty or veterans status in accordance with applicable federal, state and local laws.

Abik Healthcare Services, Inc. complies with applicable state and local laws governing non-discrimination in employment at every location in which we operate.

This policy applies to all terms and conditions of employment including, but not limited to hiring, placement, promotion, termination, recall, transfer, leaves of absence, compensation and training. The Board of Directors and Senior leadership at Abik Healthcare Services, Inc. strongly support this policy and expect that all employees will give their continuing support to it as well.

_____

Employee's Name, Signature & Date

RN JOB DESCRIPTION

JOB DESCRIPTION

SUMMARY:

Field Registered Nurse who is the case manager of the Home Health Team is responsible for the Nursing care of the patients assigned to them and direct the Home Health Aides in quality patient care. The field Registered Nurse is responsible for assessing patient and family needs in order to promote the best care the Home Health can give for recovery and rehabilitation. Provide nursing services within the scope of practice authorized by the license issued by the DHMH for a Registered Nurse.

Lines of authority and reporting responsibilities: Reports to the Director of Nursing/Nurse Supervisor, Manger.

JOB FUNCTIONS:

1. Knows the philosophies, purposes, policies and standards of the Home Health and their nursing Services department and provides for their explanation and implementation to the Home Health Aide. Be the case manager in all cases involving nursing and therapy care.
2. Assesses in depth upon the admission of the patient, the patient's physical and emotional status, level of competency, home environment, safety factors, family or household member's ability to assist with care and the need of the patient. These are incorporated into the admission notes. Conducts regular assessments accurately, according to instructions in the Policy Manual, and corresponding to documentation contained elsewhere in the assessment note.
3. Help formulate a patient care plan with the goals indicated and the means of implementing the correct procedures to attain these goals.
4. Records all clinical and progress notes and enters them into the patient's permanent record files. Be responsible for the clinical record for each patient receiving nursing care.
5. Weekly reviews the utilization and progress of the patient with the supervisor and attending physician as necessary.
6. Has knowledge of patient's condition at all times and informs the physician and/or the Nursing Supervisor immediately of any change in the patient's condition that warrants attention. Also observes, evaluates, and reports to the physician the patient's reaction to drugs or treatments, or there are deviations from the plan of care.
7. Interprets to the patient and family the expectations of the diagnosis and the nature of the treatment consistent with the action and wishes of the physician interpret to the social and physical factors in the environment that affect patient care.
8. Observe and evaluates potential danger of disabling conditions and indicates preventive and corrective measures.

9. Is responsible for the execution of the physician's orders and keeps the physician informed of all pertinent information concerning the patient's condition and response to treatment gives skills of care to patients.
10. Extends paramedical services in carrying out the rehabilitative aspects of nursing care.
11. Obtains laboratory specimens when indicated per Doctor's orders.
12. Meets weekly with Nursing Supervisor for the purpose of discussing nursing care, policies, and future planning, and keeps the Supervisor informed of all pertinent information concerning patients and the Home Health Aides.
13. Assists the Nursing Supervisor in surveying, analyzing, and determining staff requirements for the assigned patients.
14. Coordinates treatment with Paramedical personnel.
15. Make supervisory visits to all assigned Home Health Aides no less than once every two weeks.
16. Helps the family accept responsibility for providing care. Teaches and supervises family members regarding care of the patient.
17. Assumes the responsibility for orientation of new personnel and participates in in-service training programs.
18. Schedules her daily itinerary primarily based on the Priority of care needed, length of time visits will require, proximity to other patients to be visited and other related factors.
19. A weekly itinerary is to be projected for regularly scheduled visits, allowing time for new admissions, emergency cases, and Home Health Aide introduction.
20. Must advice the office of any itinerary changes and where she/he can be contacted at all times while in the field. She/he should call the office between 8:30 to 5:30 pm each day
21. Responsible for the certification and recertification of the Plan of Care.
22. May assign selected portions of patient care to licensed practical nurses and home health aides, but always retains the full responsibility for the care given and for making supervisory visits to the patient's home.
23. Performs other related duties as assigned by the Manager
24. Assure that progress reports are made to the physician for patients receiving nursing services when the patient's condition changes or there are deviations from the Plan of Care.
25. Ensure Confidential guidelines and procedures are maintained

PHYSICAL REQUIREMENTS:

1. Able to speak, read and write in English
2. Able to read assignments, follow directions
3. Able to communicate and respond clearly on telephone and respond to patient's spoken needs
4. The ability to physically transfer, lift or assist patients whose average weight is 160 pounds with or without the aid of mechanical devices
5. Able to walk, climb stairs, stop, twist, bend and squat to perform essential job functions

This Job Classification will have a Potential risk for Occupational Exposure to Blood and other Potential Infections body fluids. Protective equipment will be provided by our Agency to limit the exposure and promote self-protection practices in the delivery of the Home Health Care. The RN shall provide appropriate treatment to home health care workers in the event of exposure incident and promote compliance with the universal precautions.

MENTAL REQUIREMENTS

1. Able to concentrate on detail with frequent interruptions
2. Able to follow, complete and remember daily routines and requirements
3. Able to comprehend and utilize professional educational materials
4. Able to cope with the mental and emotional stress of the position

QUALIFICATIONS:

1. A graduate of an accredited School of Nursing and be licensed in the state of Maryland
2. Complete knowledge of nursing principles and procedures of skills in the technique of good patient care.
3. Good mental health and the quality of retaining emotional stability in situations of varying circumstances.
4. Minimum of one-year experience, preferable in community health
5. Meets the physical and health requirements of the job

RESPONSIBLE TO: Report to the Director of Nursing/Nurse Supervisor, Manager.

Employee Name: _____

Employee Signature:_____ Date: _____

Manager:_____ Date: _____

****TECHNOLOGY ASSISTED WAIVER/EPSDT**

NURSING SERVICES PROVIDER

SKILLS CHECKLIST FOR INDIVIDUALS CARING FOR TRACHEOSTOMIZED AND/OR VENTILATOR ASSISTED CHILDREN AND ADULTS

Agency Name_____

Name of Nurse Providing Service_____

	Experience		Date of Most Recent Experience
	Yes	No	
Breath Sounds – Auscultation:	☐	☐	
Before Suction	☐	☐	
After Suction	☐	☐	
Need for Aerosol	☐	☐	
Signs & Symptoms:	☐	☐	
Respiratory Distress	☐	☐	
Hypoxia	☐	☐	
Side Effects of Medications	☐	☐	
Fluid Retention	☐	☐	
PROCEDURES	☐	☐	
Chest Physical Therapy	☐	☐	
Suctioning: Positioning for	☐	☐	
Nasopharyngeal	☐	☐	
Trachea	☐	☐	
Trach Care:	☐	☐	
Clean Trach Site	☐	☐	
Change Trach Ties	☐	☐	
Change in Trach Tube	☐	☐	
Cleaning of Inner Cannula	☐	☐	
Place on Trach Collar	☐	☐	
Manual Resuscitation Device Application	☐	☐	
Via Trach	☐	☐	
Via Mouth	☐	☐	
Emergency Protocol/Procedure	☐	☐	
Knowledge of Individualized Plan	☐	☐	
Monitoring & Equipment:	☐	☐	
Vital Signs	☐	☐	
Skin Care	☐	☐	
Oral Hygiene	☐	☐	
Use of Apnea/Bradycardia Monitor	☐	☐	
Placement on Oxygen Delivery Device/Trach Collar	☐	☐	
DMAS 259 Page 2 of 3 Pages	☐	☐	
Experience Date of Most	☐	☐	
Yes No Recent Experience	☐	☐	
Monitoring & Equipment (Continued)	☐	☐	
Placement on Ventilator	☐	☐	
Calibrate Oxygen Analyzer	☐	☐	
Check Oxygen Level/Liter Flow/Tank Level	☐	☐	
Check/Calibrate Ventilator Settings	☐	☐	
IMV	☐	☐	
	☐	☐	
PEEP	☐	☐	
Pressure Units	☐	☐	
Tidal Volume	☐	☐	

	Experience		Date of Most Recent Experience
	Yes	No	
Systematic Troubleshooting of Ventilator	☐	☐	
Use of Respirometer	☐	☐	
Humidity System:	☐	☐	
Check Water Level	☐	☐	
Check Temperature	☐	☐	
Filling Procedure	☐	☐	
Draining Water from Tubing	☐	☐	
Cleaning of Humidity Bottles/Cascade	☐	☐	
Check Compressor Operation	☐	☐	
Clean Compressor Unit Screen	☐	☐	
Assess Suction Machine Pressure	☐	☐	
Clean Suction Machine	☐	☐	
Clean Suction Catheters	☐	☐	
Clean Corrugated Tubing	☐	☐	
Clean Manual Resuscitation	☐	☐	
Device (Reservoir Bag & Assoc. Equip)	☐	☐	
Clean Trach Collar	☐	☐	
Clean Track Tubes	☐	☐	
Disposable	☐	☐	
Metal	☐	☐	
Medication Administration:	☐	☐	
Administration Technique (as appropriate)	☐	☐	
Installation of Normal Saline	☐	☐	
Administration of Aerosol Treatments	☐	☐	

Additional individualized Assessments/Skills:

I (Supervisor/Designee) _____, have in serviced the Nurse regarding assessment and skills listed above.

Print Name (Supervisor/Designee) _____

Title _____

Organization_____

(Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.)

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

Print Name (Orientee) _____

*Please indicate N/A when nonapplicable

SKILLS CHECKLIST FOR NURSES CARING FOR INDIVIDUALS WITH NUTRITIONAL NEEDS

Agency Name_____

Name of Nurse Providing Services _____

ASSESSMENTS:

Assess and Record Intake and Output	Date Described/Observed	Date Demonstrated
Assess Signs and Symptoms		
Dehydration		
Fluid Retention		
Procedure/Techniques		
Weight		
Skin Care		
GT site		
NG Site		
PO (By Mouth) Feeding:		
Preparation of Special Formula/Feeding		
Nasogastric Feeding		
Preparation of Special Formula/Feeding		
Insert NG Tube		
Check NG Placement		
Check NG Residual		
Bolus Feed		
Use of Feeding Pump		
Gastrostomy Feeding:		
Insert GT Tube		
Check Placement of GT Tube		
Bolus Feed		
Use of Feeding Pump		
Hyperalimentation (As Per Physicians Orders):		
Reading/Checking Hyperalimentation Prescription		
Operation of Infusion Pump		
Troubleshooting of Infusion		
Placement/Care of Infusion Line		

I (Supervisor/Designee) _____, have in serviced the Nurse regarding assessment and skills listed above.

Print Name (Supervisor/Designee) _____

Title _____

Organization_____

(Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.)

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

Print Name (Orientee) _____

Abik Healthcare Services, Inc.

EMPLOYMENT AGREEMENT

This employment agreement made and entered into today, _____ by and between **ABIK HEALTHCARE SERVICES, INC.** hereinafter called "**COMPANY**", incorporated in the State of Maryland and doing business at No. 6103 Baltimore Avenue, Suite 203, Riverdale MD 20737 and _____, (**EMPLOYEE**) of _____ (address) for the purpose of employment as company Healthcare Provider;

WHEREAS Company is in the business of providing Home Healthcare and Therapy Services to the elderly, sick and physically challenged individuals in the comfort of their own home/s.

WHEREAS Company recruits' healthcare providers namely; RN, PT, OT, ST, LPN, CNA, HHA/CMT professionals and post them to the homes and/or as the case maybe for the purpose of providing the quality care in accordance with the prescribed professional responsibilities.

WHEREAS _____ is desirous of the employment with the company for the position of _____ and will always provide high quality care in adherence to the prescribed professional responsibilities.

WHEREAS Employee hereby pledge and verify that he/she is duly qualified, experienced and properly licensed for the position and that all the certificates, licenses and permits he/she submitted to Company are genuine and verifiable.

WHEREAS Employee certifies that he/she is duly authorized to receive employment in the United States.

NOW THEREFORE, it agreed that;

1. Employee will be employed by Company in the position of _____ on a temporary basis for the purpose of performing services for Company's clients, in their respective homes.

2. It is anticipated that the Project will begin on **_____.** The starting and ending dates are subject to change. Employee's employment with Company will commence or will terminate (if your employment has commenced) if the Client cancels, postpones or otherwise alters the Project.

3. **Duties and Responsibilities:** During the period of this employment, employee shall perform his/her duties and responsibilities diligently and consistent with the policies, procedures and practices of the Company and in accordance with accepted professional practice.

4. While working on the Project at the Client's worksite, employee will work under the supervision of the Client and will be required to abide by all of the Client's policies. You will not be an employee of the Client and will not enter into any contractual agreement with the Client.

5. Employee will be paid at a regular hourly rate of $____.00. Your compensation will be paid in bi-weekly installments in accordance with the Company's normal payroll practices. You are required to submit visit notes promptly and not later than last day of each week since any delay will not guarantee your payment for that week.

6. Employee may be eligible to participate in the Company's employee benefit programs that the Company may, in its discretion, from time to time maintain for employees of your level. The Company expressly reserves the right to modify, substitute or eliminate such benefits at any time or completely scrap the program completely.

7. Although we anticipate that your employment will continue until completion or earlier termination of the Project, your employment at Company is "at will". This means that either you or the Company may end your employment at any time; however, two-week prior written notice is required for proper termination of this contract. Without altering your at-will status, your employment will be deemed automatically terminated upon completion or earlier termination of the Project, without any further action from or by Company. You further acknowledge that nothing in this letter is intended to create a contract of employment for a definite term or a contract of continuing employment.

8. **Indemnity:** Employee must perform his/her duties diligently and to promptly report to Company about any complaints, claims, damages, injuries to persons or property of whatever kind or nature arising out or as a result of the performance of his/her duties and must promptly submit a written report clearly stating the said incident. Employee is being offered Insurance coverage in respect of any such loss, however Employee agrees to indemnify Company for any liability incurred as a result of his/her negligence and/or intentional misconduct.

9. Company does not reimburse Employee their travel costs for getting to and from the Client worksite or any relocation costs. Staff are entitled to 40 hours per week but may choose to do more hours without expecting overtime pay since the contract did not provide overtime compensation

10. All disputes arising out of this agreement shall be exclusively resolved in the State of Maryland Court of competent jurisdiction. Each party consents to the jurisdiction of the State of Maryland and/or the Federal Court sitting in the State of Maryland and therefore waives any objection or rights as to forum.

11. **Confidentiality:** Except as authorized or directed by the Company, you shall not, at any time during or subsequent to your employment, directly or indirectly publish or disclose any Confidential Information of the Company or the Company's clients that has come into your possession in the course of your employment with the Company and you shall not use any such Confidential Information for your own personal or advantage or the use or advantage of any person or entity other than the Company or the Company's clients, or make it available to others for use. All Confidential Information, whether oral or written, regarding the business or affairs of the Company or the Company's clients including, without limitation, information as to the Company's or the Company's clients' products, medical records, social security number, services, systems, designs, inventions, finances (including prices, costs and revenues), marketing plans, sales, sales strategies, prospects, pricing, pricing strategies, programs, methods of operation, prospective and existing contracts, customer lists and other business arrangements or business plans, procedures, and strategies, shall all be deemed Confidential Information, except to the extent the same shall have been lawfully and without breach of obligation made available to the general public without restriction, or that you can prove, by documentary evidence, was previously known to you prior to the term of your employment.

12. Upon expiration or termination of this contract for any reason, Employee agrees to deliver to the Company all Company or Company's client Confidential Information and proprietary materials in his/her possession or control, including but not limited to manuals, photographs, reports, customer and supplier lists, plans, costs of materials, software, equipment, and all other materials or other things in his/her possession, custody, or control which are the property of the Company or the Company's client.

13. Employee agrees that he/she will not accept any assignment or employment from Client to be performed anywhere directly or through an intermediary with the Client for 180 days from termination of this assignment without written consent from Company.

14. This employment is contingent upon having and maintaining authorization to work in the United States. Employee will be required to produce documents showing that he/she are authorized to be employed in the United States. The Company reserves the right to terminate Employee's employment should he/she fail to possess or maintain such work authorization, or if such work authorization expires.

15. This employment with the Company is also contingent upon our completion of a satisfactory background check.

16. This agreement supersedes any and all other agreement or understanding either oral or written between the parties, and contains all the terms and conditions of this contract. This agreement may only be modified or amended in writing, signed by authorized representatives of both parties. Neither this agreement nor any rights or obligations accrued hereunder may be assigned or transferred by either party without prior written consent of the other party.

In witness therefore, the parties hereto execute this agreement hoping to be bound.

_____	_____
ABIK Healthcare Services, Inc.	Name of Employee:
Date: _____	Date: _____

ABIK HEALTHCARE

RN ORIENTATION CHECKLIST FOR FULL TIME AND PART TIME PERSONNEL

GOAL: To assure that staff possess the basic competencies to fulfill the responsibilities of their job descriptions and comply with the agency policies and procedures. it is essential that every new employee be oriented to the policies of the agency. An orientation period provides an opportunity to assess the new employee's competencies and provide instruction, coaching, and mentoring to strengthen any deficits identified. In addition to being assured that they are competent to fulfil the responsibilities associated with their roles, new employees can gain an understanding of the organization's vision, mission, and culture during the orientation period. A sound orientation program is an investment in retaining employees and promoting a high quality of services

NAME OF PERSONNEL:_____ORIENTATION DATE; _____

SUBJECT	ONE WHO INITIAL	ORIENTS DATE
1. AGENCY PHILOSOPHY, GOALS, OBJECTIVES, STANDARDS		
2. ORGANIZATIONAL CHART		
3. INTRODUCTION OF ADMINISTRATIVE AND SUPPERVISORY PERSONNEL		
4. PERSONNEL POLICIES – COPY OF EMPLOYEES HANDBOOK		
5. GRIEVANCES & COMPLAINT MANAGEMENT/INCIDENT REPORT 6 UNIFORM – PERSONEL APPEARANCE/DRESS CODE 7 REVIEW OF EMPLOYEE RIGHT AND RESPONSIBILITIES 8 STAFF PROBATIONARY PERIOD 9 CPR/FIRST AIDE REQUIREMENT & APPLICATION 10 CONFLICT OF INTEREST 11 JOB DESCRIPTIONS & STAFF DEVELOPMENT		
12 INTRODUCTION TO HOME HEALTH a. ELIGIBILITY FOR HOME HEALTH CRITERIA b. WHAT IS HOME HELATH AND WHAT SERVICES ARE PROVIDED		
13 CRITERIA FOR ACCEPTANCE OF PATIENT TO HOME HEALTH		
14 JOB DESCRIPTION a DOCUMENTATION OF SERVICES PROVIDED b SAFETY PRSCTICES: FIRE & ACCIDNT PREVENTION c STANDARD PRECAUTIONS FOR INFECTION CONTROL & HAZZARD WASTE d. EMPLOYEE HEALTH PROGRAM e. FALL PREVENTION & CONTROL f. STEPS TO FOLLOW IN EVENT OF FIRE, TONADO, BOMB, DISASTER PLAN g. ABUSE AND NEGLECT h. REVIEW OF PATIENTS RIGHT & RESPONSIBILITIES		
15 SIGN-UP PROCEDURE DOCUMENTATION a. DISCREMINATION AND HARASSMENT b. SEXUAL HARASMENT c. ETHICS & CONFIDENTIALITY OF PATIENT d. LEGAL AND REGULATORIEY ISSUES: REGULATORY REQUIREMNTS, CONFIDENTIALITY OF PATIENT & ABUSE CONCERNING RESTRAINTS, AVOIDING LEGAL PROBLEMS.		

SUBJECT	ONE WHO INITIAL	ORIENTS DATE
H. MEDICATION SHEET/MANAGEMENT I. CARE PLAN J. HOME HEALTH AIDE ASSIGNMENT SHEET K. ADVANCE DIRECTIVES L. PATIENT BILL OF RIGHTS M. GRIEVANCE PROCEDURES N. SAFETY ISSUES IN THE HOME (INCLUDING SECURITY & GUNS IN THE HOME O. IDENTFYING & REPORTING ABUSE, NEGLECT & EXPLOITATION		
16 OTHER DOCUMENTATION a. TIME/TRAVEL b. HOME HEALTH AIDE SUPERVISORY DOCUMENTATION c. FALSE CLAIMS FALSE STATEMENT AND WHISTLE BLOWING d. REINSTATEMENT AFTER BTERMINATION OF EMPLOYMENT e. DOCUMENTATION -RECORD KEEPING INCLUDING MAR f. ACTION TO TAKE INUNSAFE SITUATION g. FRAUD AND ABUSE h. MEAL PREPARATION AND ASSIST IN FEEDING		
16. ETHICS ND CONFIDENTIALITY		
17 OVERVIEW a. HOME SAFETY (BATHROOM, ELECTRICAL, ENVIRONMENTAL, HAZARDS) b. CONSENT TO AGENCY INSERVICE TRAINING PROGRAM c. PATIENTS'S RIGHTS, PROFESSIONAL BOUNDARIES d. PATIENT CARE PROCEDURE MANUAL, PAIN MANAGEMENT e. TEAM RESPONSIBILITIES, CARE PLAN, UPDATE/REPORTS GUIDELINES f. AGENCY'S PERFORMANCE PLAN, INCIDENT/VARIENCE REPORTING		
18 COMMUNICABLE DISEASES POLICY & PROCEDURES a. COPING WITH ALZHEIMER DISEASE & DEMENTIA PATIENTS b. EMERGENCY PREPARDNESS ACTION PLAN TO TAKE DURING DISASTERS c. PERFORMANCE IMPROVEMENT d. EMPLOYEE RANDOME DRUG TESTING CONSENT e. POLICY GUIDELINES REGARDING PERSONS WITH CONFIRMED OR SUSPECTED DISABLING OR INFECTIONS DISEASES		

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION. I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISED THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

_____ _____

Employee Name: **Date**

_____ _____

SIGNATURE OF ORIENTER **DATE**

HEPATITIS B VACCINE ACCEPTANCE/DECLINATION FORM

ACCEPTANCE:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by bloodborne pathogens, Including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). This is to certify that I have b e e n informed about the symptoms and the hazards associated with these viruses, as well a s the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B (HBV) vaccine. Based on the training I have received; I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

DECLINATION:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination 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.

CHECK ONE:

☐ I ACCEPT Hepatitis B vaccine inoculation: OR

☐ I DECLINE Hepatitis B vaccine inoculation.

Employee's Name: _____

Employee's Signature: _____ Date: _____

Agency Representative Signature: _____ Date: _____

ALCOHOL ACKNOWLEDGEMENT BY EMPLOYEE

I_____, an employee of Abik Healthcare Services, Inc. does certify that I have read and understand the "control of alcohol and Drug Abuse Policy of this firm. I understand that I may be terminated from employment for criminal conviction of Federal or Non- Federal statues involving alcohol or drug abuse on or at workplace. This statement simply acknowledges the firm's Control of Alcohol and Drug Abuse Policy" on or at the workplace, and is not intended to circumvent any existing firm disciplinary rules.

Signed by me on this_____day of_____, 20____

_____ _____

Employee **Witness**

Cc: Personnel file

COVID-19 VACCINE

Name_____Date_____

Address: _____

Phone Number_____

☐ I have received the COVID-19 Vaccine and will provide the agency with valid documentation.

☐ I have received the COVID-19 Vaccine and will provide the agency with valid documentation.

Signature _____ Date_____

PHYSICAL EXAMINATION VERIFICATION

SECTION I

(TO BE FILLED OUT BY APPLICANT)

_____ (Last 4 digits_____)

Name Social security number

_____

Physician's Name Phone number

_____

Physician Address

_____

City, State, Zip code

I hereby request and authorize Abik healthcare services, inc. to contact my physician. I authorize the physician stated to release results of my last physical exam. To the best of my knowledge, I am free from communicable disease, illness and any disabilities, which would interfere with my performance in the health care field.

SECTION II

(TO BE COMPLETED BY PYSICIAN)

Date of last physical exam_____

I hereby verify that the above applicant was examined by me on the date stated above. The individual, according to my records is free from communicable diseases including TB and is eligible for employment in the health care field with no restrictions.

Results of PPD_____ Date _____Chest X-Ray _____Date_____

Comments_

Physicians signature:_____ Date_____

ANNUAL TUBERCULOSIS SYMPTOMS SCREENING FOR EMPLOYEE

Employee Name: _____

All employees will be evaluated annually by PPD screening for the prevention of tuberculosis. Employees with a positive PPD test result must have a chest x-ray as part of the initial evaluation of their PPD test. If the chest x-ray is negative, no repeat chest x-ray is required unless symptoms developed that are attributed to tuberculosis

Employees with negative tuberculosis chest x-ray must be monitored once per year for tuberculosis (TB) symptoms using the questionnaire below. We are not asking for you to repeat the x-ray.

Follow Up Questionnaire

I. When did you have a chest x-ray? _____

2 What were the results?

3	Do you have a cough?	☐ YES	☐ NO
4	Do you have night sweats?	☐ YES	☐ NO
5.	Do you have unexplained weight loss?	☐ YES	☐ NO
6.	Have you been exposed to anyone who has TB?	☐ YES	☐ NO

If the answer is yes to two or more of the above questions, please notify your supervisor immediately about your arrangement for an evaluation with a practitioner.

Tuberculosis Testing PPD

The tuberculin skin test is done to see if someone has ever had tuberculosis (TB) bacteria
The Mantoux PPD tuberculosis test involves injecting a very small amount of substance called PPD tuberculin just under the top layer of the skin (intracutaneously).

By adding my signature below, I attest to the data above as true.

Employee's Signature: _____Date:_____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

► **START HERE.** **Read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*Aliens authorized to work must only one your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code – Section 1
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(check one):*

a) I did not use a preparer or translator. b) 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

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

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

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 Last Name, First Name and Middle Initial from Section 1:

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

Identity and Employment Authorization	**Identity**	**Employment Authorization**
Document Title:	Document Title:	Document Title:
Issuing Authority:	Issuing Authority:	Issuing Authority:
Document Number:	Document Number:	Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:		
Issuing Authority:		
Document Number:	Additional Information	
Expiration Date *(if any)(mm/dd/yyyy)*:		
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		

QR Code – Section 2 & 3
Do Not Write in This Space

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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		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)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy):*

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

W-4

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▸ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▸ **Give Form W-4 to your employer.**
▸ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		▸ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld..... ▸ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▸ $ _____

Multiply the number of other dependents by $500..... ▸ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▸ _____ ▸ _____

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

MW507 FORM

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland Income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions you will claim on your tax return. However, if you wish to claim more exemptions, or if your adjusted gross Income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based on itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland Income tax if:

a. Last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND,
b. This year you do not expect to owe any Maryland Income tax and expect to have a right to a full refund of all Income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland Income tax from your wages.

Students and Seasonal Employees whose annual Income will be below the minimum filing requirements should claim exemption from withholding. This provides more Income throughout the year and avoids the necessity of filing a Maryland Income tax return.

Certification of no residence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Residents of Pennsylvania who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more, should complete line 5 to exempt themselves from the state portion of the withholding tax. These employees are still liable for withholding tax at the rate in effect for the Maryland county in which they are employed, unless they qualify for an exemption on either line 6 or line 7. Pennsylvania residents of York and Adams counties may claim an exemp- tion from the local withholding tax by completing line 6. Pennsylvania residents living in other local jurisdictions which do not impose an earnings or Income tax on Maryland residents may claim an exemption by completing line 7. Employees qualifying for exemption under 6 or 7, should also write "EXEMPT" on line 4.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland Income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total Income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland Income tax on wage or salary Income, regardless of the length of time you may have spent in Maryland.

Under the Service members Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland Income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 8; enter "EXEMPT" in the box to the right on Line 8; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. You have any reason to believe this certificate is Incorrect;
2. The employee claims more than 10 exemptions;
3. The employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to Incur no tax liability this year and the wages are expected to exceed $200 a week;
4. The employee claims an exemption from withholding on the basis of nonresidence; or
5. The employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee must file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507 Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security Number
Street Address, City, State, ZIP	County of residence (Nonresidents enter Maryland county (or Baltimore City) where you are employed.)

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2. . . . . 1. _____
2. Additional withholding per pay period under agreement with employer. . . . . 2. _____
3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   ☐ a. Last year I did not owe any Maryland Income tax and had a right to a full refund of all Income tax withheld and
   ☐ b. This year I do not expect to owe any Maryland Income tax and expect to have the right to a full refund of all Income tax withheld. (This Includes seasonal and student employees whose annual Income will be below the minimum filing requirements). If both a and b apply, enter year applicable_____(year effective) Enter "EXEMPT" here . . . . . 3. _____
4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here. . . . . 4. _____
5. I claim exemption from Maryland **state** withholding because I am domiciled in the Commonwealth of Pennsylvania and I do not maintain a place of abode in Maryland as described in the instructions on Form MW507. Enter "EXEMPT" here. . . . . 5. _____
6. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction within York or Adams counties. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 6. _____
7. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction that does not impose an earnings or Income tax on Maryland residents. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 7. _____
8. I certify that I am a legal resident of the state of_____and am not subject to Maryland withholding because I meet the requirements set forth under the Service members Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Enter "EXEMPT" here. . . . 8. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on whichever line(s) I completed.

Employee's signature	Date
Employer's name and address including ZIP code (For employer use only)	Federal Employer Identification Number

COM/RAD-036 16-49