NorthCrest MEDICAL ◆ CENTER

Instructions for completing new hire paperwork:

1) **Please print off the paperwork and complete all highlighted areas. If you are not sure of how to complete something, please skip that area and we can complete together in the office.**

2) **Please bring all signed and completed paperwork to the Human Resources' office at your assigned appointment time.**

3) **Please allow 15 minutes to complete the paperwork and allow ample time to go to employee heatlh after your paperwork is complete for your pre-employment physical. You will need a photo ID to complete the physical.**

4) **Be prepared to have your picture taken for your name badge.**

ITEMS to bring with you to your appointment:

1) **One document from Column A**
   OR
   One document from Column B + one document from Column C

A	B	C
Identity + Right to Work	**Identity Only**	**Right to Work Only**
• U.S. Passport of U.S. Passport Card • Permanent resident card or Alien Registration receipt card • Foreign passport w/ temp I-551 stamp or temp I-551 printed notation on a machine-readable immigrant visa • Employment authorization doc w/ photo • Foreign passport w/ form I-94/A • Passport from FSM or RMI w/ form I-94/A	• Driver's license or photo ID issued by state • Photo or info ID issued by federal, state, or local gov't agency • Voter's registration card • U.S. military card or Military dependent ID card • School I.D. card with photo • U.S. Coast Guard Merchant Mariner Card • Native American tribal document • Canadian gov't issued driver's license • (Under 18 may choose one): School record/Report Card/day-care record/hospital record	• Social Security card • Certification of Birth Abroad • Certification of Report of Birth • Original or certified copy of birth certificate • Native American tribal documents • U. S. citizen ID card • Resident citizen ID card • Unexpired employment authorization by DHS

2) **Voided check or account and routing number (deposit slips are not acceptable)**

3) **Social Security card for W-4 tax form**

4) **Copy of HS diploma, GED, College Degree, or transcript (THIS IS ONLY REQUIRED FOR THOSE WITHOUT A CLINICAL LICENSE) If you have a clinical licensure you do not have to bring this.**

5) **Copy of shot records (MMR, Varicella, Pertussis, Hep B) TB skin test, Mask fit, Flu**

6) **Copy of CPR, BLS, PALS, certifications required for clinical staff**

*** For any questions or assistance, please contact Human Resources at 615-384-1513.**

NorthCrest
MEDICAL ◆ CENTER

Authorization to Withhold Monies
From Final Paycheck

I, _____, authorize NorthCrest Medical Center
PRINT NAME
and/or its representatives to deduct the cost of my background investigation, costs associated with my pre-employment physical & immunizations (if applicable) from my final paycheck if I terminate, voluntarily or involuntarily, employment prior to completing three (3) months of service.

In addition, should I fail to return my employee handbook, name badge, keys, beeper, parking permit at time of termination, I authorize NorthCrest Medical Center to deduct the cost of replacing those items from my final paycheck.

I understand that should my employment at NorthCrest Medical Center terminate, voluntarily or involuntarily, my last check will be direct deposit and the check stub will be mailed to me.

Should there be any outstanding monies due to NorthCrest Medical Center, I understand that my signature below authorizes these monies to be deducted from my last paycheck to satisfy any outstanding balances.

_____ _____
Employee signature Date

_____
On behalf of NorthCrest Medical Center

BENEFICIARY DESIGNATION FORM

Life Insurance Company of North America

CIGNA Group Insurance
Life · Accident · Disability

Employer Name *NorthCrest Medical Center*

Employee Name_____ Employee Social Security # _____

Current Address_____ City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ *please enter all dates in mm//dd/yyyy format.*

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Basic Life Insurance, Life Insurance Company of North America - Policy No. *FLX-963258*

Employee's Primary Beneficiary(ies):	Relationship	SS #	Date of Birth	% (total must equal 100%)
Contingent(s):	**Relationship**	**SS #**	**Date of Birth**	**% (total must equal 100%)**

Basic Accident Insurance, Life Insurance Company of North America - Policy No. *OK-964914*

Employee's Primary Beneficiary(ies):	Relationship	SS #	Date of Birth	% (total must equal 100%)
See above				
Contingent(s):	**Relationship**	**SS #**	**Date of Birth**	**% (total must equal 100%)**
See above				

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature N/A Date___/___/____

Owner Signature_____ Date___/___/____

Please refer to page 2 to review *Guidelines for Designation of Beneficiaries*. If you need additional space, using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here	7	N/A

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)
NORTHCREST MEDICAL CENTER 100 NORTHCREST DR, SPRINGFIELD, TN 37172		64-1049595

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er) / $9,350 if head of household / $6,350 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Pension and Tax Deferred Annuity Plans of NorthCrest Medical Center

Beneficiary Designation Form

1 PARTICIPANT INFORMATION

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI

STREET ADDRESS		
CITY	STATE	ZIP

DATE OF BIRTH	DATE OF HIRE	TELEPHONE NUMBER	OFFICE LOCATION

2 BENEFICIARY(IES) INFORMATION

☐ **I AM NOT MARRIED**

I understand that if I become married in the future, this form automatically ceases to apply and I should file a new beneficiary designation.

☐ **I AM MARRIED**

If my spouse is not the only Primary Beneficiary, my spouse has signed the consent and acknowledgement below. If my spouse does not sign such consent, I understand that any death benefits under the Plan will automatically be payable in full to my surviving spouse.

I designate the following individual(s) as beneficiary of my account with regard to the percentage I have indicated below.

Primary Beneficiary(ies)

LEGAL NAME	ADDRESS	SS#	RELATIONSHIP	AGE	
					%
					%

Secondary Beneficiary(ies) — if primary beneficiary(ies) dies before you

LEGAL NAME	ADDRESS	SS#	RELATIONSHIP	AGE	
					%
					%

3 SPOUSAL CONSENT AND ACKNOWLEDGEMENT

I consent to this beneficiary designation. My consent is not revocable — I cannot take it back. I know that this beneficiary designation controls payment of the entire death benefit. Because I have consented to this beneficiary designation, I may receive no death benefit at all from the Plan. If the Participant changes this beneficiary designation and dies while married to me, however, I will have the right to receive his or her entire death benefit unless I, in writing witnessed by a notary public, have consented to and acknowledged the effect of the changed beneficiary designation.

Day Month Year

Signature of Participant's Spouse Date

Signature of Notary Public (or Plan Representative) Date

4 PARTICIPANT AUTHORIZATION

I have read and understand the instructions contained on this form. Any previous beneficiary designation made by me is hereby revoked. Subject to spousal consent, I reserve the power to change this designation at any time by a form similar to this both signed by me and received by the Plan Administrator prior to my death. If my primary beneficiary(ies) precedes me in death, distribute my Plan benefit to my secondary beneficiary(ies). If none of the named beneficiaries survive me, distribute according to the Plan and Trust Document.

Participant's Signature

Date

Please make a copy of this form for your records.

NorthCrest Medical Center
Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password.
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    a. Share/disclose user-IDs, passwords or tokens.
    b. Use tools or techniques to break/exploit security measures.
    c. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

The following statements apply to physicians accessing the Company systems that contains patient identifiable health information (e.g.Healthmatics Enterprise/Envista):

17. I will only access software systems to review patient records when I have that patient's consent to do so. By accessing a patient's record, I am affirmatively representing to the Company at the time of each access that I have the requisite patient consent to do so, and the Company may rely on that representation in granting such access to me.
18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.
19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician Signature	Facility Name	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name	

New Hire EEO-1 Data Sheet

Please complete this New Hire EEO-1 Data Sheet. It will supply us with information we need for federal reporting obligations. Please be advised that this information will be used and kept confidential, in accordance with applicable laws and regulations. This information will not be used as the basis for any adverse employment decision.

Name _____ Social Security # (last 4 digits) _____
Last First Middle

EEO-1 Self-Identification

We are subject to certain government recordkeeping and reporting requirements for the administration of civil rights laws and regulations. To comply with these laws, we invite you to voluntarily self-identify your race or ethnicity. **Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment.** The information obtained will be kept confidential and separate from personnel files. It may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those requiring information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Please check the EEO Identification Group that best applies to you:

☐ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

- OR -

☐ **White (Not Hispanic or Latino):** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American (Not Hispanic or Latino):** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino):** A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino):** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino):** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

☐ **Two or More Races (Not Hispanic or Latino):** All persons who identify with more than one of the above races, excluding those who identify themselves as Hispanic or Latino.

Gender: ☐ Male ☐ Female

_____ _____
Signature Date

If you should have any questions regarding this form, please contact Human Resources.

NorthCrest
MEDICAL ◆ CENTER

SECURITY

Employee Information

Name:_____ Date of Hire: _____

Dept:_____ Employee No._____

Extension Number:_____

Employee Badge No._____ Parking Pass #1:_____

#2:_____

Date Issued:_____

Date Returned:_____

Vehicle Information

Year: Make: Model: Color: State: License Plate #:

#1 _____

Vin # _____

#2 _____

Vin # _____

#3 _____

Vin # _____

You are issued one pass for your vehicle at no charge. If you should need an extra pass there is a $5.00 charge. You are responsible for the pass & it must be returned if you should terminate employment. There is a $5.00 charge for any lost passes.

_____ _____

Employee Signature Date

Security & Parking 2011

CONSUMER DISCLOSURE & AUTHORIZATION FOR BACKGROUND INVESTIGATION

In connection with my application for employment with NorthCrest Medical Center, I fully understand that NorthCrest Medical Center and/or Verified Credentials, as their agent, may request/perform a consumer report/background investigation on me.

The consumer report/background investigation may contain the following types of information: verification of prior employment(s) and dates of employment, academic achievement, professional licensure, and credit reports. I further understand the report may contain information about any prior criminal history, civil litigation, social security number verification, driving records, Uniform Commercial Code (UCC) filings, any liens or judgments, and bankruptcy as a result of a public record(s) search from any federal, state, or any other agency which might contain such records. Information regarding conviction will not necessarily bar an applicant for employment, but will be reviewed in light of all the surrounding circumstances, including age at the time of the offense, seriousness and nature of the violation, rehabilitation, relationship of the offense to employment and federal statutory requirements.

I authorize and request all persons, schools, business, corporations, credit bureaus, courts, law enforcement agencies, armed forces, employment commissions, and all government agencies to release said information without restriction or qualification. I authorize a Photostat (or facsimile "Fax") of this release to be considered as effective as the original. All results will be proprietary and kept confidential, and will not be provided to any parties other than NorthCrest Medical Center or its legal representative. I am aware that I have the right to request the nature and scope of the results, as reported, from NorthCrest Medical Center. I voluntarily waive all recourse and release the requested parties from liability for complying with this request/release.

All background information obtained shall be utilized to assist in verification of the employment application. Retrieval and usage of this information complies with all Equal Opportunity Commission, Americans With Disabilities Act, and the Fair Credit Reporting Act (Laws, Rules, and Regulations). NorthCrest Medical Center is an Equal Opportunity Employer, and does not discriminate as to race, color, gender, national or religious origin, age, disabilities or any other characteristic protected by law. I understand that the request for Date of Birth is for permissible purpose and not for purposes prescribed by the laws prohibiting age discrimination. The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are least 40 years of age. It is unlawful for an employer to refuse to hire; discharge; or otherwise discriminate with respect to compensation, terms, conditions, or privileges of employment because of an individual's age.

I hereby declare that the answers to the questions on my application and related paperwork which I have been asked to complete, and any attachments to same, are true and correct and that any misstatements of fact(s) or omissions may form the basis for rejection of my application or for my dismissal after employment. I authorize Verified Credentials to provide the results of said information to NorthCrest Medical Center or its representatives. If hired, this authorization shall remain on file and shall serve as ongoing authorization for NorthCrest Medical Center and/or Verified Credentials to procure consumer reports/background investigations at any time during my employment period. I further release NorthCrest Medical Center and Verified Credentials, its officers, employees, and agents, from any and all liability from the results and preparation of any reports concerning my background or myself. I understand and acknowledge that except as provided in the Fair Credit Reporting Act, I may not bring any action or proceeding against Verified Credentials, NorthCrest Medical Center, or any user or furnisher of information, for defamation, invasion of privacy, or negligence with respect to the reporting of information disclosed pursuant to the Fair Credit Reporting Act, except as to false information furnished with malice or willful intent to injure me. **The facts set forth by me in this application are true and correct to the best of my knowledge and belief.**

_____ _____

PRINT NAME SOCIAL SECURITY NUMBER

_____ _____

SIGNATURE DATE

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AUTHORIZATION—SUBSTANCE SCREENING

By my signature below, I voluntarily and knowingly agree to the following:

a. I consent to take any physical or medical examinations, including blood and urine or other tests for alcohol and drugs, requested by the hospital in connection with the processing of my application for employment, and further agree to take any such physical or medical examinations requested by the hospital during my employment if I am offered and accept a job. I understand that such an examination is needed in order to determine my competence to perform the job or work for which I was hired, or to identify any physical or mental condition bearing on my job performance. I understand that refusal to submit to any physical or medical examination ordered by the hospital is grounds for rejection for employment or for disciplinary action up to and including immediate discharge. I further understand that any information obtained through such exams may be retained by the hospital and is exclusively the hospital's property. I also understand that the examinations will be performed by medical personnel, clinics or laboratories qualified to do the necessary work and costs for such examinations will be borne by the hospital.

b. I consent to submit to and cooperate in any questioning, any searches of my assigned vehicle, locker or storage areas, or bags or other belongings on or in the hospital's property that the hospital, in its discretion, may request, and I understand that the refusal to submit to or cooperate in these procedures is grounds for disciplinary action up to and including immediate discharge.

c. I acknowledge I have read, understand and will abide by the above notice; that a copy has been furnished to me; and another copy is made part of my personnel file if I am hired.

_____
Signature

_____
Date

NorthCrest Medical Center
Policy & Procedure

TITLE: Immunizations/Employees	POLICY NUMBER: EH.013	PAGE #: 1
ORIGINAL POLICY DATE: 01/09	MOST RECENT REVIEW OR REVISION DATE: 10/10	
INITIATED BY: Infection Control/Employee Health		

Purpose:
Optimize use of immunizing agents to safeguard the health of the employee/volunteer while protecting patients of NorthCrest Medical Center

Policy:
NCMC will follow current CDC recommendations for a comprehensive vaccination program for employees/volunteers.

Procedure:

Influenza

1. To reduce staff illnesses and absenteeism during the influenza season and to reduce the spread of influenza from workers to patients, all healthcare workers should be immunized annually.
2. An influenza vaccine should not be administered to persons known to have anaphylactic hypersensitivity to components of the influenza vaccine without first consulting a physician. Persons with acute febrile illness typically should not be vaccinated until their minor illnesses are over.
3. Pregnant or breast-feeding employees will be encouraged to take an influenza vaccination without fear of adverse reactions.
4. Influenza (inactivated) vaccinations will be offered to employees and volunteers free of charge each flu season (October-March). Employees or volunteers refusing a vaccination will be required to complete a declination form and wear a surgical mask during work hours throughout the flu season. Noncompliance will result in disciplinary action. Please initial

Rubella

1. All healthcare workers (male or female) should be immune to Rubella.
2. Upon hire to NCMC, employee will be screened for Rubella immunity. If the employee is found to be without immunity, he/she will be instructed to seek MMR vaccine from Employee Health during the orientation period. Compliance will be monitored.

Hepatitis B

1. The Hepatitis B series will be offered free of charge to all NCMC employees/volunteers through the Care Center or Employee Health at extension 3864. Employees refusing the vaccination series will be required to complete a declination form.

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I certify that I am not currently ineligible to participate in any of the Federal health care programs, and if at any time during the course of my employment I become ineligible to participate, I will immediately notify Human Resources Department which will, in turn, notify the Compliance Officer.

_____
Print Name

_____ _____
Signature Date

Reward and Recognition Motivation Assessment

Name: **Department:**

Please place an "x" in the appropriate box to rate each item listed 1-5 (5 being most appreciated) as to your preference for receiving rewards and recognition.	1	2	3	4	5
Informal verbal words of thanks given privately					
Informal verbal words of thanks given publicly					
Written note of appreciation					
Probationary period completion recognition					
Certificate of appreciation (i.e. for attendance, serving on teams, etc.)					
Recognition in newsletters					
Team celebration (pizza party, ice cream social, etc.)					
Organization-wide celebration (cookout, picnic, hospital week)					
Immediate reward and recognition from multiple sources (employee to employee, leader to employee)					
Department or Team Recognition (from multiple sources)					
Gift Certificates (please rate on an individual basis)					
Walmart					
Lowes					
Kroger					
Belk					
Any Food Service					
Gifts with NorthCrest Logo					
T-shirts					
Other					
Birthday Recognition (please rate on an individual basis)					
Meal in cafeteria					
Movie Ticket					
Grapevine Gift Shop Discount					
S!P Card – Coffee Shop					

My Favorites Reward: Please circle your favorite(s) from each category:

Soft Drink:	Snack Choice:	Other Rewards or Ideas
Pepsi	Healthy Snack	
Diet Pepsi	Fruit	
Diet Sierra Mist	Candy	
Sierra Mist		
Water		

T-shirt size:
S M L XL 2X 3X 4X

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Please submit this page to the helpdesk for your HR appointment.

I have an appointment with HR to do the new hire paperwork. Please direct me to HR.

Thanks,