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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 name badge, keys, any NorthCrest Health equipment, 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

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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 an 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 in part of my personnel file if I am hired.

_____

Signature

_____

Date

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 _____

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.

BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
Unum Life Insurance Company of America
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)

Social Security Number

Policy Number(s)

Division Number(s)

Employer Name

Check the coverages listed below to which this beneficiary designation applies:
☐ Basic Life ☐ Supplemental Life ☐ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X

Employee Signature **Date**

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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 when not in use 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, 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:

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.

igning 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 NCMC	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name NORTHCREST	

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Acknowledgements

Influenza

It is the policy of NorthCrest Medical Center that Influenza Vaccination will be offered to all employees free of charge each flu season (March – October.) Each employee refusing the vaccination will be required to complete a declination form and must wear mask from the time they enter the building until they exit the building during their work hours. Noncompliance will result in disciplinary actions.

I acknowledge the above policy:

Signed: _____ *Date:* _____

Federal Health Care Programs

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 Resource Dept. which will, in turn, notify the Compliance Officer.

Print Name: _____

Signature: _____

Date: _____

New Hire EEO-1 Data Sheet

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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 #**_____-_____-_____

First **Middle** **Last**

GENDER: ☐ **Male** ☐ **Female**

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 may only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for devil 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
- ☐ **White (Not Hispanic or Latino)** – A person having origins in any of the original people of Europe, The Middle East or North Africa.
- ☐ **Black of 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 people 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, Camobida, 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 people of North and South American (including Central America), and who maintain tribal affiliation of community attachment.
- ☐ **Two or More Races (Not Hispanic or Latino)** – All persons who identify with more than one of the races above, excluding Hispanic or Latino

Signature: _____

Date: _____

HR Created: 02 08. 04 18
Revised:

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Security
Employee Information

Name _____ **Date of Hire** _____

Dept. _____ **Employee No.** _____

Extension Number _____

Parking Pass No. #1_____

#2 _____

#3_____

Date Issued _____

Date Returned _____

Vehicle Information

	Year	Make	Model	Color	State	License No.
#1						
#2						
#3						

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 and it must be returned if you should leave. There is a $5.00 charge for any lost passes.

All Employee vehicles must display a parking pass when you are working. Please note that this form after completed, can be turned into Plant Operations Dept. Monday thru Friday 8:00 A.M. to 4:00 P.M. or to Security after hours to coordinate receiving a parking pass.

_____ _____

Employee Signature **Date**

04/2018