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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 ample time to complete the paperwork and go to employee health for your pre-employment physical/screening. Photo ID is required. Approximate time will be 1 hour.**

4) **Copy of shot records (MMR, Varicella, Pertussis, Hep B) TB skin test, and Flu**

5) **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 Licensure**

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

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

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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 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

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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

ACKNOWLEDGEMENT & AUTHORIZATION FOR BACKGROUND REPORT

I acknowledge and fully understand that NorthCrest Medical Center may request a consumer report (background check) on me in connection with my application for employment by NorthCrest or, if I am hired, may request a consumer report at any time during the course of my employment.

The consumer report may contain the following types of information: verification of prior employment(s), dates of employment, academic achievement, professional licensure, and credit reports (credit history will be requested only where such information is substantially related to the duties and responsibilities of the position I am seeking or hold. 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. The Consumer Financial Protection Bureau's **"Summary of Your Rights under the Fair Credit Reporting Act"** is attached to this authorization.

I authorize and request all persons, schools, business, corporations, financial institutions, credit bureaus, courts, law enforcement agencies, institution, school or university, information service bureau, armed forces, employment commissions, and all government agencies to release said information without restriction or qualification as requested by Verified Credentials, 20890 Kenbridge Court, Lakeville, MN 5504, www.verifiedcredentials.com, 800-473-4934. I authorize a fax, electronic image or copy 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 will be in compliance 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 identification purposes and not for purposes prohibited 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 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 or any subsequent consumer reporting agency acting on behalf of NorthCrest to procure consumer reports at any time during my employment by NorthCrest. I further release NorthCrest Medical Center, Verified Credentials, and any subsequent consumer reporting agency acting on behalf of NorthCrest, as well as their respective 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.

I understand that I have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about me and to request a copy of the report from Verified Credentials, 20890 Kenbridge Court, Lakeville, MN 5504, www.verifiedcredentials.com, 800-473-4934.

PRINT NAME (as it appears on driver's license)

SOCIAL SECURITY NUMBER

SIGNATURE

DATE OF BIRTH

DATE SIGNED

DRIVER'S LICENSE STATE & NO.

NEWPORT GROUP

NORTHCREST MEDICAL CENTER EMPLOYEES RETIREMENT PLAN

DESIGNATION OF BENEFICIARY FORM

Division (if applicable): _____

Name of Employee (First, Middle, Last) _____ Social Security Number _____

Address _____ Date of Birth _____

City, State, ZIP Code _____ Date of Hire _____

PARTICIPANT'S CERTIFICATION

I hereby certify that I am a participant in the above -named plan. The details of said plan have been made available to me, and I hereby acknowledge receipt of the Summary Plan Description. I agree to abide by all of the rules and regulations set forth in the plan, and, with respect to any amount payable under the plan by reason of my death, certify that I am ○ MARRIED* ○ UNMARRIED**

○ Initial Designation ○ Change in Designation

* As certified by my signature below, I understand that, as a married Participant in the plan, any amount payable under the plan by reason of my death must be paid to my surviving spouse unless I choose another beneficiary, and my spouse consents in writing to that choice (see below). I further understand that, in the event of a divorce, I must complete and sign a new beneficiary form.

** As certified by my signature below, I understand that, as an unmarried plan participant, I am designating the person (s) or entity named below and the beneficiary of my death benefit. However, I understand that if I hereafter marry, this designation will be revoked, and I must immediately inform the administrator of the change in my marital status.

I hereby designate the following to be beneficiary(ies), such designation(s) to supersede any prior designation(s):

Primary Beneficiary(ies): ○ Spouse Only OR ○ Other as Designated Below

	Beneficiary 1	Beneficiary 2	Beneficiary 3
Name:			
Percentage:			
Address:			
Social Security #:			
Relationship:			
Date of Birth:			

If I am not survived by any of the Primary Beneficiary(ies), then the following shall be my Secondary Beneficiary(ies):

	Beneficiary 1	Beneficiary 2	Beneficiary 3
Name:			
Percentage:			
Address:			
Social Security #:			
Relationship:			
Date of Birth:			

I understand that where I have designated more than one beneficiary, unless I have specified otherwise, the Primary Beneficiary(ies) or the Secondary Beneficiary(ies) who survive me shall share equally in any payment(s) from the plan. I also understand that I have the right to change a beneficiary without the consent of the beneficiary. I further understand that if I am married, and I designate someone other than my spouse as my sole beneficiary, or in addition to my spouse, then my spouse must sign and date the following Spousal Consent section in the presence of a Notary Public or Plan Representative.

_____ _____

Participant's Signature Date

SPOUSAL CONSENT

I,_____, understand that I am not the sole beneficiary. I recognize that I may not receive any benefits under this plan. I further understand that once I sign this Spousal Consent, I may not revoke it.

_____ _____

Spouse's Signature Date

(Notary Seal) Sworn to before me this _____ day of _____ ,20_____.

_____

Signature of Notary Public or Plan Representative

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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.

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 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 plate 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**

01/23/20