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Productive Work Environment Complaint Investigation Summary

Employee Filing Complaint:_____ Date:_____

Facility Assignment:_____

Job Title:_____

Employee's Supervisor:_____

I. Reported Incident:

II. Conclusions of Complaint Review Committee:

III. Results/Response of Management:

_____

Employee's Signature Date

_____

QP's Signature Date

_____

HR Director's Signature Date

LIFE, Inc.
Corporate Office
2609 Royall Avenue
Goldsboro, N.C. 27534
Telephone: (919) 778-1900
Fax: (919) 778-1911

Date:

Dear

Thank you very much for giving us the opportunity to consider you for employment. After carefully considering your background and qualifications, we find that we do not have an appropriate position for you at the present time.

All employment applications are retained for a period of one year. Should an appropriate position develop we will contact you. Please note that you may reapply after a one-year period.

Again, thank you for your time and interest in our company.

Sincerely,

LIFE, Inc.
REQUEST FOR REHIRE

Attention: **Human Resources Department,** at fax number: **(919) 778-2928**

From: _____ , _____ _____
(Person Requesting Rehire of Employee) *(Title)* *(Fax #)*

I am requesting permission to rehire the following individual:

Name: _____

Previous Employee #: _____ Position Held: _____

Facility/Region _____

***Check Appropriate Box Below*:** Corporate ☐ Contract Services ☐ ICF ☐

Dates of Employment: From _____ to _____

Reason for Separation from Company: _____

Appropriate Notice Given? ☐ Yes ☐ No Comments and/or other relevant information: _____

1

CORPORATE OFFICE HUMAN RESOURCES DEPARTMENT

Date Request Received _____ Eligible for Rehire? ☐ Yes *As indicated On Separation Notice* ☐ No

Reason for TERM *(as indicated on Separation Notice)* : _____

Dates of Employment Consistent with Above? ☐ Yes ☐ No Is Break in Service **Over** (6) Mos? ☐ Yes ☐ No

Retirement Loan Defaulted? ☐ Yes ☐ No Previous Distribution Requested? ☐ Yes ☐ No
If Yes, Date Processed _____

Information Verified By: _____ Date: _____

2

TO BE COMPLETED BY HR DEPARTMENT **CHECKS PERFORMED BY:**

Criminal Record Check Processed: ☐ Date: _____ OK to Hire? ☐ Yes ☐ No

MVR Screening Processed: ☐ Date: _____ OK to Hire? ☐ Yes ☐ No

Comments: _____

3

CORPORATE APPROVAL & SIGNATURES

Once all appropriate signatures have been obtained, please route form back to HR Department.

Approve Request For Rehire?

_____ _____ … ☐ Yes ☐ No
Director of ICF/MR ***OR*** *Director of Contract Services* *Date*
OR *Director of Business Operations*

_____ _____ … ☐ Yes ☐ No
Director of HR/Executive Vice-President *Date*

LIFE, Inc. Corporate Office
2609 Royall Avenue
Goldsboro, NC 27534
Telephone: (919) 778-1900
HR Department Fax: (919) 778-2928

REQUEST FOR OUTSIDE EMPLOYMENT

Name:_____

Date Submitted:_____

Name of Agency Requested for Outside Employment:

_____

Address of Agency Requested for Outside Employment:

_____

Projected Hours of Employment per Month of Outside Employment:_____

Comments:_____

_____

_____

_____ **APPROVED** _____ **DISAPPROVED**

Comments:_____

_____

_____

_____

Supervisor's Signature ***Date***

EXIT INTERVIEW

It is the policy of LIFE, Inc. to conduct an exit interview with each employee upon separation. We appreciate your honest opinions about your employment with our company. Your objective feedback can help us to improve work place conditions in a variety of areas, allowing us to make LIFE, Inc. a better place to work. Please complete this questionnaire and return it to the appropriate Departmental Director in the attached stamped envelope. Thank you for your valued opinion and for your service to LIFE, Inc.

Employee Name: _____ Separation Date: _____

Position Title: _____ Facility/Shift: _____

Supervisor's Name: _____

Place an "X" within the bracket which best describes your feelings about the following aspects of your employment experience at LIFE, Inc.

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
Job Duties	☐	☐	☐	☐
Utilization of Skills and Experience	☐	☐	☐	☐
Performance Appraisals/ Feedback Regarding Job Performance	☐	☐	☐	☐
Training, Orientation, and Staff Development Programs	☐	☐	☐	☐
Opportunities for Advancement	☐	☐	☐	☐
Salary	☐	☐	☐	☐
Work Schedule	☐	☐	☐	☐
Supervision	☐	☐	☐	☐
Quality of Care for Residents	☐	☐	☐	☐
Company Policies	☐	☐	☐	☐
Workload	☐	☐	☐	☐
Company Benefits	☐	☐	☐	☐
Overall, as a place to work	☐	☐	☐	☐

If you marked dissatisfied or very dissatisfied in any of the categories listed above, please explain, (use additional space if needed).

_____

_____

_____

_____

_____

The main reasons I am leaving LIFE, Inc. are (use additional space if needed).

If you are leaving to accept other employment, please list the new employer's name, title of your new position, your starting salary, and any benefits that you will be receiving that you did not receive at LIFE, Inc.

If you are leaving to accept other employment, describe how your new position will be different from your job at LIFE, Inc.

Please describe your relationship with your immediate supervisor and how it could have improved, if at all (use additional space if needed).

Please describe your relationship with other staff members or management team who may have supervised you indirectly or provided direction to you in carrying out the responsibilities of your job and how it could have improved, if at all (use additional space if needed).

Has LIFE, Inc. and/or your supervisor provided enough feedback and recognition for your work achievements? If not, please describe how you would have preferred to have been recognized.

Please complete the following sentences.

In my opinion, the best thing about working at LIFE, Inc. is

_____

_____

_____

In my opinion, LIFE, Inc. would be a better place to work if

_____

_____

_____

Would you recommend this company as a place to work?

☐ Yes ☐ No

If not, why?

_____

_____

_____

_____

Employee's Signature: _____

Date: _____

I would like to schedule a telephone interview through the Human Resources Department to further discuss contents of this exit interview.

☐ Yes ☐ No

Please indicate telephone number to call: _____

Best day/time to call: _____

TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT

Employment Start Date: _____

Employment End Date: _____

Employee ID#: _____

Entered by: _____ Date: _____

X _____ _____

Signature of Executive Vice-President Date

SEPARATION NOTICE

Employee Name:		**Employee Position:**	
Employee #:		**Department/Facility:**	
Shift:		**Status:**	☐ Full-Time Reg. ☐ Part-Time Reg. ☐ Part-Time/Back-Up
Supervisor's Name/Title:			
First Day Worked:		**Last Day Worked:**	
		Date Inactivated: (Date Terminated:)	

TYPE OF SEPARATION:

☐ Resignation Appropriate notice given? ☐ Yes OR ☐ No

☐ Involuntary Termination

(Please attach copies of all performance reviews, entries, and disciplinary actions which are relevant to this termination.)

☐ Lay Off ☐ Retirement

Remarks (Optional):

REASON:

☐ Personal ☐ Accepting another Position ☐ Unacceptable Attendance

☐ Unacceptable Job Performance ☐ Unacceptable Conduct ☐ Lack of Work

☐ Violation of other Company policy (Specify): _____

Remarks (Optional):

WOULD YOU REHIRE?

☐ YES ☐ NO

Supervisor's Signature:		**Date:**	

~EXIT INTERVIEW FORM WILL BE MAILED FROM CORPORATE OFFICE~

TO BE COMPLETED BY CORPORATE OFFICE STAFF

PAYROLL: Date Rec'd: _____ ☐ Entered By: _____ 1

HR DEPT: Date Rec'd: _____ ☐ Entered By: _____ 2

Exit Interview Mailed on: _____ to the following address: _____

_____

_____

CRIMINAL RECORD BACKGROUND CHECK **214(a)**

CRIMINAL BACKGROUND INVESTIGATION CONSENT

LIFE, Inc. is required by law to conduct a criminal background investigation, including a national record and fingerprint check conducted by the State Bureau of Investigation (SBI), for any applicant that has been a resident of North Carolina for less than five 5) years.

Further, employment with LIFE, Inc. is contingent upon an acceptable criminal record. LIFE, Inc. reserves the right to terminate or disqualify any offer of employment should the results of a criminal background investigation be unacceptable or if it is deemed that any direct misrepresentation, falsification, or omission of facts has occurred.

I have read and fully understand the above statements and hereby authorize and request any law enforcement agency to furnish LIFE, Inc. with a criminal history check and other mandatory information as it relates to the requirements of my employment.

I will request a copy of any results of a national criminal record check and will forward a copy to LIFE, Inc. I understand that failure to do so will result in disciplinary action up to and including termination.

Applicant's Printed Name: _____

Applicant's Signature_____Date_____

COMBINED DISCLOSURE NOTICE AND AUTHORIZATION REGARDING BACKGROUND CONSUMER REPORTS

Important: Please Read Carefully Before Signing

A consumer report and/or investigative consumer report including information concerning your character, employment history, general reputation, personal characteristics, police record, education, qualifications, motor vehicle record, mode of living and/or credit and indebtedness may be obtained in connection with your application for and/or continued employment with the employer. **A consumer report and/or an investigative consumer report may be obtained at any time during the application process or during your employment with the employer.** A consumer report containing injury and illness records may be obtained after a tentative offer of employment has been made. Upon timely written request of the personnel department of the employer, and within 5 days of the request, the name, address and phone number of the reporting agency and the nature and scope of the investigative consumer report will be disclosed to you. Before any adverse action is taken, based in whole or in part on the information contained in the consumer report, you will be provided a copy of the report, the name, address and telephone number of the reporting agency, and a summary of your rights under the Fair Credit Reporting Act.

☐ For applicants residing in *California*, *Minnesota*, or *Oklahoma*, check this box if you would like a copy of the consumer report, if one is obtained.

NEW YORK APPLICANTS OR VOLUNTEERS ONLY: Upon request, you will be informed whether or not a consumer report was requested, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

CALIFORNIA APPLICANTS OR VOLUNTEERS ONLY: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW.

AUTHORIZATION

You hereby authorize and request, without any reservation, any present or former employer, school, police department, financial institution, division of motor vehicles, consumer reporting agencies, or other persons or agencies having knowledge about you to furnish *SmartStart Employment Screening* on behalf of their client with any and all background information in their possession regarding you, in order that your employment qualifications may be evaluated.

By signing below, you hereby authorize without reservation, any party or agency contacted by this employer / employer's agent to furnish the above mentioned information. You further authorize ongoing procurement of the above mentioned reports at any time during your employment (or contract). You also agree that a fax, photocopy, or electronic signature (eSignature) of this authorization may be accepted with the same authority as the original.

Your background investigation is conducted by SmartStart Employment Screening, PO Box 61237 Raleigh, NC 27661. (919) 355-5053, www.SmartStartEmploymentScreeningInc.com.

READ, ACKNOWLEDGED AND AUTHORIZED

_____ _____

Signature Full Printed Name

_____ _____

Date of Birth Today's Date

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

• You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

• You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identify theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

• You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

• You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

• Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

• Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

• Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

• You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

• You may limit “prescreened” offers of credit and insurance you get based on information in your credit report. Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567- 8688.

• You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

• Identity theft victims and active duty military personnel have additional rights. For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552
Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates. To the extent not included in item 1 above:	Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
National banks, federal savings associations, and federal branches and federal agencies of foreign banks	Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
Federal Credit Unions	National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, SE Washington, DC 20590
Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street S.W. Washington, DC 20423
Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

New York Article 23-A Correction Law

§ 750. Definitions. For the purposes of this article, the following terms shall have the following meanings: (1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission. (2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons. (3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question. (4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm. (5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§ 751. Applicability. The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§ 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:
(1) there is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or
(2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§ 753. Factors to be considered concerning a previous criminal conviction; presumption. 1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors: (a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses. (b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person. (c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities. (d) The time which has elapsed since the occurrence of the criminal offense or offenses. (e) The age of the person at the time of occurrence of the criminal offense or offenses. (f) The seriousness of the offense or offenses. (g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct. (h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public. 2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§ 754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§ 755. Enforcement. 1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules. 2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW

This employer intends to obtain information about you for "employment purposes" from an investigative consumer reporting agency or consumer credit reporting agency. Thus, you can expect to be the subject of "investigative consumer reports" and "consumer credit reports" obtained for "employment purposes." Such reports may include information about your character, general reputation, personal characteristics and mode of living. With respect to any investigative consumer report from an investigative consumer reporting agency ("ICRA"), the Company may investigate the information contained in your application and other background information about you, including but not limited to obtaining a criminal record report, verifying references, work history, your social security number, your educational achievements, licensure, and certifications, your driving record, and other information about you, and interviewing people who are knowledgeable about you. The results of this report may be used as a factor in making decisions for "employment purposes." The source of any investigative consumer report (as that term is defined under California law) will be SmartStart Employment Screening Inc, Consumer Disputes, PO Box 61237, Raleigh, NC 27611 (919) 355-5053. www.SmartStartE,mploymentScreeningInc.com.

The Company agrees to provide you with a copy of an investigative consumer report when required to do so under California law. Under California Civil Code section 1786.22, you are entitled to find out from an ICRA what is in the ICRA's file on you with proper identification, as follows: In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person.

The ICRA may not charge you more than the actual copying costs for providing you with a copy of your file. A summary of all information contained in the ICRA's file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

By requesting a copy be sent to a specified addressee by certified mail. ICRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the ICRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the ICRA require additional information concerning your employment and personal or family history in order to verify your identity.

The ICRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection.

You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An ICRA may require you to furnish a written statement granting permission to the ICRA to discuss your file in such person's presence.

CRIMINAL RECORD BACKGROUND CHECK **214(c)**

LIFE, Inc. Application Information

(Please PRINT the following information:)

Name:

Last: _____ First: _____ Middle: _____

Maiden/Alias: (1) _____ (2) _____

For Identification Purposes:

Date of Birth: Month: _____ Day: _____ Year: _____ Race: _____ Gender: _____

Drivers License No.: _____ State: _____

Social Security No.: _____

Professional License (if any): State: _____ Type: _____ No.: _____

PAST SEVEN (7) YEARS OF RESIDENCE (List additional on reverse or separate sheet)

Current Address: _____

City: _____ State: _____ Zip: _____ Years at Residence: _____

Previous Address: _____

City: _____ State: _____ Zip: _____ Years at Residence: _____

Signature: _____ Date: _____

FOR REGIONAL OFFICE USE ONLY:

Supervisory Contact: _____ Telephone Number: _____

If hired, facility where applicant will primarily work: _____

Employee's / Applicant's response regarding past convictions: ☐ Yes ☐ No

If "Yes", indicate nature of past conviction(s), **as well as pending charges** (if any).

☐ Speeding ☐ Assault ☐ Misdemeanor Drug Possession ☐ Revocation/Suspension of License

☐ DUI ☐ Felony: _____

☐ Other: Please specify: _____

_____

Position/Positions Applied for: _____

Will this person drive a LIFE, Inc. Vehicle? ☐ Yes ☐ No

Will this person drive a personal auto with consumers inside? ☐ Yes ☐ No

Will this person drive a personal auto for company business? ☐ Yes ☐ No

If yes, explain: _____

_____

_____

LIFE, Inc.
Motor Vehicle Record
Disclosure and Release

In connection with my ongoing employment or my application for employment, should I have or secure a position with LIFE, Inc., I understand that a motor vehicle record, which contains public record information, may be requested. I further understand that such report(s) will contain personal information and public record information concerning my driving record from federal, state, and other agencies that maintain such records, as well as independent services that provide driving record information.

I authorize, without reservation, any party or agency contacted to furnish the above- mentioned information to Snipes Insurance Service, Inc. or its agent.

I hereby authorize procurement of my motor vehicle report. If hired, this authorization will remain on file and shall serve as ongoing authorization for you to procure such reports at any time during my employment. **------ commercial auto insurer and agent will also use this information in conjunction with loss control and safety review efforts.**

_____ _____

Full Legal Name ***(include middle initial)*** **Social Security Number**

_____ _____

Drivers License Number **Date of Birth**

_____ _____

Signature **Date**

FOR REGIONAL OFFICE USE ONLY

Position/Position Applied For**:** _____

Will this person drive a LIFE, Inc. vehicle? ☐Yes ☐No

Will this person drive a personal auto with consumers inside? ☐Yes ☐No

Will this person drive a personal auto on company business? ☐Yes ☐No

If Yes, explain: _____

_____

Person to contact for results: _____

Telephone Number: _____

MEMORANDUM

To:_____
{Employee}

From:_____
{Appropriate Manager/Supervisor}

Subject: Request for Medical Information

Date:_____,_____,20____

Attached is our request for medical information from your treating physician regarding your current medical condition and its effect on your ability to perform the essential functions of your job. This inquiry is job-related and of business necessity based upon your disclosure to me that you have been diagnosed with _____
_____
{Condition}

Also attached is your consent and authorization for the release of medical information to us. All medical information will be maintained by LIFE, Inc. in a separate medical file and will be treated as confidential in accordance with the Americans with Disabilities Act (ADA) and other laws.

You are to sign the authorization and take a copy of it with the letter to your physician immediately. You must return your signed authorization and all of the requested medical information from your doctor to me **within ten 10) days.** Time is of the essence in determining your job-related medical status.

If you have any questions, please contact me at _____.
{Telephone Number}

Thank you for your cooperation.

Enclosures

AUTHORIZATION FOR RELEASE OF JOB-RELATED MEDICAL INFORMATION

I, _____, do hereby authorize
{Employee}

Dr. _____to release to my employer,
{Name of Primary Physician(s) for Impairments(s)

LIFE, Inc., all of the medical information requested in the letter dated to him/her on

_____, from_____and
{Date} *{Appropriate Manager/Supervisor}*

all other pertinent information. I understand and agree that the medical inquiry is job-related and based on business necessity.

_____

Consented to this_____day of _____, 20_____.

Employee Printed Name:_____

Employee Signature:_____

Social Security Number:_____

Witnessed this _____day of _____, 20_____.

Name:_____

Title:_____

_____

Date:_____

Dear Dr._____:

Your patient,_____, (DOB:_____) is employed by our Company in the position of _____. Because it has become necessary for us to determine if [he/she] is still able to perform the essential functions of [his/her] position, this inquiry as to [his/her] medical condition as it affects [his/her] ability to perform the job-related functions is legally permitted. [He/she] has consented to this inquiry and [his/her] authorization for release for medical information is attached.

We request that you provide the following information regarding the above-referenced employee's medical condition:

1. Please describe each physiological or condition and each mental or psychological disorder from which [he/she] currently suffers.

2. With respect to each of the disorders or conditions identified in response to No. 1, please state whether each such disorder substantially limits one or more of [his/her]'s major life activities (e.g., performing manual tasks, lifting, caring for oneself, walking, seeing, hearing, speaking, breathing, or working); and if so, describe each such limitation.

3. With respect to each disorder or condition, please state the diagnosis and date of diagnosis, the prognosis, expected duration of the condition, and the period and expected duration of the limitations(s) imposed by the impairment.

4. In addition, we request that you evaluate [his/her] ability, based upon the physical or mental conditions or disorders you have identified above, to perform [his/her] job-related functions as set forth in the attached position description, which states [his/her] duties and responsibilities, plus the job requirements of regular and predictable attendance.

   [*NOTE: You should specify the functions raised by this employee, i.e., actual job duties and responsibilities and attach position description. ***]**

   a) Please identify in your evaluation **each and every** job duty, responsibility, and requirement that [he/she] **cannot** perform due to the physical or mental disorders you have identified, and describe the nature of the impairment.

   b) Please also identify **each and every** job duty, responsibility, and requirement that [he/she] **cannot** perform without posing a "direct threat" to the health or safety of {himself/herself] or others and describe the reasons for your answer.

5. With respect to each job-related function that [he/she] is not medically able to perform, please advise us what, if any, minimum reasonable accommodation is needed to enable [him/her] to perform such duties and the period of time such accommodation would be necessary.

6. Please describe in detail the course of treatment for [him/her]'s condition for which [he/she] is required to comply.

Since time is of the essence, _____ is required to ensure that the above-requested information is forwarded to me **within ten 10) days.**

Thank you for your cooperation and prompt attention to this matter. If you have any questions or wish to discuss anything, please contact me at _____.

Sincerely,

LIFE, Inc. Manager/Supervisor

FORM I-9 **217(a)**

Form I-9 Retention Worksheet

Step 1: On the employee's *first day,* complete employee name and date of hire. Staple this form directly to the Form I-9.

Step 2: On the employee's *last day,* complete date of termination, complete the calculations, and enter the retention date in the box provided. Move these documents to a termination file.

Step 3: On the *retention date*, shred this form, the Form I-9, and the Case Verification email (if applicable)

For all *current employees,* complete this form in its entirety on the employee's *last day* and move to termination file.

_____

Employee Name

1. Enter employee hire date:_____

Add 3 years to line 1 A._____

2. Termination date:_____

Add 1 year to line 2 B._____

Which date is later: A or B? Enter retention date here. C._____

Store Form I-9 until this date.

24

401(a)

PERSONAL AUTOMOBILE USAGE

EMPLOYEE # _____ PERIOD FROM/TO _____

DATE	LOCATION/FACILITY	MEALS	HOTEL	TOTAL MILES	MILEAGE AMOUNT	MISC	TOTAL	EXPLANATION
TOTAL EXPENSES								Amount to be Reimbursed

_____

I hereby certify that the information listed above is correct - Employee Signature

_____

Approved for reimbursement - Supervisor Signature

LIFE-0043

REQUEST FOR PAID TIME OFF

REQUEST FOR PAID TIME OFF 501:2(a)

Date of Request _____ **Employee No.** _____

Employee Name _____ **Employee Signature** _____

Date(s) Requested _____ **Amount of Hours** _____

_____ _____

Request ☐ Approved
☐ Denied

_____ _____

Supervisor Signature **Date**

Personnel File - white copy *Employee - yellow copy*

Goldsboro Record Printing 3/09

LIFE, Inc.

I understand that LIFE, Inc. will provide a safety strap for employees to wear to assist in preventing eye glasses from being broken during work hours. I understand that if I wear glasses and choose not to wear a safety strap that I will not be eligible for reimbursement as outlined in LIFE, Inc. Policy 602:1 – "Personal Property/Personal Property Damages".

_____

Employee Signature

_____

Date

LIFE, Inc.
FACILITY VISITATION LOG

Facility Name: _____

Month: _____

NAME	EMPLOYEE #	DATE	TIME IN	TIME OUT	COMMENTS

EMERGENCY RELOCATION OF CLIENTS **608(a)**

To: DHSR Mental Health Licensure and Certification Section

From: _____, _____
(name) (title)

Re: Emergency Relocation of Clients
LIFE, Inc./_____, _____
(Name of facility) (MHL #)

Date: _____

Name and address of LIFE, Inc. facility:

_____
_____
_____

Reason for Evacuating the facility: _____
_____
_
_____
_
_____
_

Name and address of site where clients

_____
were relocated: _____
_____

Facility Contact Person:

_____

Anticipated Date of Return to facility:

_____

Names of Client Case Managers
Notified: (for Contract Service facilities)

Name	Phone #	Date Notified

Enclosure
LIFE, Inc. Emergency Plan

LIFE, Inc.

EMPLOYEE LEAVE OF ABSENCE REQUEST
(Family and Medical Leave Act)

Employee Name:_____

Employee ID#:_____ Primary Facility Assigned to:_____

Date:_____

_____**I request a FAMILY MEDICAL LEAVE OF ABSENCE (FMLA)**

_____**I request a LEAVE OF ABSENCE (LOA)**

Please provide explanation of the need for a leave of absence:_____
_____
_____
_____
_____

I understand that I must provide LIFE with at least **30 days advance** notice before leave is to begin if the need for the leave or FMLA is foreseeable. I understand that I must provide the requested certifications to LIFE within **15 calendar days** after LIFE requests the certifications. If leave or FMLA is unforeseeable, certifications must be received as soon as possible. I understand if the above requirements are not met, leave or FMLA may be denied.

Do you have any of these payroll deductions? (*Please check all that apply)*

_____**Health Insurance/BCBS**
_____**Retirement Loan** _____**Garnishment**

_____ _____
Signature of Employee **Date**

_____ _____
Signature of Employee's Supervisor **Date**

Date Supervisor Requested certifications_____

{TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT ONLY}

Approved?_____Yes _____No Date:_____
Leave Start Date:_____Entered by:_____
Anticipated Date of Return to Work:_____
Actual Date of Return to Work:_____

Notes:_____

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three (3) years. **RETURN THIS FORM TO THE EMPLOYEE.**

LIFE, Inc.
Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE'S SUPERVISOR

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee.

Supervisor:_____

Employee's Job Title:_____

Regular Work Schedule:_____

{Attach employee's position description}

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least fifteen (15) calendar days to return this form.

Your Name:_____
(First) *(Middle)* *(Last)*

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic test, genetic services or the manifestation of disease or disorder in the employee's family members.

Provider's Name:_____

Business Address:_____

Type of practice/Medical specialty:_____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
_____No _____Yes

If so, dates of admission: _____

Date(s) you treated the patient for condition: _____
_____

Will the patient need to have treatment visits at least twice per year due to the condition?
_____No _____Yes

Was medication, other than over-the-counter medication, prescribed?
_____No _____Yes

Was the patient referred to other health care provider(s) for evaluation or treatment?
(e.g., physical therapist)? _____No _____Yes

If so, state the nature of such treatments and expected duration of treatment: _____
_____

2. Is the medical condition pregnancy? _____No _____Yes

If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?
_____No _____Yes

If so, identify the job functions the employee is unable to perform: _____
_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____
_____
_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?
_____No _____Yes

If so, estimate the beginning and ending dates for the period of incapacity:

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition:
_____No _____Yes

If so, are the treatments or the reduced number of hours of work medically necessary?
_____No _____Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:
_____hour(s) per day; _____days per week from _____through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____No _____Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?
_____No _____Yes If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next six (6) months (e.g., 1 episode every 3 months lasting 1-2 days)

Frequency:_____times per _____week(s) _____month(s)
Duration:_____hours or _____days(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITONAL ANSWER:

Signature of Health Care Provider **Date**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three (3) years.
RETURN THIS FORM TO THE PATIENT.

Rev. 9/2015

LIFE, Inc.
Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE'S SUPERVISOR

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking SMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee.

Supervisor:_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FLMA request. Your employer must give you at least fifteen (15) calendar days to return this form to your employer.

Your Name:_____
(First) *(Middle)* *(Last)*

Name of family member for whom you will provide care:

_____
(First) *(Middle)* *(Last)*

Relationship of family member to you:_____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:_____
_____
_____
_____
_____
_____

_____ _____
Employee Signature **Date**

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's Name:_____

Business Address:_____

Type of practice/Medical specialty:_____

Telephone:(_____)_____Fax: (_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced:_____

   Probable duration of condition:_____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   _____No _____Yes

   If so, dates of admission:_____

   Date(s) you treated the patient for condition:_____
   _____

   Was medication, other than over-the-counter medication, prescribed?
   _____No _____Yes

   Will the patient need to have treatment visits at least twice per year due to the condition?
   _____No _____Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? _____No _____Yes

   If so, state the nature of such treatments and expected duration of treatment:_____
   _____

2. Is the medical condition pregnancy? _____No _____Yes

   If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   _____
   _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety, or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
_____No _____Yes

If so, estimate the beginning and ending dates for period of incapacity:

During this time, will the patient need care? ___No _____Yes

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatment, including any time for recovery?

_____No _____Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? _____NO _____Yes

Estimate the hours the patient needs care on an intermittent basis, if any:
_____hour(s) per day; _____days per week from _____through _____.

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____No _____Yes

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next six (6) months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency:_____times per _____week(s) _____month(s)
Duration:_____hours or _____days(s) per episode

Does the patient need care during these flare-ups? _____No _____Yes

Explain the care needed by the patient, and why such care is medically necessary:

_____
_____
_____
_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITONAL ANSWER:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Health Care Provider **Date**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three (3) years. **RETURN THIS FORM TO THE PATIENT.**

LIFE, Inc.
Certification for Serious Injury or Illness of Current Service Member – for Military Family Leave (Family and Medical Leave Act)

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYEE'S SUPERVISOR: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertification's, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29CFR 1630.14(c), if the American with Disabilities Act applies.

SECTION I:
For Completion by the EMPLOYEE and/or the Current SERVICEMEMBER for whom the Employee is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require than an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614 (c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f) The employer must give an employee at least fifteen (15) calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on 703:16(a) has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not and that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

SECTION I: For completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee is Requesting Leave. (This section must be completed before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for current servicemember): _____

Name of employee requesting leave to care for current servicemember:

_____

(First) *(Middle)* *(Last)*

Name of current servicemember (for whom employee is requesting leave to care):

_____

(First) *(Middle)* *(Last)*

Relationship of employee to current servicemember:
_____ Spouse _____Parent _____Son _____ Daughter _____ Next of Kin

PART B: CURRENT SERVICEMEMBER INFORMATION

1. Is the servicemember a current member of the Regular Armed Forces, the National Guard, or Reserves? _____Yes _____No

   If yes, please provide the servicemember's military branch, rank, and unit currently assigned to:_____

   Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?
   _____Yes _____No

   If yes, please provide the name of the medical treatment facility or unit:
   _____

2. Is the servicemember on the Temporary Disability Retired List (TDRL)?
   _____Yes _____No

PART C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the care to be provided to the current servicemember and an estimate of the leave needed to provide the care:_____

SECTION II: For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provide4r who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 20 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). *(Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.*

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:_____

Type of Practice/Medical Specialty:_____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:_____

Telephone: (_____) _____ Fax: (_____) _____
Email:_____

PART B: MEDICAL STATUS

1. Current servicemember's medical condition is classified as (check one of the appropriate boxes):

   _____ **(VSI) Very Seriously Ill/Injured**
   Illness/injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

   _____ **(SI) Seriously Ill/Injured**
   Illness/injury is of such a severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

   _____ **OTHER Ill/Injured**
   A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

   _____ **NONE OF THE ABOVE**
   (Note to employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

2. Is the current Servicemember being treated for a condition which was incurred or aggravated by service on active duty in the Armed Forces? _____Yes _____No

3. Approximate date condition commenced:_____

4. Probable duration of condition and/or for care:_____
   _____

5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy for this condition?
   _____Yes _____No

   If yes, please describe medical treatment, recuperation, or therapy:

   _____

PART C: CURRENT SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery?
   _____Yes _____No

   If yes, estimate the beginning and ending dates for this period of time:_____
   _____

2. Will the servicemember require periodic follow-up treatment appointments? _____Yes _____No

   If yes, estimate the treatment schedule:_____
   _____

3. Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? _Yes _____No

4. Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up appointments (e.g., episodic flare-ups of medical condition)? _____Yes____No

If yes, please estimate the frequency and duration of the periodic care:_____

_____ _____

Signature of Health Care Provider **Date**

DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.

LIFE, Inc.
Certification of Qualifying Exigency for Military Family Leave (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE'S SUPERVISOR

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Supervisor's Name:_____

Contact Information:_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310 While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least fifteen (15) calendar days to return this form to your employer.

Your Name:_____
(First) *(Middle)* *(Last*

Name of military member on active duty or call to active duty status:

_____
(First) *(Middle)* *(Last*

Relationship of military member to you:_____

Period of military member's covered active duty:_____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

_____A copy of the military member's covered active duty orders is attached.

_____Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

_____I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):_____
_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

_____Yes _____No _____None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced:_____

   Probable duration of exigency:_____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency:
   _____No _____Yes

   If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency?
   _____No _____Yes

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

   Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

   Frequency:_____times per week(s)_____month(s)

   Duration: hours_____day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual:_____

Title:_____ Organization:_____

Address:_____

Telephone: (_____) _____ Fax: (_____) _____

Email:_____

Describe nature of meeting:_____

PART D:

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee **Date**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three (3) years.
RETURN THIS FORM TO YOUR SUPERVISOR

LIFE, Inc.

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

Notice to the EMPLOYER

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

INSTRUCTIONS to the EMPLOYEE and/or VETERAN: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II can be completed by a health care provider.)

Part A. EMPLOYEE INFORMATION

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran);

_____

Name of employee requesting leave to care for a veteran:

_____

First Middle Last

Name of veteran (for whom employee is requesting leave):

_____

First Middle Last

Relationship of employee to veteran:

Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐ (please specify relationship)

Part B: VETERAN INFORMATION

1) Date of the veteran's discharge:

_____

2. Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? _____
_____Yes _____No

3) Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?
_____Yes _____No

Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

_____

_____

SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 20 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran and is:

i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or

ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or

iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or

iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave.

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). (**DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.)**

Part A: HEALTH CARE PROVIDER INFORMATION

Health care provider's name and business address:

_____

Telephone: (_____) _____ Fax: (___) _____Email:_____

Type of Practice/Medical Specialty:_____

Please indicate if you are:

_____a DOD health care provider

_____a VA health care provider

_____a DOD TRICARE network authorized private health care provider

_____a DOD non-network TRICARE authorized private health care provider

_____other health care provider

PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

1) The Veteran's medical condition is:

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered is a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) or 50% or higher and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veteran's Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above.

2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes ☐ No ☐

3) Approximate date condition commenced: _____

4) Probable duration of condition and/or need for care: _____

5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

If yes, please describe medical treatment, recuperation or therapy:

_____

_____

PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

1) Will the veteran need care for a single continuous period of time, including any time for treatment and recovery? Yes ☐ No ☐

If yes, estimate the beginning and ending dates for this period of time: _____

2) Will the veteran require periodic follow-up treatment appointments? Yes ☐ No ☐

If yes, estimate the treatment schedule: _____

3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments? Yes ☐ No ☐

4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes ☐ No ☐

If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider **Date**

DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION;

RETURN IT TO THE EMPLOYEE REQUESTING LEAVE

(As shown in Section I, Part "A" above)

LIFE, Inc.

Employer Response to Employee Request for a Leave of Absence

Date: _____

To: _____
(Employee's Name)

From: _____
(Name of Appropriate Employer Representative)

Subject: Request for a Leave of Absence

On _____, you notified us of your need to take a leave of absence due to:
(Date)

_____ the birth of a child, or the placement of a child for adoption or foster care; or

_____ a serious health condition that you need care for; or

_____ a serious health condition of your ___ spouse; ___ child; ___ parent, for which you are needed to provide care; or

_____ because of a qualifying exigency (urgency) arising out of the fact that your ___ spouse; ___ son or daughter; ___ parent is on active duty or call to active-duty status in support of a contingency operation as a member of the National Guard or Reserves; or

_____ because you are the ___ spouse; ___ son or daughter; ___ parent; ___ next of kin of a servicemember with a serious injury or illness; or

_____ because you are the ___ spouse; ___ son or daughter; ___ parent; ___ next of kin of a Veteran with a serious injury or illness, for which you are needed to provide care.

_____ Other: Please state reason from Employee Leave of Absence Request {703:6(a)}:

_____
_____
_____
_____

Except as explained below, you have a right under the FMLA for up to twelve (12) weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; unless you have used all of your twelve (12) weeks or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: (check appropriate boxes; explain where indicated)

{<u>To be completed by Corporate HR Department only</u>.}

1. You are ___ **APPROVED** ___ **DENIED** a leave of absence.

{<u>To be completed by Corporate HR Department only</u>.}

2. You are ___ **ELIGIBLE** ___ **NOT ELIGIBLE** for leave under the FMLA because:

___ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.

___ You have not met the FMLA's 1,250-hours of service requirement.

___ You have used all of your FMLA entitlement hours in the rolling 12-month period. Due to this, we are not required to reinstate you to the same or an equivalent job.

If you have any questions regarding the above criteria, contact the Corporate Office Human Resources Department.

3. The requested leave ___ will ___will not be counted against your annual FMLA leave entitlement.

4. You ___ will ___will not be required to furnish us certification of your reason. If required, you must furnish certification by _____ using the _____. (Note: If form is required, it must be furnished at least fifteen (15) calendar days after you are notified of this requirement or we may delay the commencement of your leave until the certification is submitted.)

5. You must use all available PTO to cover as much of the FMLA leave as possible.

6(a). Your portion of the premiums for your health insurance will continue during the period of leave. Premium payments for the entire month are due the first day of each month.

6(b). **You have a 30-day grace period to make payment. If your payment is not made within this 30-day grace period, your health insurance will be cancelled back to the last day of coverage paid. We will provide you notice of this lapse 15 days prior to termination. No additional reminders will be sent to you regarding this policy. If your health insurance is cancelled due to non-payment, coverage will be offered when you return from FMLA.**

6(c). **We will <u>NOT</u> pay your share of the premiums for your health insurance while you are on leave.**

6(d). You ___will ___will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until such certification is provided.

7(a). You ___ are ___are not a "key employee" as described in § 825.218 of the FMLA regulations. If you are a "key employee", restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.

7(b). We ___have ___have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (Explain {a} and/or {b} below):
_____
_____

8. You ___will ___will not be required to furnish us with periodic reports of your status and intent to return to work every thirty (30) days while on leave.

9. You ___will ___will not be required to furnish recertification every thirty (30) days relating to a serious health condition. (Explain if necessary): _____
_____
_____

_____ _____
Signature of Employee **Date**

_____ _____
Signature of Employee's Supervisor **Date**

_____ _____
Signature of Director of ICF/IDD Services; or Director of Contract Services; or Director of Business Operations **Date**

_____ _____
Signature of Executive Vice-President **Date**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three (3) years. **RETURN THIS FORM TO THE EMPLOYEE**.

LIFE, INC.
LEAVE OF ABSENCE
SCHEDULE OF EMPLOYEE PERIODIC REPORTS DURING LEAVE

TO BE COMPLETED BY EMPLOYER

Employees on leave must contact the Human Resources Administrator of LIFE, Inc. on th_____ of each month regarding their status and intention to return to work.

This form is to be used by the Human Resources Department of LIFE, Inc. to keep track of the periodic reports by the employee.

Date of Periodic Report	Status of Health Condition	Date of Anticipated Return to Work	Signature of Person Who Conducted Periodic Report

Employer Remarks: _____

_____

_____

_____

MISDEMEANOR AND FELONY CHARGES REPORT FORM
(Including any Traffic Violations)

Employee Name:_____

Date of Incident:_____

Date Reported:_____

Facility:_____

Reported to:_____

Describe Misdemeanor or Felony Charge:_____

Court Date: _+____

Resolution:_____

**File in Employee Personnel File:*

2609 Royall Avenue • Goldsboro, North Carolina 27534

Phone (919) 778-1900 • Fax (919) 778-1911

DISCIPLINARY PROCEDURE **806(a)**

Employee Name: _____ Date of Warning: _____

Employee #: _____ Department/Facility: _____

Date(s) of Incident(s): _____ Shift: _____

NATURE OF INCIDENT

☐ Unexcused Absence	☐ Harassment	☐ Drug/Alcohol Concern
☐ Tardiness	☐ Client Rights Issue	☐ Failure to Follow Instructions
☐ Violation of Safety Rules	☐ Improper Conduct	☐ Leaving Worksite without Permission
☐ Mistreatment, Negligence, Abuse of a Client		☐ Violation of Company Policy or Procedure
☐ Failure to Report an On-The-Job Injury		☐ Work Performance Concern

☐ Other: _____

EMPLOYER STATEMENT, FACTS OF THE INCIDENT(S):

_____

_____

_____

_____

X _____ _____

Signature of Person Writing Statement Date

Has the Employee been warned previously? ☐ Yes ☐ No

If Yes, list type(s) of warning, nature of incident(s), and date(s): _____

_____

EMPLOYEE STATEMENT:

☐ I **AGREE** with the Employer's statement

☐ I **DISAGREE** with Employer's description of incident for these reasons: _____

_____

X _____ _____

Signature of Employee Date

ACTION TO BE TAKEN REGARDING THIS INCIDENT:

☐ 1st Written Warning ☐ 2nd Written Warning ☐ Suspension ☐ **Final** Written Warning

☐ Termination ☐ Other: _____

Desired Outcome(s): _____

Consequences of further incidents: _____

SIGNATURES:

Signature of Next Level of Management:

X *(If this is a final written warning)* _____ Date: _____

X Signature of Supervisor: _____ Date: _____

X Signature of Witness *(if applicable)*: _____ Date: _____

X Signature of Employee*: _____ Date: _____

(*Employee Signature indicates that they have reviewed the form.)

NOTICE: POST AT ALL JOB LOCATIONS

To: All LIFE, Inc. Employees
Re: Drugs (Awareness Message)
Date: November 15, 20____

Dear Employee:

Drug use has a serious impact on our nation's workforce. Each year, billions of dollars are being lost because of the use of illegal drugs and narcotics.

The illegal use of drugs on or off-duty by any employee is inconsistent with the law-abiding behavior expected of all citizens. Drug-related activities seem to dissolve the bond of trust between employees and employers which leads to additional work-related concerns.

Employees who use illegal drugs tend to be less productive and less reliable, and have higher rates of absenteeism than their fellow employees who do not use illegal drugs.

The use of drugs not only impairs employee efficiency, but also diminishes public confidence in the individual.

Additionally, drugs pose a serious health and safety threat to members of the general public and to our employees. Drug users themselves must be primarily responsible for changing their behavior and for beginning the process of rehabilitation.

I have instructed all Supervisors to issue the following guidelines to assure a "Drug-Free Workplace":

1. LIFE, Inc. employees must refrain from the use of illegal drugs and narcotics:

2. Illegal use of drugs and narcotics is in violation of LIFE, Inc. policy;

3. Persons manufacturing, distributing, possessing or using (including reporting to work under the influence of) illegal drugs and narcotics are not suitable for employment with LIFE, Inc. and such persons will be terminated immediately.

Individuals who are using drugs should voluntarily seek assistance and referrals through our health insurance plan. Otherwise, discovery of drug use while employed by LIFE, Inc. will be grounds for immediate termination.

Sincerely,

Sharon Raynor

Sharon Raynor
President

NOTICE
TO BE POSTED AT ALL JOB SITES AND ON COMPANY BULLETIN BOARDS

To: All LIFE, Inc. Employees
Re: Drug-Free Workplace Awareness Message
Date: February 1, 20___

POLICY:

LIFE, Inc. strictly prohibits any employee from unlawfully manufacturing, distributing, dispensing, possessing or using (including reporting to work under the influence of) illegal drugs, narcotics or alcohol in the workplace.

ACTION:

Any employee who violates any of the above policy will be immediately terminated from employment with LIFE, Inc. Valid prescriptions from a medical doctor are not included: however, you must report the use of legal drugs and narcotics to your immediate supervisor.

DANGERS:

The danger of illegal drugs, narcotics and alcohol in the workplace is enormous. Employees using drugs endanger their lives, the lives of others and cause physical property damage. A person's reaction time is slowed, thus causing potential safety hazards. Use of illegal drugs, narcotics and abuse of alcohol may also harm the health of the person taking the drugs.

COUNSEL AND REHAB:

If you are experiencing difficulty with drugs, narcotics or the abuse of alcohol, we urge you to voluntarily seek assistance through our health insurance plan. Otherwise, discovery that you are using illegal drugs or narcotics while employed by LIFE, Inc. or abusing alcohol while on duty by supervisory personnel will result in disciplinary action, up to and including termination.

Sincerely,

Sharon Raynor
President

2609 Royall Avenue • Goldsboro, North Carolina 27534
Phone (919) 778-1900 • Fax (919) 778-1911

LIFE, Inc.
CORPORATE COMPLIANCE QUESTIONNAIRE
(Employee will complete and mail to Corporate Compliance Officer)

1. Do you have any knowledge of any employee falsifying any information on his/her time sheet, expense report, MAR, Service Notes or other documentation?

   _____
   _____
   _____

2. A) Have you ever known a co-worker to leave the work site without permission from his/her supervisor?

   _____
   _____
   _____

   B) Have you ever known a former employee to call the work site or to visit the work site without permission?

   _____
   _____
   _____

3. Have you ever known of any accident/incident that was not reported to management?

   _____
   _____
   _____

4. A) Do you feel that you have a good understanding of the policies and procedures of LIFE, Inc.?

   _____
   _____
   _____

   B) Do you think they are consistently implemented with all staff? If no, give examples.

   _____
   _____
   _____

5. Have you been trained on the Client's Rights policy and the Promotion of Client Well Being and Abuse Prevention policy?

6. Are you aware of any mistreatment, neglect or abuse of any clients?

7. What would you do if you actually witnessed a client being mistreated, neglected, or abused?

8. What would you do if you heard a rumor that a client was being mistreated, neglected, or abused?

9. Do you know or suspect any employee is violating company policy? If so, who and what policy?

10. A) In your opinion, have you been trained adequately?

    B) Would additional training be beneficial?

11. Do you know or suspect any misuse of client funds, company petty cash or other company funds?

_____
_____
_____

12. Do you know or suspect any employee stealing client property? Who?

_____
_____
_____

13. Do you know or suspect any employee stealing LIFE, Inc. property? Who?

_____
_____
_____

14. Do you know or suspect any employee making false statements? Who?

_____
_____
_____

15. Have you been harassed or mistreated by an employee of LIFE? Who? Explain.

_____
_____
_____

16. Do you have knowledge of an employee violating N.C. Confidentiality Laws and/or HIPAA Laws? Who?

_____
_____
_____

17. A) Do you have knowledge of an employee accepting gifts, including tips, in exchange for favors? Who?

_____
_____
_____

B) Do you have knowledge of an employee giving gifts in exchange for favors? Who?

_____
_____
_____

18. Do you have knowledge of any racial discrimination or sexual harassment issues? Give examples.

_____
_____
_____

19. Do you feel that you have an open relationship with your supervisor? Can you go to him/her and express concerns and feel that they will respond to your concerns?

_____
_____
_____

20. Do you feel that there is an appropriate level of respect between you, your coworkers and your supervisor? If no, please explain.

_____
_____
_____

21. Do you have knowledge of any employee participating in any illegal activity? Who?

_____
_____
_____

22. Do you have any suggestions for management? Please explain.

_____
_____
_____

I believe these answers and statements to be true to the best of my knowledge. I understand that any information not revealed at this time may not be considered at a later time by management unless required by law.

_____
Employee Printed Name

_____ _____ _____
Employee Signature Group Home/Region Date

LIFE, Inc.
Corporate Compliance and Ethics
Review Form

Summary of Questionnaire Concerns:

_____
_____
_____
_____

Resolution of Concerns:

_____
_____
_____
_____

_____ _____
Corporate Compliance Officer Signature Date

CORPORATE COMPLIANCE RESOLUTION FORM

☐ Interview Questionnaire Question #:_____
☐ Mail-In Questionnaire Question #:_____
☐ Via Telephone Date:_____
☐ Via Email Date:_____

Employee:_____

Interviewer/Supervisor:_____

GrpHm/Office:_____

☐ CS ☐ ICF ☐ Corp

Summary of Concerns:

_____
_____
_____
_____
_____
_____

Resolution of Concerns:

_____
_____
_____
_____
_____
_____

Resolution Rec'd and Reviewed by:

X_____ _____
Corporate Compliance Officer's Signature *Date*

☐ Discussed with Board of Directors this date:_____

X_____ _____
President's Signature *Date*

FILED:_____

LIFE, Inc.
Grievance Review Form

Name of Aggrieved Employee: _____ Department/Facility: _____

Date of Filing: _____ Date of Occurrence: _____

SECTION I (To be completed by supervisor)

Summary of Employee Grievance: _____

_____

_____

Proposed Resolution to Grievance: _____

_____

_____

_____
Supervisor Signature

_____
Date

SECTION II (To be completed by aggrieved employee)

Place an "X" in the appropriate box:

☐ I accept the supervisor's resolution to my grievance as stated above.

☐ I reject the proposed resolution as stated above and appeal the decision to the department head. (*Employee should complete Section III.)

_____
Employee Signature

_____
Date

SECTION III (To be completed by aggrieved employee)

Employee's Summary of Grievance and Response from Supervisor: _____

_____

_____

_____
Employee Signature

_____
Date

SECTION IV (To be completed by Department Head)

I have thoroughly reviewed the grievance and proposed resolution stated above and have conferred with the employee, supervisor and other appropriate management staff. After investigating the issue, I have made the following decision:

_____

_____

_____

_____ _____
Department Head Signature Supervisor Signature

_____ _____
Date Date

_____ (Employee should complete Section V at this time)
Employee Signature

_____
Date

SECTION V (To be completed by aggrieved employee)

Place an "X in the appropriate box:

☐ I accept the department head's decision as stated in Section IV.

☐ I reject the department head's decision as stated in Section IV and appeal the decision to the Director of Human Resources. I further understand that the decision reached by the Director of Human Resources will be final.

_____
Employee Signature

_____
Date

SECTION VI (To be completed by Director of Human Resources)

I have reviewed and investigated the grievance and have reached the following decision:

_____

_____

_____

_____
Director of Human Resources

_____
Date

_____	_____	_____
Employee Signature	Supervisor Signature	Department Head Signature
_____	_____	_____
Date	Date	Date

LIFE, Inc. Email Policy Review

I have received a copy of the LIFE, Inc.'s E-Mail Policy and have had an opportunity to ask any questions I may have had concerning this policy.

Name:_____

My E-Mail Address is:_____

Signature:_____

Date:_____

LIFE, Inc.

NOTICE OF PARTICIPATION

ELECTRONIC SIGNATURE

By signing this notice, I am agreeing to participate in the use of electronic signature to authenticate documents via the LIFE, Inc. Network.

I understand that the password assigned to me is confidential. I certify that I will not disclose my password to another person or permit another person to use it. I further certify that I will not utilize another person's password.

I understand that failure to comply with or misuse of LIFE, Inc.'s Electronic Signature Policy will result in revocation of my electronic signature privileges.

I understand that I am responsible for the content of all entries that I sign electronically.

_____ _____

Signature Date

_____

Typed or Printed Name

COMPANY CELL PHONES **909(a)**

Effective: May 2003
Last Revision Date: August 2, 2018
Responsibility: Executive Vice President

I have received my LIFE, Inc. cell phone.

I have read the LIFE, Inc. Personal Telephone Usage policy (805:1)

I understand that personal phone calls are my responsibility, as is the care of the phone. LIFE, Inc. will replace lost or damaged phones on a one-time basis only. After that, the replacement will be my responsibility.

I accept and understand the policies concerning personal telephone calls and my responsibility of my cell phone.

_____ _____

Employee Name Cell Phone Number

_____

Date

LIFE, Inc. Feedback and Suggestion

Submit form back to local Day Program or to the HR Department at

HR Department
Corporate Office, LIFE, Inc.
2609 Royall Avenue
Goldsboro, NC 27834

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
Job Duties				
Utilization of Skills and Experience				
Performance Appraisals/Feedback				
Training, Orientation, Development				
Opportunities for Advancement				
Salary				
Work Schedule				
Supervision				
Quality of Care for Residents				
Company Policies				
Work Load				
Company Benefits				
Overall Employment				

Please comment on selections above, especially if you marked dissatisfied or very dissatisfied:

Any other Feedback you would like to provide?

LIFE, INC.
EMPLOYEE ANNUAL
PERFORMANCE EVALUATION

For any sections requiring additional space, please attach a separate sheet of paper.

Name: _____ Date: _____

Department: _____ Position Title: _____

Supervisor's Name: _____

POSITION FUNCTIONS: List these from position description and evaluate using rating scale.

	Rating
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
6. _____	
7. _____	
8. _____	
9. _____	

Comments: _____

_____

_____

COMPETENCIES: List these from position description and evaluate using rating scale.

	Rating
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
6. _____	

7. _____ ☐

8. _____ ☐

9. _____ ☐

Comments: _____

_____

_____

ASSESSEMENT OF PERFORMANCE OF OBJECTIVES FROM LAST EVALUATION PERIOD.

List these here and evaluate using the rating scale.

Rating

1. _____ ☐

2. _____ ☐

3. _____ ☐

4. _____ ☐

5. _____ ☐

6. _____ ☐

7. _____ ☐

8. _____ ☐

9. _____ ☐

Comments: _____

_____

_____

PERFORMANCE OBJECTIVES FOR NEXT YEAR:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

EMPLOYEE COMMENTS: Enter below any comments you wish to make about your evaluation or the objectives for the next year.

_____

_____

_____

_____

_____

_____

Additional page(s) attached? ☐ Yes If so, how many? _____ ☐ No

SIGNATURES:

Evaluator: _____ Date: _____

Employee: _____ Date: _____

Reviewer: _____ Date: _____

Date Reviewed with Employee: _____

LIFE, Inc.

RELEASE TO RETURN TO WORK

Name of Employee: _____

First *Middle* *Last*

(To be completed by Physician)

I saw and treated this patient on _____*, for* _____.

Date *Diagnosis*

☐ I recommend his/her return to work with no limitations (Including attendance and full participation of all required training which includes, but is not limited to CPR, First Aid, and North Carolina Interventions (NCI).

☐ He/She may return to work with the following limitations:

- ☐ Stooping
- ☐ Kneeling
- ☐ Bending
- ☐ Lifting more than ____ lbs
- ☐ Standing
- ☐ Sitting
- ☐ Grasping
- ☐ Transporting clients in a Company vehicle
- ☐ Interpreting and implementing client medical/medication orders
- ☐ Administering prescription and control medication to clients
- ☐ Other: _____

_____

_____

_____

Physician's Printed Name: _____

X _____ _____

Physician's Signature ***Date***

LIFE, Inc.
Medical/Tuberculosis Assessment

Date: _____ Home Phone: _____

Date of Birth: _____

Date of Hire: _____

Name: _____

Address: _____

Name of Medications you are currently taking that may interfere with your ability to perform your job duties. (*For example: Darvocet for pain; drugs with codeine; or Xanax for anxiety.)*

_____

_____

_____

Any drug allergies? ☐ Yes ☐ No If so, what? _____

_____

WOMEN: Do you suspect that you are pregnant? ☐ Yes ☐ No

If you are pregnant, you must have a written release from your doctor after the third month.

TB RISK ASSESSMENT: Do you have close contact with anyone who has Tuberculosis?

☐ Yes ☐ No ☐ Do not know

Have you ever been treated for Tuberculosis or had a positive T.B. Test? ☐ Yes ☐ No

Do you experience any of the following?

1. Unexplained cough? ☐ Yes ☐ No
2. Unexplained fever? ☐ Yes ☐ No
3. Night sweats that leave the sheets and clothes wet? ☐ Yes ☐ No
4. Shortness of breath/chest pain? ☐ Yes ☐ No
5. Unexplained weight loss/loss of appetite? ☐ Yes ☐ No
6. Unexplained tiredness for no apparent reason? ☐ Yes ☐ No

Have you ever been treated for/had a history of any of the following?

1. Seizures? ☐ Yes ☐ No
2. Back pain/problems? ☐ Yes ☐ No
3. Diabetes? ☐ Yes ☐ No
4. Hypertension? ☐ Yes ☐ No
5. Mental/emotional disturbance? ☐ Yes ☐ No
6. Drug/alcohol dependency? ☐ Yes ☐ No
7. Heart problems? ☐ Yes ☐ No
8. Bleeding/circulation problems? ☐ Yes ☐ No
9. Fainting/dizzy spells? ☐ Yes ☐ No

Please explain any problem(s) in which you answered "yes": _____

_____

_____

_____

Is there any other information we should know about your medical history? _____

_____

_____

_____

_____

_____

I acknowledge the above information is accurate and complete to the best of my knowledge. If any of the above symptoms occur, I will seek medical attention. I will not hold LIFE, Inc. responsible for any errors or omissions that I made in the completion of this form.

Signature: _____

Date: _____

LIFE, Inc.

Hepatitis Vaccination Consent Form

Background

The Occupational Safety & Health Administration of the U.S. Department of Labor (OSHA) issued regulations regarding occupational exposure to Hepatitis B virus (HBV), Human Immunodeficiency Virus (HIV), and other blood borne pathogens. Under these regulations, employers in the health care industry are required to implement measures to prevent HBV & HIV exposure to employees. HBV vaccine is one such measure. It provides active immunity against Hepatitis B only and not against HIV infection. The vaccine must be taken in three doses at initial, one, and six-month intervals for full immunization effect.

Who Should Consider Receiving HBV Vaccine?

In accordance with OSHA's regulations, LIFE, Inc. is offering the HBV vaccine free of charge to all employees who may reasonably anticipate occupational exposure to blood or other potentially infectious materials.

I have been informed of the modes of transmission of blood borne pathogens including the Hepatitis B virus. I have been instructed on LIFE, Inc.'s exposure control plan and understand the procedure to follow if an exposure incident occurs, method of administration, benefits and possible adverse reactions of the Hepatitis B vaccine.

☐ **I choose not to receive the vaccine.**

☐ **I have previously received the Hepatitis B vaccine series.**

Date	Signature
Witness	Print Name

☐ I understand the potential benefits and side effects/adverse reactions of HBV vaccine. **I choose to receive the vaccine.**

I consent to receive the Hepatitis B vaccine. I release LIFE, Inc. and its employees from all liability in connection with the administration of the vaccine. I understand that the vaccine is given in three doses: initial, in one month, and in six months. I understand that the HBV vaccine is being offered to me and I understand that it is my responsibility to arrange an appointment for each of the three doses throughout the six-month period.

Date	Signature
Witness	Print Name

Witness: _____ Date: _____ 1105:5

Nurse: _____ Date: _____

QP or Manager: _____ Date: _____

OSHA's Form 301
Injuries and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone _____ Date _____

Information about the employee

1) Full Name _____

2) Street _____

City _____ State ____ Zip _____

3) Date of birth _____

4) Date hired _____

5) ☐ Male
☐ Female

Information about the physician or other health care professional

6) Name of physician or other health care professional

_____

_____

7) If treatment was given away from the worksite, where was it given?

Facility _____

Street _____

City _____ State ____ Zip _____

8) Was employee treated in an emergency room?
☐ Yes
☐ No

9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☐ No

Information about the case

10) Case number from the Log _____ *(Transfer the case number from the Log after you record the case.)*

11) Date of injury or illness _____

12) Time employee began work _____ AM/PM

13) Time of event _____ AM/PM ☐ Check if time cannot be determined

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

15) **What happened?** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

17) **What object or substance directly harmed the employee?** Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

18) **If the employee died, when did death occur?** Date of death

North Carolina Industrial Commission

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT

IC File #_____

Emp. Code #_____

Carrier Code #_____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name		LIFE, Inc.	(919) 778-1900
		Employer's Name	Telephone Number
Address		2609 Royall Ave	Goldsboro NC 27534
		Employer's Address	City State Zip
City	State Zip	Argent, West Bend	B-198106-0
		Insurance Carrier	Policy Number
( ) -	( ) -	1900 South 18th Ave.	West Bend WI 53095
Home Telephone	Work Telephone	Carrier's Address	City State Zip
- -	☐ M ☐ F / /	(800)236-5010	(888) 926-9299
Social Security Number	Sex Date of Birth	Carrier's Telephone Number	Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ___/___/___ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent	Printed Name of Signer	E-mail Address	( ) - Telephone Number

Address	City	State	Zip Code	/ / Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FORM 18
03/2020
PAGE 1 OF 2

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

ATTORNEYS: FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML OR
IF NO IC FILE NUMBER, FOLLOW EMPLOYEE FILING OPTIONS.
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
1235 MAIL SERVICE CENTER
RALEIGH, NC 27699-1235
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other two spaces "Emp. Code No." and "Carrier Code No." are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

Employee Refusal of Medical Treatment after an Injury/Exposure

I, _____, am employed by _____

as a _____.

On _____, 20____, I was injured/exposed (circle one) when I (describe incident):

_____

_____

_____

_____

_____

My employer has offered to provide follow-up medical assistance for me in order to assure that my injury/exposure is not more serious than it appears. However, I, of my own free will and volition, and despite my employer's offer, have elected not to receive a medical evaluation.

_____
Employee's Signature

_____
Employee's Name (Printed)

_____

_____
Address

_____
Date

_____
Witness Signature

_____
Date

This form will be kept on file for the duration of the above mentioned employment at LIFE, Inc. plus 30 years.

North Carolina Industrial Commission

IC File #_____

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name	LIFE, Inc.	(919)778-1900	
	Employer's Name	Telephone Number	
Address	2609 Royall Ave	Goldsboro	NC 27834
	Employer's Address	City	State Zip
City State Zip	Argent, West Bend	B-198106-0	
	Insurance Carrier	Policy Number	
( ) -	( ) - 1900 South 18th Ave.	West Bend	WI 53095
Home Telephone	Work Telephone Carrier's Address	City	State Zip
- - ☐ M ☐ F / /	(800)236 - 5010	(888)926 - 9299	
Social Security Number Sex Date of Birth	Carrier's Telephone Number	Fax Number	

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / /
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Time employed by you (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No / Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY:_____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:** HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE) O SU NÚMERO DE SEGURO SOCIAL.

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:** **HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML**

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: **FORMS@IC.NC.GOV** OR MAIL TO: **NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235**
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year

U.S. Department of Labor
Occupational Safety and Health Administration

You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Form approved OMB no. 1218-0176

Establishment name

City State

Identify the person			Describe the case			Classify the case											
(A) Case No.	(B) Employee's Name	(C) Job Title (e.g., Welder)	(D) Date of injury or onset of illness (mo./day)	(E) Where the event occurred (e.g. Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch)	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Check the "injury" column or choose one type of illness:					
						Death	Days away from work	Remained at work		Away From Work (days)	On job transfer or restriction (days)	(M) Injury	Skin Disorder	Respiratory Condition	Poisoning	Hearing Loss	All other illnesses
								Job transfer or restriction	Other record-able cases								
						(G)	(H)	(I)	(J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(6)
					Page totals	0	0	0	0	0	0	0	0	0	0	0	0

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

		(1) Injury	(2) Skin Disorder	(3) Respiratory Condition	(4) Poisoning	(5) Hearing Loss	(6) All other illnesses

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

OSHA NO. 300 FORM

1107(a)

LIFE, Inc.
Mileage Log
Revised June 2007

Vehicle:________________________

Date	Destination	Driver's Signature	Client Head Count	Beginning Miles	Ending Miles	Cone Placed Behind Van

DIRECT SUPPORT PROFESSIONAL WITH NO DRIVER'S LICENSE OR INSURANCE AGGREEMENT

LIFE, Inc.

Policy 1110, 12 states that LIFE, Inc. employees are required to have a valid driver's license from employee's current state of residency. If an employee does not have a valid driver's license or insurance, they may be hired with the Executive Vice President's approval with the criteria listed below:

Employee/Potential Employee's Initials	Criteria
	1. An employee without a valid driver's license may not drive a company or personal vehicle while on duty for LIFE, Inc.
	2. An employee without a valid driver's license may not drive a personal vehicle to report to work for LIFE, Inc.
	3. If being dropped off, the employee should be dropped off on the street, and the vehicle should not enter LIFE, Inc.'s property.
	4. The employee will be required to obtain a valid driver's license within their first 60 days of employment. This timeline may be reviewed and changed by the Executive Vice President.
	5. Not meeting any of the criteria above will result in termination of employment.

_____

Employee's Printed Name

Employee's Signature Date

QP's Signature Date

Executive Vice President's Signature Date

LIFE, Inc. REQUEST FOR MEDICAL ACCOMODATION

To request an exemption from required vaccinations or policy please complete section 1 below and have your medical provider complete section 2 before returning this form to the human resources department.

Section 1

Name (print):	Date:
Facility:	Position:
Manager:	Work/Cell Phone:

I am requesting a medical accommodation from a LIFE, Inc. required vaccination or policy for the following vaccine/policy(s):

Describe the reason you are requesting a medical accommodation:

I verify that the information I am submitting to substantiate my request for exemption from LIFE, Inc.'s vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.
I further understand that LIFE, Inc. is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for LIFE, Inc.

Employee Signature: Date:

Section 2
Medical Certification for Accommodation (If required)

Employee Name: _____

Dear Medical Provider,
LIFE, Inc. requires vaccination(s) as outlined by CMS and has health and safety policies as a condition of employment. The individual named above is seeking an exemption to a vaccination or a policy due to medical contraindications.
Please complete this form to assist LIFE, Inc. in the reasonable accommodation process.

The person named above should not receive the COVID vaccine due to:

This exemption should be:

- ☐ Temporary, expiring on: __/__/____, or when _____
- ☐ Permanent

I certify the above information to be true and accurate, and request exemption from the [*insert disease name*] vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

- ☐ Approved __/__/____
  Describe specific accommodation details:
  _____

- ☐ Denied __/__/____
  Describe why accommodation is denied:
  _____

LIFE, Inc. SINCERELY HELD RELIGIOUS BELIEF, OBSERVANCE, OR PRACTICE REQUEST FORM

Part 1: To be completed by employee

Name (print):	Date:
Facility:	Position:
Manager:	Work/Cell Phone:

Requested accommodation (job change, schedule change, dress/appearance code exception, vaccination exemption, etc.):

_____

_____

Length of time the accommodation is needed: _____

Describe the religious belief or practice that necessitates this request for accommodation:

_____

_____

_____

Describe any alternate accommodations that might address your needs:

_____

_____

_____

I have read and understand LIFE, Inc.'s policy on religious accommodation. My religious beliefs and practices, which result in this request for a religious accommodation, are sincerely held. I understand that the accommodation requested above may not be granted but that the company will attempt to provide a reasonable accommodation that does not create an undue hardship on the company. I understand that LIFE, Inc. may need to obtain supporting documentation regarding my religious practice and beliefs to further evaluate my request for a religious accommodation.

Employee signature: _____ Date: _____

Part 2: To be completed by the HR Department

Describe the requested accommodation:

_____

_____

Evaluation of impact (if any): _____

_____

_____

Approved: _____ Denied: _____

If the requested accommodation is denied, what are some alternative accommodations (list in order of preference):

1. _____
2. _____
3. _____

Date discussed with employee: _____

Final accommodation agreed upon: _____

If no agreement on an accommodation, provide an explanation:

_____

_____

Director of ICF Business or Contract Services: _____ Date: _____

HR Director: _____ Date: _____

LIFE, Inc.
Confidential Investigative Statement

As part of the investigative process, it is required that you complete this form by answering questions and filling in blanks as indicated. Please keep in mind that any written and/or verbal information shared during the investigation will be kept confidential. This means that you should not discuss the situation with anyone except members of the investigative team or DSS representatives. If it is determined that you have discussed the matter with anyone except authorized individuals, you will be in violation of LIFE, Inc. policy and subject to appropriate disciplinary actions per established procedures up to and including termination. You are expected to cooperate with members of the investigative team, as well as protective workers from the Department of Social Services throughout the investigation. Your refusal to do so could also result in disciplinary action. Your signature on this form indicates acknowledgement of the importance of your cooperation and the significance of confidentiality throughout the investigative process.

Date of Incident/Allegation: _____
Time of Incident/Allegation: _____
Location of Incident/Allegation: _____
Client(s) Involved: _____

_____

Staff Member(s) Directly Involved: _____

_____

Staff Member(s) who were present and/or have knowledge of Incident/Allegation:

_____

_____

Indicate any documentation which occurred (check all that apply):

Accident/Incident Form_____ Behavioral Data_____
Communication Book_____ Daily Shift Report_____
Other type of documentation, List:_____
To my knowledge no documentation occurred._____

Provide a detailed account of what occurred. Include your observations, what was said, how the client responded, etc. BE SPECIFIC (continue on back if necessary*):

_____

_____

_____

_____

_____

_____ _____ _____
Printed Name and Title of Person Writing Statement Signature of Person Writing Statement Date

*please sign and date on reverse or any additional pages.

LIFE, Inc.
Formal Inquiry Form

Consumer(s) involved:_____ Group Home:_____

Injury Sustained:_____yes____no (as appropriate attach accident/incident report).

Chairperson of LIFE, Inc. Human Rights Committee or designee Notified:
Name:_____ Date:_____ Time:_____
Comments from Human Rights Representative:_____
_____

Parent/Guardian of consumer(s) notified:
Name:_____ Date:_____ Time:_____
Comments from Parent/Guardian:_____
_____

Local Department of Social Services Protective Services Notified:
Name of Contact:_____ Date:_____ Time:_____
DSS Investigation Initiated:_____yes_____no
DSS Recommendations:_____
_____

Local Law Enforcement Notified:
Name of Contact:_____ Date:_____ Time:_____
Law Enforcement Investigation Initiated:_____yes_____no
Law Enforcement Recommendations:_____
_____

NC IRIS/NC Health Care Personnel Registry Notification:
Date of Initial NC IRIS for 24 Hour Report Completion:_____ Time:_____
Date of Final NC IRIS Completion for 5 Day Report:_____ Time:_____

Contact by NC Health Care Registry: (indicate any phone contact or on-site visits that have occurred thus far):_____

NC IRIS Incident Number Assigned:_____

Staff Members Interviewed (list names and attach written statements):_____
_____
_____
_____

Consumer(s) interviewed (if any, list names and indicate their comments):_____
_____
_____
_____

Investigative Team Members: (give name and title of team members who assisted with the Inquiry):

Summary of violation or allegation: (what allegedly happened, when, where, who reported it, did an injury, etc.)

Summary of inquiry process: (indicate how the allegation was investigated)

Results of the inquiry: (what was determined to have occurred?)

Recommendations of the Investigative Team and Action Taken: (be specific and indicate dates action was taken)

QP I Signature Date QP II Signature Date

Director of Social Work Date

Signature and Acknowledgement of Company President or designee:

President's Signature Date

LIFE, Inc.
STAFF INSERVICE REPORT

Date: _____ Instructor's Printed Name: _____

Time Length of Break: _____ Instructor's Signature: _____

Inservice Begin Time: _____ Inservice End Time: _____

* Topic Covered:	1. Bloodborne Pathogens	Expiration Date:	(1 yr.)
* Topic Covered:	2. Code of Conduct (in Corp Compliance and Ethics Training binder)	Expiration Date:	(1 yr.)
* Topic Covered:	3. Corp Compliance Deficit Reduction Act '05 (in Corp Compliance and Ethics Training binder)	Expiration Date:	n/a
* Topic Covered:	4. CPR-Adult	Expiration Date:	(2 yr.)
* Topic Covered:	5. Cultural Diversity	Expiration Date:	(1 yr.)
* Topic Covered:	6. Emergency Preparedness	Expiration Date:	(1 yr.)
* Topic Covered:	7. Fire Safety	Expiration Date:	(1 yr.)
* Topic Covered:	8. First Aid	Expiration Date:	(2 yr.)
* Topic Covered:	9. General Orientation - ICF	Expiration Date:	n/a
* Topic Covered:	10. General Orientation - Policy Rel	Expiration Date:	n/a
* Topic Covered:	11. General Orientation-Cont Serv	Expiration Date:	n/a
* Topic Covered:	12. HIPAA (in Corp Compliance and Ethics Training binder)	Expiration Date:	n/a
* Topic Covered:	13. MANDT	Expiration Date:	(1 yr.)
* Topic Covered:	14. Medical/TB Asessment	Expiration Date:	(1 yr.)
* Topic Covered:	15. Medical Review (annually after Medication certified)	Expiration Date:	(1 yr.)
* Topic Covered:	16. Promotion of Consumer Well-Being	Expiration Date:	(1 yr.)

EMPLOYEE'S PRINTED NAME (Please print clearly)	EMP ID #	Is this Employee a NEW HIRE?	EMPLOYEE'S SIGNATURE (Please sign legibly)	FACILITY #	ARRIVAL TIME	DEPARTURE TIME	TOPICS	PASS/FAIL

PLEASE FAX ALL COMPLETED FORMS TO THE CORPORATE OFFICE: (919) 778-2928

Rev. 2/2018

CONSUMER INCIDENTS **1202(a)**

Consumer's Name _____

Date of Intervention _____ Start Time _____ End Time _____ ○ AM PM ○

Name of Staff Administering the Restrictive Intervention (*Please Print)* _____

TYPE OF RESTRAINT USED: ☐ **Side Body Hug** ☐ **One/Two Person Standing** ☐ **Two Person Moving Restraint**

Purpose of the Intervention (Check all that apply)

☐ Prevent Harm to Self
☐ Prevent Harm to Others
☐ Planned Intervention per Behavior Plan
☐ Prevent Serious Property Damage

Positive and/or Less Restrictive Interventions Attempted: (Check all that apply)

☐ Verbal Redirection
☐ Distractions (e.g. take a walk)
☐ Removing Consumer from situation (verbal and/or physical prompt)
☐ Separation from Group (verbal and/or physical prompt)

Health Status Information

ITEM	INITIAL CHECK (prior to intervention)	ENDING CHECK (immediately after intervention)	FOLLOW-UP CHECK (30 minutes after intervention)
Consciousness	☐ Alert ☐ Dazed	☐ Alert ☐ Dazed ☐ Unconscious	☐ Alert ☐ Dazed ☐ Unconscious
Speech	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Breathing	☐ Normal ☐ Hard/Irregular	☐ Normal ☐ Hard/Irregular	☐ Normal ☐ Hard/Irregular
Movement	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Skin Color	☐ Normal ☐ Pale ☐ Flushed	☐ Normal ☐ Pale ☐ Flushed	☐ Normal ☐ Pale ☐ Flushed
Orientation	☐ Person ☐ Place ☐ Time	☐ Person ☐ Place ☐ Time	☐ Person ☐ Place ☐ Time
Effect/Mood	☐ Appropriate ☐ Inappropriate	☐ Appropriate ☐ Inappropriate	☐ Appropriate ☐ Inappropriate

Describe the person's behavior after the intervention:

_____

Was the person monitored continuously during the intervention and for 30 minutes afterward? ☐ Yes ☐ No
If not monitored continuously, provide an explanation:

_____

Name/Title of persons providing monitoring *(Please print):*

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____

Name/Title of staff person documenting intervention *(Please print):*

Name: _____ Signature: _____ Date: _____

Debriefing completed by QP to review the incident. Name of QP Completing Debriefing *(Please print):*

Name: _____ Signature: _____ Date: _____
Comments/concerns noted:

_____

_____

Recommendations:_____

_____

***Attach this form to the completed Accident Injury Report.**

LIFE, Inc.

MEDICATION ERROR REPORT

Consumer's Name:_____ **Date:**_____
Form completed by:_____ **Group Home:**_____

Medication Tech Staff:_____ Title:_____
Med Monitor Staff: _____ Title:_____
Staff who discovered error:_____ Title_____

Date Error Occurred:_____Time:_____ am pm *(circle time of day)*

Date Error was discovered:_____Time discovered:_____am pm *(circle time of day)*

Description of error in detail: (include what was ordered, what was given or omitted and exactly what happened). Be sure to include the name and doses of the medications.

How could this have been avoided?

Employee's section:

Nurse's section:

Signatures:

Med Tech:_____ Date:_____

Staff or Habilitation Coordinator must notify Nurse and QP immediately. Nurse must immediately notify the Physician. QP must immediately notify the consumer's legally responsible person.
Date RN notified:_____Time:_____Signature:_____
Date Physician notified:_____Time:_____Signature:_____
**Physician Recommendations and Comments:_____
_____
**Adverse Reactions Noted:_____
Date QP notified:_____Time:_____Signature:_____
Date Legally Responsible Person notified:_____Time:_____Name:_____
**Legally Responsible Person comments:_____
_____
Habilitation Coordinator:_____Date:_____
Pharmacist Signature:_____Date:_____

Provider Quarterly Incidents Report
(Form QM11, Revised January 2006)

State Fiscal Year and Quarter of this Report:	**SFY05-06**	**3rd Qtr (Jan, Feb, Mar)**

Name of Provider and Facility/Unit:

Provider Identification Number:

[Use MH License Number if available, otherwise in preferred order (from top down on the list to the right) -- Medicaid Enrollment Number, IPRS Attending Number, LME Assigned Number, Provider Tax ID, or Social Security Number]

Check which type of Provider Identification Number was provided:

MH License Number	☐
Medicaid Enrollment Number	☐
IPRS Attending Number	☐
LME Assigned Number	☐
Provider Tax ID	☐
Social Security Number	☐

Section 1 - Summary of Level 1 Incidents

	Number of Incident Reports[1]	Unduplicated Count of Consumers Involved[2]	Highest Number of Incidents for One Consumer[3]
Restrictive Interventions			
[A Level 1 incident is any planned use of a restrictive intervention administered appropriately and without discomfort, complaint, or injury.]			
Total Unduplicated Count[4]			
Seclusion			
Isolated Time-Out			
Restraint			
Medication Errors			
[A Level 1 incident is any error that a physician or pharmacist has determined does not threaten the consumer's health or safety. Providers of periodic services should report errors for consumers who self-administer medications as soon as learning of the incident.]			
Wong Dosage Administered			
Wrong Medication Administered			
Wrong Time (Over 1 hour from prescribed time)			
Missed or Refused Dose of Prescribed Medication			
Other Incidents			
[All searches/seizures are classified as a Level 1 incident.]			

Any Search of Consumer/Living Area or Seizure of Consumer's Property			

1. A count of the number of incident reports completed during the quarter for the type of incident indicated.
2. Provide an unduplicated count of the consumers for which an incident report was completed during the quarter for the type of incident indicated. For example, if one consumer had multiple incidents during the quarter of the type indicated, that consumer should be counted only once.
3. Identify the individual consumer with the highest number of incidents during the quarter for the type indicated and report this number as the highest number of incidents for one consumer. For example, if 30 medication errors out of a total of 35 during the quarter were attributed to one consumer, the highest number for one consumer would be 30. If 35 consumers each had one medication error during the quarter, the highest number for one consumer would be one.
4. For **total unduplicated count**, count each incident report only once regardless of the number of different types of restrictive interventions that may be listed on an individual report. For each **type** of restrictive intervention listed (seclusion, isolated time-out, or restraint), count each incident reported on the incident report. It is possible that the sum of each type of incident may exceed the total unduplicated count if more than one type of restrictive intervention is reported on a single incident report.

Section 2 - Summary of Level 2 and 3 Incidents

This section provides a summary of the number of Level 2 and Level 3 Incident Reports that were completed and submitted to the host LME during the quarter.

	Number of Incident Reports	Unduplicated Count of Consumers Involved	Highest Number of Incidents for One Consumer
Number of Level 2 Incident Reports			
Number of Level 3 Incident Reports			

If no Level 2 or Level 3 Incident Reports were submitted, did any Level 2 or Level 3 incident occur and go unreported? ☐ Yes ☐ No

Section 3 - How the Provider is Analyzing Trends and Using Incident Report Data

Provide a brief description of patterns or trends identified through data analysis, strategies developed to address identified problems or opportunities for improvement, actions taken, evaluation of the results of actions taken, and/or next steps being planned. The information provided below should address quality improvement efforts related to any type of incidents (Level 1, 2, and 3) and should not be limited to the Level 1 incidents reported on this form.

	Description
Analyses (Trends, patterns)	
Strategies Developed	

Actions Taken	
Evaluation of Results of Actions Taken	
Next Steps	

Print Name of Person Completing Report for Provider:
Title:
Date:
Phone: Email:

Instructions

Requirement to Submit the Report:

10A NCAC 27G .0604, requires Category A and B providers to submit a report each quarter to the host Local Management Entity (LME) providing summary information of selected Level 1 incidents* that occurred during the quarter involving restrictive interventions, medication errors, any search of a client or a client's living area, and any seizure of a client's property or property in the client's possession. **A separate report shall be submitted for each provider facility/site**. The report shall be submitted using a form provided by the Secretary of the North Carolina Department of Health and Human Services (NC DHHS). The Provider Quarterly Incidents Report (Form QM11) is the designated form for submitting this report. A copy of this form may be found on the Division of MH/DD/SAS website:

http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm

* *A Level 1 incident is any occurrence that is not consistent with the routine operation of a facility or service or the routine care of a client and that is likely to lead to adverse effects upon a client and does not meet the definition of a Level 2 or 3 incident. For further explanation, please refer to the DHHS Incident and Death Response System Manual, a copy of which also may be found on the above referenced web site.*

Even if there are no Level 1 incidents of the types to be reported during the quarter, providers are still required to submit this form to the host LME indicating "0" incidents. This will allow the host LME to distinguish between no incidents and a failure to report by a provider.

When to Submit the Report:

The quarterly summary and analysis of incidents is to be done every three months and submitted no later than 10 days after the end of the quarter. The following table describes the months covered and the due dates for each quarterly report.

Report	Months Covered	Due Date
First Quarter	July, August, September	October 10

Second Quarter	October, November, December	January 10
Third Quarter	January, February, March	April 10
Fourth Quarter	April, May, June	July 10

Where and How to Submit the Report:

This report should be emailed, faxed or mailed to the Host LME Incident Report Contact Person Below:

[LME Name]
[Address]
[City, State, Zip Code]

Attention: [LME Incident Report Contact Person]

Phone Number:
Fax Number:
Email:

Questions:

Questions about the quarterly report form should be directed to the Host LME Incident Report Contact Person named above at the email address or phone number provided.