INVO PEO
innovative national value outsourcing

Employee Information Form

Client Company Name: _____

Employees, please fill out all information requested below. Employers are responsible for all information on second page. Incomplete forms will not be accepted.

Employee Details

Social Security Number	First Name (As appears on Social Security Card or Valid ID)	Last Name (As appears on Social Security Card or Valid ID)

Middle Name	Nickname (If applicable)	Date of Birth

Gender	Racial or Ethnic Group		
	☐ White / Caucasian	☐ Black / African American	☐ American Indian / Alaskan
	☐ Asian / Pacific Islander	☐ Hispanic / Latino	☐ Other

Marital Status

☐ Single	☐ Married	☐ Divorced
☐ Widowed	☐ Civil Union	☐ Other

Employee Contact

Resident Address Line 1	Resident Address Line 2

City	State	County	Zip Code

Mailing Address Line 1 (If different from Resident)	Mailing Address Line 2

City	State	County	Zip Code

Phone Number	Email Address

INVO PEO Global Life Beneficiary Election: Please provide the name and social security number of the person you would like to designate for the INVO PEO Global Life Benefit, (if applicable).

Beneficiary Name: _____ SSN: _____

-Second Page To Be Completed By Employers Only-

Employers, please ensure all information below is accurate before submitting.

Employee Name: _____

Employment Information

Employee Original Hire Date	Primary Workers' Comp Code (Refer to Schedule A – Code Required)	Exempt Status ☐ Exempt ☐ Non-Exempt

EEOC Class Code

☐ 1. Officials & Manager ☐ 2. Professional ☐ 3. Technician ☐ 4. Sales Worker

☐ 5. Administrative Support Worker ☐ 6. Craft Worker ☐ 7. Operative ☐ 8. Laborer / Helper

☐ 9. Service Workers ☐ 11. First/Mid Level Officials & Managers

Employee Type	Work State
☐ Full-Time ☐ Part-Time ☐ On-Call ☐ Seasonal ☐ Temporary	

Division	Department	Location	Job Title

Payroll Information

Pay Rate (Annual if Salary)	Pay Method	Pay Group
	☐ Salary ☐ Hourly ☐ Commission ☐ Other	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Yearly

Voluntary Deductions by pay period [Example: Uniforms, Equipment, Background Check, Loans, Advances] :

Deduction Name		Deduction Name	
Amount	☐ Scheduled ☐ Recurring	Amount	☐ Scheduled ☐ Recurring
Deduction Name		Deduction Name	
Amount	☐ Scheduled ☐ Recurring	Amount	☐ Scheduled ☐ Recurring

Benefits by pay period [Example: Medical, Dental, Vision, Supplemental Insurance] :

Deduction Name	Amount	Deduction Name	Amount

Retirement Plans

Plan Type: ☐ FSA ☐ HSA	Employee Annual Contribution Amount

Notes (list any other information required for this employee)

INVOPEO

innovative national value outsourcing

Employee Agreement

I, _____ (print your name), acknowledge that I have been hired as an at-will leased/ assigned employee of INVO PEO (hereafter referred to as "INVO") which is a Professional Employer Organization (PEO) and agree to the following:

I understand and agree that I am employed in a co-employment relationship where the duties and responsibilities that are applicable to me are set forth in the Client Service Agreement entered between the client for whom I am working and INVO. I understand that there is no contract of employment between myself and INVO and that INVO has no liability with regards to any employment agreement between me and the client for whom I am working. I understand that either INVO or I can terminate this co-employment relationship at any time as I am an at-will employee.

I understand that INVO's client at all times ultimately remains obligated to pay me my regular hourly rate of pay if I am a non-exempt employee and to pay me my full salary if I am an exempt employee, In the case that INVO does not receive payment from the client for whom I am working for and for service which I have performed. I understand and agree that INVO does not assume responsibility of payment of bonuses, commissions, severance pay, deferred compensation, profit sharing, vacation, sick or other paid time off, or for any other payments where payment for such items has not been received by INVO from the client for whom I am working, however, INVO does assume this responsibility where such payment has been received from the client.

I recognize the fact that any work-related injuries which might be sustained by me are covered by the state workers' compensation statutes. To avoid the circumvention of such state statutes which may result from suits against the customers or clients of INVO or against INVO based upon the same injury or injuries, and to the extent permitted by law, I hereby waive and forever release any rights I might have to make claims or bring suit against any client or customer of INVO for damages based upon injuries which are covered under such workers' compensation statutes. I also agree to comply with any and all drug testing policies which may be adopted and I specifically agree to post-accident drug testing in any situation where it is allowed by law.

I agree and understand that if at any time during my employment I am subjected to any type of discrimination, including discrimination because of race, sex, disability, color, age, national origin, ancestry, religion, veteran status, military status, union status, or in retaliation, or if I am subjected to any type of harassment, including sexual harassment, that I will immediately contact an appropriate person in the client company for whom I am working. I understand and agree that INVO does not have actual control over my workplace and as such is not in any position to end or remediate any discrimination, harassment or retaliation which may be occurring. The responsibility to end such inappropriate conduct will rest with the client company; however, INVO may attempt to facilitate a resolution. Should I choose to not contact the client company for any reason, I may contact INVO's human resources department at 1-866-986-0118 in order to obtain assistance in the resolution of such matters.

I understand and agree that as an assigned employee of INVO that I am expressly prohibited from performing any work outside the state in which I am currently performing services (the "home state") for the client during my status as an assigned employee except as allowed pursuant to the workers' compensation benefits through INVO or the applicable workers' compensation carrier.

I understand and agree that in the event I am terminated from the client for whom I am working, that I am required as part of my co-employment with INVO to notify an INVO representative within 48 hours of my termination.

_____ _____

Employee Signature Date

Form **W-4**
(Rev. December 2020)
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

NEW YORK STATE
2021

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an *X* in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Complete the worksheet on page 4 before making any entries.

1	Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 19)*	1
2	Total number of allowances for New York City *(from line 31)*	2

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3	New York State amount	3
4	New York City amount	4
5	Yonkers amount	5

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an *X* in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instructions)*:

A Employee claimed more than 14 exemption allowances for NYS ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see Instr.)*:

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*:

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)*	Employer identification number

Instructions

Changes effective for 2021

Form IT-2104 has been revised for tax year 2021. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2021 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you did not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in federal and New York State tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $107,650 or more during the tax year.

Employment Eligibility Verification

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

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

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one)

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Payroll Payment Request

Please complete this form to notify INVO how to process your wages. Form *must* be submitted at least two business days prior to processing day.

Employee Name:_____ **Employee SSN:** _____

☐ **Direct Deposit**

Employee Authorization and Acknowledgement of All Terms

- **For any returned direct deposit due to invalid information provided, a $25.00 fee will be charged to the employee.** To avoid this charge, include a voided check or letter from your bank with your correct bank account number and ABA routing number when submitting this form. This additional information is not required for processing.
- It takes at least one pay cycle for new direct deposits or changes to take effect.
- Should you change your banking branch, institution or account numbers, please notify your payroll department at least ten (10) days in advance so there is adequate time for change to take place.
- Errors or omissions on this form or any failure to notify INVO PEO of changes in a timely manner may result in delay of your payroll funds being deposited. INVO PEO will not reissue any unsuccessful direct deposit until the original transaction is returned to INVO PEO by the originating bank. This process may take up to 5 days. INVO PEO is not responsible for these delays and will not reimburse any fees the employee may incur as a result of outdated or inaccurate information provided by employee.

I agree to these terms and authorize INVO to direct deposit my payroll check to the checking and/or savings account(s) listed below. In the event that funds are deposited into my account(s) in error, I authorize INVO PEO to debit my account to correct the error.

Account Type (C)hecking (S)avings	ABA Routing Number (9 Digit Number)	Account Number	Bank Name	For multiple accounts, specify the percentage or dollar amount to be deposited in each
○ C or S ○				
○ C or S ○				
○ C or S ○				

☐ **Brinks Paycard**

Account Number: _____

Routing Number: _____

By providing the information requested above and signing below, I hereby elect and consent to receive my wages, including but not limited to off cycle wage payments and wage payments upon discharge, by electronic transfer of wages to a paycard. In addition, to the extent permitted by applicable law, I hereby authorize INVO PEO to make all of my deposits and deposit adjustments, including those involving off cycle wage payments and wage payments upon discharge, to my paycard, and I authorize the bank where such funds are deposited to accept such deposits and make such adjustments. I acknowledge I have received a copy of the terms, conditions, and fees associated with using such paycard. This authorization shall remain in effect until fourteen (14) days after INVO PEO receives written notice from me terminating my authorization.

Alternatively, if you would prefer to receive wages via check, please contact your supervisor.

Employee Signature_____ Date_____

800 Oak Ridge Turnpike #A-700 | Oak Ridge, TN 37830 | Ph 865-481-0910 Fx 877-299-9849 | www.invopeo.com

B1 **2962006-ARE-6** OFFICE USE ONLY LOCATION _____ New Hire ☐ Rehire ☐ Date __/__/_____

ENROLLMENT FORM

MSC/MEC 4ENAL P1M v19.0

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name	Home Phone	
Social Security #	Date of Birth / /	Sex M F
Address		Apt. #
City	Zip	State

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare Benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ $21.98	$5.40	$2.42	$0.60	$4.20
Employee + Child(ren)	☐ $36.49	$14.58	$6.54	$0.90	
Employee + Spouse	☐ $41.76	$10.80	$4.84	$0.90	
Employee + Family	☐ $55.61	$20.52	$9.20	$1.80	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Death & Dismemberment please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82962006-M-ARE-6 **List Bill Monthly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan satisfies the federal healthcare reform Individual Mandate. This is an offer of ACA compliant coverage and by purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$58.19** Employee Only ☐ **$65.79** Employee + Child(ren) ☐ **$71.00** Employee + Spouse ☐ **$80.87** Employee + Family

☐ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage. I affirmatively consent to the voluntary receipt of the plan documents elections, via email or website.

DATE __/__/_____ ▶ **SIGNATURE**

This is a Medical StaffCARE Enrollment Form.

Med Temps Consumer Directed Personal Assistant Program

1597 West Ridge Road Suite 301 · Rochester, NY 14615 · T.585.623.8796 · F.585.623.8798

3140 Sheridan Dr · Buffalo, NY 14226 · T.716.833.0200 · F.716.833.0203

PERSONAL ASSISTANT ANNUAL HEALTH ASSESSMENT

This is a health questionnaire please complete at initial hire and annually (this form only).

Name: _____ Date: _____

Physician Name: _____ Last Visit Date: _____

Phone Number: _____ Address: _____

Any known allergies: _____

Do you feel that you are in good health and able to perform the job you are being hired to do? Yes☐ No☐

If no, please explain: _____

Within the last 12 months have you had any of the following:

	No	Yes	Explanation
Surgery	____	____	_____
Hospitalization	____	____	_____
A visit to the doctor	____	____	_____
Habitual drug or alcohol use	____	____	_____
Heart Condition	____	____	_____
Diabetes	____	____	_____
Tobacco Use	____	____	_____
Any allergy to pets	____	____	_____
Work restriction(s)	____	____	_____
Any medical condition(s)	____	____	_____

_____ _____

Employee Signature Date

Med Temps Consumer Directed Personal Assistant Program
1597 West Ridge Road Suite 301 · Rochester, NY 14615 · T.585.623.8796 · F.585.623.8798
3140 Sheridan Dr · Buffalo, NY 14226 · T.716.833.0200 · F.716.833.0203

PRE-EMPLOYMENT PHYSICAL AND IMMUNIZATION FORM

The physical examination must be current, within 12 months prior to CDPAP participation. Must be completed by an RN, NP, PA, DO or MD only.

PART 1: EMPLOYEE INFORMATION

Name:	Date of Birth:	Sex: M ☐ F ☐
Address:		Title:

PART 2: PHYSICAL EXAMINATION

Please indicate physical findings related to the following:

HEAD/ENT:	LUNGS:
EYES:	CARDIOVASCULAR:
NECK:	ABDOMEN:
MUSCULOSKELETAL:	CENTRAL NERVOUS SYSTEM:
COMMENTS/NOTES:	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

PART 3: IMMUNIZATION RECORDS

Please show test results and dates given for the following:

TEST	DATE PERFORMED and RESULTS			TEST	DATE PERFORMED and RESULTS	
1st PPD DATE IMPLANTED:	DATE READ:	RESULTS (mm x mm)		LOT NUMBER:		EXPIRATION DATE:
CHEST X-RAY (if +PPD)	DATE:			CHEST X-RAY RESULTS:		
MMR MEASLES, MUMPS, RUBELLA	VACCINTATION #1: ___/___/___	VACCINATION #2: ___/___/___		**RUBEOLA**	DATE: ___/___/___	☐ IMMUNE ☐ NON-IMMUNE
OR **POSITIVE TITERS** (MMR)	MEASLES TITER: ___/___/___			MUMPS TITER: ___/___/___		RUBELLA TITER: ___/___/___
TETANUS/DIPTHERIA (MUST BE WITHIN 10 YEARS)	DATE:			**FLU SHOT** (IF ON FILE)		DATE:
HEP B VACCINE (IF ON FILE):	1. ___/___/___			2. ___/___/___		3. ___/___/___
HEP B VACCINE DECLINE DATE:						

☐ I certify that I have examined the above named individual and find him/her free from any health impairment that is a potential risk to the patient or to other employee(s) or which may interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs, or substances which may alter the individual's behavior.

☐ I certify that I have transcribed the above immunizations from the patient's medical record.

Additional comments and/or any limitations: _____

Signature: _____ **Title** (RN, NP, PA, DO, MD only): _____ **Date:** _____

Physician Office Phone: _____ **Address:** _____