

AGENCY ONLY-PERSONNEL INFORMATION for SELECTED EMPLOYEES

Agency Name:		Employee Name:		Date of Hire:	
		Employee Title:		Date of Birth:	
Review Date:		Reviewer Agency:		Reviewer Name:	
				County:	
Employee Provides Waiver Services In:		<input type="checkbox"/> Works with specific Behavior Supports <input type="checkbox"/> Administers Meds or Health Tasks <input type="checkbox"/> Provides Transportation Services		<input type="checkbox"/> ISP required training in: Identify type of specialized training.	
<input type="checkbox"/> I.O. <input type="checkbox"/> Level One <input type="checkbox"/> Both					

Directions: For each item check Yes, No or N/A. If the answer indicates a deficiency check the box to the far left.

Key	Box 1	Box 2	Box 3	Box 4:	Box 1 Deficiency Box 2 Yes, required information is present. Box 3 No, required information is absent. Box 4 N/A, not required or does not apply.
Background Checks	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	If the employee was a resident of Ohio for the 5 years prior to employment: There is a BCII check dated: _____ <i>(Required for employees hired after 5/12/95)</i> - OR -
	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	If the employee was not a resident of Ohio for the 5 years prior to employment: There is a BCII check dated: _____ AND there is an FBI check dated: _____
	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	The Abuser Registry check is completed on or before date of hire. Abuser Registry check on file is dated: _____ <i>(Required by the date of hire if hired after 9/22/02)</i>
	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Nurse Aide Registry check is completed prior to employment. Nurse Aide Registry on file is dated: _____ <i>(For Waivers - Required on any date for all employees hired after 1989 but before 7/1/05.)</i>
	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	The BCII or FBI documentation lists a prohibited offense from 5123:2-1-05.1 -if yes-
	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	The employee has met the standards of rehabilitation as outlined in 5123:2-1-05.1
	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Employee signed a Pre-employment Statement indicating the employee has not been convicted of or pleaded guilty to any disqualifying offense. Date statement signed: _____ <i>(Required for all employees hired after 5/12/95.) (This statement may be combined with the statement below and/or included on an application if all required elements are present.)</i>
	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Employee signed a Pre-employment Statement indicating the employee will notify employer within 14 days if they are formally charged with, convicted of or plead guilty to any disqualifying offense. Date statement signed: _____ <i>(Required for all employees hired after 5/12/95.)</i>
<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Employee providing direct care is 18 years of age or older.	
Annual Abuser Registry Notification					
<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Dates of annual notifications: _____ <i>Written evidence that employee has received annual notices about the conduct that will lead to placement on the abuser registry. Employee signature is <u>not</u> required. (ORC 5123.542)</i>	

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Training Requirements

Initial & Annual Training on Incidents Adversely Affecting Health & Safety

- Yes No N/A Date of initial training: _____ *(Required within the first 30 days of employment and prior to working alone with individuals as of 7/1/07.)*
- Yes No N/A Dates of annual training: _____

Annual Training on Resident Rights

- Yes No N/A Dates of training: _____

Medication Administration and the Performance of Health Care Tasks - Valid ODMRDD Training Certificate if Required

- Yes No N/A **Oral & Topical Medications** ODMRDD Certificate Expiration Date: _____
- Yes No N/A **G Tube and J Tube** ODMRDD Certificate Expiration Date: _____
- Yes No N/A **Insulin Injections** ODMRDD Certificate Expiration Date: _____

- Yes No N/A **CPR Certification** Expiration Date: _____ *(For at least one employee per shift.)*
- Yes No N/A **Behavior Support Training** on specific individual's BSP if applicable. Date: _____

Continuing Education/Training

- Yes No N/A The employee has at least 8 hours of training annually based on their hire date.
- Dates of year span reviewed: _____ to _____ Number of training hours for the year span reviewed: _____
- (8 hours may include required training topics i.e. Incidents, Rights, CPR etc.)(Requirement is met if training is scheduled & completed within 30 days of deadline.)*

Transportation

- Yes No N/A **Proof of Valid Liability Insurance**, if the employee provides transportation services and uses own vehicle. Expiration Date: _____
- Yes No N/A **Certified Driver's Abstract** from any source directly linked to the BMV, if the employee provides transportation services. Date of abstract: _____ *(Required after rule dated 9/22/02)*
- Yes No N/A The employee has a **Valid Driver's License** from any state. Expiration Date: _____
- Yes No N/A **First Aid Certification** Expiration Date: _____ *(Required for I.O. Transportation Mileage Only)*
- Yes No N/A **CPR Certification** Expiration Date: _____ **OR Emergency Medical Technician Certificate** Expiration Date: _____ *(Required for all drivers.) (EMT certification only acceptable for I.O. Transportation Mileage Only)*