

Employee Name:

DOCUMENTS REQUIRED: RN/LPN, and Professional Staff

1. State of Florida License
2. Proof of Liability Insurance
3. CPR Card
4. HIV/AIDS Certificate (ORIGINAL 4 hrs and Update)
5. OSHA Certificate (Update)
6. Domestic Violence Certificate
7. Driver License
8. Auto Insurance
9. Proof of Citizenship/Residency (Voter registration, Resident Card, etc)
10. Social Security Card
11. Physical Examination (less than six (6) months or new request)
12. Criminal Background check (less than 2 years, or 1 money order for \$ 23.00)

JOB DESCRIPTION
SPEECH THERAPIST Employee Name:

Our agency hereby approves that we shall hire a Speech Therapist, indicated for dysphasia and dysphagia, whose tenure of office shall be governed by the following rules:

1. He/she must be a graduate of an approved school for Speech Pathologists.
2. He/she must be licensed by the state -- the license must be current.

Responsibilities of the Speech Pathologist shall include but, not limited to the following:

- a. He/she shall assist the Physician, physician assistant, or advanced registered nurse practitioner in evaluating a patient determine the type of speech or language disorder and the appropriate corrective therapy.
- b. He/she shall provide rehabilitative services for speech and language disorders.
- c. He/she shall record activities and findings in the clinical record and shall report to the physician, physician assistant, or advanced registered nurse practitioner, the patient's reaction to treatment and any changes in the patient's condition, or when there are deviations from the plan of care.
- d. He/she shall instruct other health team personnel and family members of patients in methods of assisting the patient to correct speech disabilities.
- e. Ensure HIPAA guidelines and procedures are maintained.

PHYSICAL REQUIREMENTS:

1. Able to speak, read and write in English.
2. Able read assignments, follow directions,
3. Able to communicate and respond clearly on telephone and respond to patient's spoken needs.
4. Able to spend 80% of the work standing and/or moving about.
5. Able to walk, climb stairs, stoop, twist, bend and squat to perform essential job functions.

MENTAL REQUIREMENTS:

1. Able to concentrate on detail with frequent interruptions.
2. Able to follow, complete and remember daily routines and requirements.
3. Able to comprehend and utilize professional education materials.
4. Able to cope with the mental and emotional stress of the position.

Administrator

Employee/Contractor

Date

ORIENTATION CHECKLIST: PROFESSIONAL STAFF

Employee Name: _____

I. GENERAL ORIENTATION

- _____ AGENCY ORGANIZATIONAL STRUCTURE
- _____ PHILOSOPHY, GOAL & OBJECTIVES, MISSION
- _____ TOUR OF FACILITY
 - a) LOCATION OF ADMINISTRATIVE OFFICES
 - b) LOCATION OF EMERGENCY LIGHTS/EXITS
 - c) LOCATION OF FIRE EXTINGUISHERS
 - d) LOCATION OF FIRST AIDE BOX
 - e) EMERGENCY EVACUATION ROUTES
- _____ INTRODUCTION TO STAFF/CLIENTS
- _____ SCOPE OF SERVICES
- _____ EMPLOYMENT POLICIES/JOB DESCRIPTION
- _____ COMPLAINTS POLICY/GRIEVANCE FORM
- _____ PAYROLL
- _____ CORPORATE COMPLIANCE PLAN

II. CLINICAL ORIENTATION

- _____ CLIENT RIGHTS AND RESPONSIBILITIES
- _____ ADMISSION/DISCHARGE CRITERIA/THERAPY SERVICES
- _____ MEDICAL EMERGENCIES
- _____ PSYCHIATRIC EMERGENCIES
- _____ DOCUMENTATION REQUIREMENTS/TIME FRAMES
- _____ CLINICAL RECORDS

III. CONFIDENTIALITY/HIPAA GUIDELINES

- _____ CLIENT/FAMILY/SIGNIFICANT OTHER
- _____ PROGRAM/STAFF
- _____ INFORMATION

IV. SAFETY/RISK MANAGEMENT/INFECTION CONTROL

- _____ ACCIDENTAL/INCIDENT REPORTING
- _____ OSHA
- _____ UNIVERSAL PRECAUTION
- _____ BIOHAZARDOUS/INFECTION WASTE
- _____ HIV UPDATE
- _____ TB UPDATE
- _____ EMERGENCY PREPAREDNESS
- _____ FIRE DRILL
- _____ CARE OF ENVIRONMENT

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION.

I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

EMPLOYEE SIGNATURE/TITLE

DATE

SPEECH THERAPY COMPETENCY (page 1)

Name: _____

| TASKS/BEHAVIORS COMPLETED | DATE PERFORMED OR COMPETENT | INITIALS OF EMPLOYEE OR CONTRACTOR | COMMENTS |
|---|-----------------------------------|--|----------|
| Referral process | | | |
| ASSESSMENT OF: | | | |
| Level of Function | | | |
| Physical Assessment | | | |
| Expressive Language | | | |
| Receptive Language | | | |
| Cognitive Language | | | |
| Articulation | | | |
| Oral Motor Exam | | | |
| Voice/Laryngeal | | | |
| Swallowing/Deglutition | | | |
| Appropriate development of the plan of care | | | |
| Coordination of care with appropriate disciplines | | | |
| Physician Notification | | | |
| Discharge plan discussed with patient on admission/Review of all Literature | | | |
| Communication with PCC/Case Manager | | | |

| TASKS/BEHAVIORS COMPLETED | DATE PERFORMED OR COMPETENT | INITIALS OF EMPLOYEE OR CONTRACTOR | COMMENTS |
|--|-----------------------------|------------------------------------|----------|
| Timely paperwork submission/review of Regulations | | | |
| Timely notification for patient visits/use of calendar | | | |
| All paperwork due by the last day of the month by 5pm or by 8:30 am the Monday after the last day of the month to process billing. | | | |
| Review of documentation/revisit | | | |
| Review of documentation admission | | | |
| Notification of patient of discharge 2 wks prior & document | | | |
| Evaluation for additional services | | | |
| COMMENTS | | | |

SIGNATURE OF ORIENTEE _____

SIGNATURE OF PRECEPTOR _____