



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 PHYSICAL THERAPIST

Employee Name: _____

This agency hereby approves that we shall hire and employ the services of a Physical Therapist, services indicated for functional limitations and deficits in safety, mobility, strength, and range of motion.

The following rules shall apply to the Physical Therapist to be employed by our agency:

1. He/she must be a graduate of an approved school for Physical Therapist.
2. He/she must be currently licensed and registered in this state.
3. He/she must have at least one year of experience in Physical Therapy.

Our agency hereby sets forth the following responsibilities for the Physical Therapist.

- A. He/she shall provide Physical Therapist services as prescribed by a Physician which can be safely provided in the home.
- B. He/she shall assist the Physician in evaluating patients by applying diagnostic and prognostic muscle, nerve, joint and functional abilities test.
- C. He/she shall provide Physical Therapy services.
- D. He/she shall observe and record activities and findings in the clinical record and report to the Physician the patient's reaction to treatment and any changes in the patient's condition, or when there are deviations from the plan of care.
- E. He/she shall instruct the patient and patient's family in the care and use of Physical Therapy devices.
- F. He/she shall instruct other health team personnel including, when appropriate, Home Health Aides and family members in certain phases of Physical Therapy with which they may work with the patient.
- G. He/she shall instruct the patient's family on the patient's total physical therapy program.
- H. Ensure HIPAA guidelines and procedures are maintained.

These responsibilities may be subject to change from time to time to reflect the prevailing state statutes.

Administrator

Date: _____

Employee

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

PHYSICAL 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			
Rehab. Program			
Home exercise program			
Patient/Family Education			
Therapeutic Exercises			
Transfer Training			
Gait training			
Balance training			
Pulmonary Physical therapy			
Prosthetic training			
Muscle re-education			
Discharge plan discussed with patient on admission/Review of all Literature			
Communication with PCC/Case Manager			
Timely paperwork submission/review of Regulations			

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Timely notification for patient visits/use of calendar			
All paperwork due by the last day of the 3 rd week by 5pm or by 9:00 am the Monday after the last day of the 3 rd week 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			

Home Care USA, Inc.

SIGNATURE OF ORIENTEE _____

SIGNATURE OF PRECEPTOR _____

